DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

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Behavioral Health Information Notice: 23-041
Supersedes BHIN 22-033

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: 2023 Network Certification Requirements for County Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Plans

PURPOSE: To expand and clarify network adequacy certification submission requirements for the FY 2023-24 certification period

REFERENCE: Title 42 Code of Federal Regulations (CFR) Part 438.68, 438.206, and 438.207; Welfare and Institutions Code (WIC) section 14197

BACKGROUND:
On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program Managed Care Final Rule (referred to as the "Managed Care Rule"), which aligns many of the Medicaid managed care regulations with requirements of other major sources of coverage. MHPs and DMC-ODS Plans, referred to in this document as Behavioral Health Plans (BHPs) when described collectively) are classified as Prepaid Inpatient Health Plans under federal law and must therefore comply with the Managed Care Rule (with some exceptions). The Managed Care Rule directs states to develop and enforce network adequacy standards that meet federal requirements. Most network adequacy standards are set forth in 42 CFR Parts 438.68, 438.206, and 438.207. WIC section 14197 includes time or distance and timely access standards and subdivision (j) of WIC section 14197 authorizes the

Department of Health Care Services (DHCS) to interpret and implement the standards of that section by information notice. Furthermore, WIC section 14184.102(d) authorizes DHCS to implement the CalAIM statutes, including continuing to implement the Specialty Mental Health Services (SMHS) program (WIC section 14184.400(a)) and the DMC-ODS (WIC section 14184.401(a)), by information notice.

Medi-Cal is the Medicaid health care program for California and the DHCS administers this program and its requirements, which includes all federal and state network adequacy standards.

POLICY:
DHCS is required by federal and state law to certify the adequacy of each BHP's network annually. DHCS shall submit an assurance to CMS that each BHP meets the State's requirements for the availability of services, on an annual basis and each time there has been a significant change in the BHP's operations. Each BHP's documentation serves as the basis for the State's assurance to CMS that the BHP is in compliance with the State's network adequacy standards. DHCS' submission to CMS shall also include an analysis that supports the assurance of the adequacy of each BHP's provider network.[1]

BHPs shall submit documentation and data to DHCS annually, and upon the request of DHCS, to demonstrate compliance with the State's standards for access to services, including network adequacy and timely access standards.[2] The documentation and data shall demonstrate compliance for adult and pediatric services separately.[3]

Documentation submitted to DHCS shall be submitted in a format specified by DHCS and shall demonstrate compliance with the following requirements: the BHP offers[4] an appropriate range of services that is adequate for the anticipated number of beneficiaries for the service area of the BHP; and the BHP maintains a network of providers operating within the scope of practice under State law that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the service area of the BHP.[4]

Network Data and Documentation Reporting Requirements:
DHCS is required to monitor BHPs' compliance with the network adequacy requirements set forth in WIC section 14197 and 42 CFR Part 438.68, 438.206, and

[1] 42 CFR Part 438.207(d)
[2] WIC section 14197(g)(1); 42 CFR Part 438.207.
[3] WIC section 14197(g)
[4] 42 CFR Part 438.207(b)

438.207 to ensure that all Medi-Cal managed care covered services are available and accessible to beneficiaries of the BHPs.

Per the MHP Contract, MHPs are required to provide, or arrange for the provision of, all SMHS covered in the MHP contract. Each MHP's network must include providers responsible for delivering all SMHS. Information regarding which network providers deliver which SMHS shall be reported in the Network Adequacy Certification Tool (NACT) Exhibit A-2 Site tab.

Per the DMC-ODS Intergovernmental Agreement (IA), DMC-ODS Plans are required to provide, or arrange for all DMC-ODS services covered under its IA with DHCS. Each DMC-ODS network must include providers responsible for delivering all DMC-ODS services. Information regarding which network providers deliver which services shall be reported in the NACT Exhibit A-2 Site tab.

In accordance with 42 CFR Part 438.68(c)(1), the standards specified in this BHIN take into consideration the following elements:

I. Network Capacity and Composition:
   a. MHP – Provider to Beneficiary Ratios;
   b. DMC-ODS – Availability of Services; and
   c. Additional Options to meet Provider and Capacity Requirements.
II. Time or Distance Standards.
III. Timely Access.
IV. Language Assistance Capabilities:
   a. Language Capacity; and
   b. Telephonic language Line Encounters.
V. Mandatory Provider Types:
   a. American Indian Health Facilities (AIHF);
   b. Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS) (MHPs only).
VI. Continuity of Care (CoC) and Transition of Care Reports:
   a. For additional information please see MHSUDS IN 18-059 (MHP) and MHSUDS IN 18-051 (DMC-ODS Plan).
VII. System infrastructure.
VIII. Non-Compliance with network adequacy standards.
IX. Network adequacy monitoring.

Plans shall submit the following attachments to demonstrate compliance with network adequacy standards:

- Attachment A.1 – MHP Network Adequacy Certification Tool (NACT)
- Attachment A.2 – DMC-ODS Plan NACT
- Attachment B – Time or Distance Standards
- Attachment C – Alternative Access Standard Request Template (by request)
- Attachment D.1 – Timely Access Data Tool (MHP)
- Attachment D.2 – Timely Access Data Tool (DMC-ODS Plan)
- Attachment E – Certification of Network Adequacy Data
- Attachment F – Continuity-Transition of Care Report Template
- Attachment G – Language Line Encounter Template
- Attachment H – Supplemental Data Tool (if applicable)
- Attachment I – Significant Change Attestation Template
- Attachment J – Significant Change Disclosure Form (if applicable)

BHP Submission Requirements:
For the FY 2023-24 network adequacy certification period, BHPs shall submit the NACT and all requested and necessary supporting documentation no later than November 1, 2023.

MHPs should submit the NACT and supporting documentation electronically by uploading them into the applicable Behavioral Health Information System (BHIS) folder. MHPs are to use the "DHCS-NAOS-MHP" root folder and navigate to the folder with the name of their county for documentation submission.

DMC-ODS Plans should submit the NACT and supporting documentation electronically by uploading them into the applicable Behavioral Health Information System (BHIS) folder. DMC-ODS Plans are to use the "DHCS-NAOS-DMC-ODS" root folder and navigate to the folder with the name of their county for documentation submission.

BHPs unable to complete their submission via BHIS shall contact DHCS at the NAOS@dhcs.ca.gov. DHCS shall provide the BHP with instructions for an alternative and secure documentation submission process.

When submitting files, BHPs shall use the naming convention (BHP Name)_(FY XXXX-XX)_(Program)_(Document_Name)_(Submission Date YYYY-MM-DD). Examples are as follows:

- Alameda_FY 2023-24_DMC-ODS_NACT_2023-11-01

- Napa_FY 2023-24_MHP_Language_Line_Attestation_2023-11-01

The NACT should be reported as point-in-time. DHCS defines point-in-time as a reference point in which the most current representation of the provider network is being reported by the BHP. The point-in-time is at each BHP's discretion.

BHPs are required to complete all exhibits in the NACT. Modifications to the NACT in a manner other than data entry, as requested, or as instructed by DHCS may result in a compromise of the integrity of the NACT. Any unauthorized changes to the NACT are prohibited and may result in findings of non-compliance with standards.

BHPs are required to submit supporting documentation, such as 1) Timely Access data, 2) Grievances and Appeals, 3) Language Line Encounters, and 4) CoC Requests, by November 1, 2023. For state FY 2023-24 the reporting period is July 1, 2022, through March 31, 2023.

All executed agreements with contracted network providers and subcontractors, as well as supporting documentation (including agreements pertaining to interpretation, language line, telehealth services, and reserve/staffing contracts), shall apply to the certification year (e.g., valid July 1, 2023, through June 30, 2024). For auto-renewing contracts that have expired or will expire during the certification period, the BHP shall submit an attestation on county letterhead that there are no known factors that could preclude the auto-renewal. All auto-renewing contracts shall include a distinct, clear auto-renewal clause.

When DHCS finds that a BHP is deficient in meeting one or more network standards, DHCS will require the BHP to engage in corrective action. The BHP shall develop a CAP for DHCS approval and shall submit supporting data and documentation as needed to demonstrate compliance with the CAP, including but not limited to an updated NACT to support network reassessment when applicable. DHCS review of CAP submissions will consider interventions the BHP has implemented, or plans to implement, to reach compliance with the standard(s) found deficient.

Submission requirements for the CAP and compliance reassessment process are as follows:

- For state FY 2023-24 – Due March 20, 2024:
  - CAP proposal
  - Initial reassessment data and/or supporting documentation as applicable (reporting period: April 1, 2023, through June 30, 2023).

- Dependent on the approved CAP, DHCS may require subsequent submission(s) of additional documentation to demonstrate CAP compliance.

Please note, the NACT is separate from the 274 standard and MHPs shall continue to submit data via the 274 standard as outlined in BHIN 22-032, which is the Electronic Data Interchange standard, in addition to the NACT. Upon DHCS' determination of the MHP's successful and accurate implementation of the data elements for the 274 standard, DHCS shall coordinate with the MHP to phase out the NACT and the 274 standard shall become the primary source for analysis. The NACT is required until DHCS informs the MHP, in writing, that the 274 standard is the primary source for analysis. MHPs are required to submit data using the 274 standard by the 10th of each month. For additional guidance, please see BHIN 22-032.

Forthcoming guidance will be issued regarding implementation of DMC-ODS 274 Provider Network Data Reporting. DMC-ODS Plans shall continue to submit data via the 274 standard as outlined in BHIN 23-042, which is the Electronic Data Interchange standard, in addition to the NACT until further guidance is provided by DHCS.

Certification of Network Adequacy Data and Documentation Submission:
The Director, Chief Administrative Officer, or equivalent positions shall certify the information submitted by the BHP in their county is accurate and complete. This certification shall be submitted with the NACT and supporting documentation.

Submission of the NACT and supporting documentation and the accompanying certification is a condition for receiving payment.[5]

Network Capacity and Composition:

a. MHP – Provider to Beneficiary Ratios

Each MHP shall maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to SMHS for all beneficiaries within their county, including those with limited English proficiency, or physical or mental disabilities.[6] MHPs shall meet or exceed network capacity requirements and proportionately adjust the number of network providers to support any anticipated changes in enrollment.

The process by which DHCS determines if a MHP meets or exceeds network capacity pertaining to outpatient SMHS and psychiatry services includes: 1) Provider Productivity Calculation, 2) Average Minutes Calculation, 3) Provider

[5] 42 CFR Part 438.600(b)
[6] 42 CFR Part 438.206(b)(1)

Ratio Calculation, 4) Anticipated Need for SMHS and Psychiatry Services, and 5) Evaluation of County Provider-Beneficiary Ratios.

Productivity Calculation
DHCS assumed that each full-time equivalent (FTE) provider can work a maximum of 2,080 hours (or 124,800 minutes) per year (assumptions: 52 weeks × 40 hours per week). DHCS assumed a 60% productivity rate (i.e., time spent on direct billable services) to determine the total productive minutes (i.e., 74,880) per state FY for each FTE SMHS provider. The 60% productivity rate was established after convening internal and external stakeholder meetings which confirmed that, on average, most providers spend about 60% of their time providing treatment services directly, while the remaining 40% is spent on administrative or other non-service-related professional activities (e.g., participation in meetings, professional events and conferences, etc.).

Average Minutes Calculation for Psychiatry Services
Using SMHS claims data (as claimed by all qualified providers listed in the California State Plan), DHCS calculated the average number of minutes claimed statewide for SMHS, parsed into adults and children/youth for the state FY 2020-21.

For psychiatry services, each MHP's medication support services were isolated into those only claimed under a psychiatrist, a neurologist, or a psychiatric mental health nurse practitioner (PMHNP) provider taxonomy code. Then the minutes were averaged for the state FY by county and age group. The averages were divided into quartiles representing all 56 county MHPs. Then, DHCS used the median value to stabilize the billing pattern variations across the counties. The percentage of medication support services billed by psychiatrists, neurologists, or PMHNPs for the adult beneficiary population was 51.6%. The median percentage of medication support services billed by psychiatrists, neurologists, or PMHNPs for the children/youth beneficiary population was 78.1%.

DHCS adjusted the statewide average of medication support services by these percentages to create a proportionate psychiatry provider ratio.

Provider Ratio Calculation
To calculate statewide ratios for mental health services, DHCS divided the total productive minutes per year by the total average SMHS service minutes billed for adults and/or children/youth.

To calculate statewide ratios for psychiatry services, DHCS divided the total productive minutes per year by the percentage of psychiatry-billed medication support minutes calculated (as described above). The results of the provider ratio calculation are presented in Table 1.[7]

Table 1. Provider-To-Beneficiary Ratio Standards

Measurement Category	Ratio Standard
Psychiatry – Adults	1:457
Psychiatry – Children/Youth	1:267
Mental Health Services – Adults	1:85
Mental Health Services – Children/Youth	1:49

Anticipated Need for SMHS and Psychiatry Services

DHCS determined the need for SMHS in each MHP's population based on the serious emotional disturbance (SED) in children/youth and serious mental illness (SMI) in adults' prevalence estimates calculated for the Bridge to Reform Waiver, developed by the Technical Assistance Collaborative (TAC) and the Human Services Research Institute (HSRI). The TAC and HSRI report is available at CA Bridge to Reform Waiver Services. While these estimates were published in 2013, they are the only available prevalence estimates specific to the SED/SMI population within Medi-Cal. However, DHCS compared prevalence estimates within the population and determined that prevalence rates do not vary greatly over time.

Using the Medi-Cal Eligibility Data System (MEDS), DHCS calculates the average number of individuals eligible to enroll in Medi-Cal in each county during the most recent state FY. DHCS then applies the SED and SMI prevalence estimates by age group to establish the proportion of beneficiaries likely to need SMHS. This adjusted Medi-Cal enrollment population represents the anticipated need for SMHS.

DHCS uses this same methodology to estimate the need for psychiatry services (i.e., services provided directly by a psychiatrist, neurologist, physician or PMHNP). However, to determine the estimated need for psychiatry services, DHCS further calculates the proportion of beneficiaries within the existing SMHS population who received psychiatry services as a part of the beneficiary's individualized treatment plan. DHCS determined that 67% of adults and 27% of

[7] FY 2020-21 Short-Doyle claims data.

children/youth receiving SMHS receive psychiatry services as a part of their treatment. Thus, to estimate the proportion of beneficiaries that may need psychiatry services, the estimated population needing SMHS was adjusted by these percentages, respectively.

Evaluation of County Provider-Beneficiary Ratios

DHCS calculates each MHP's current provider-to-beneficiary ratio using FTE provider counts (numerator) and the anticipated SMHS and psychiatry needs population (denominator). DHCS then evaluates the MHP's provider-to-beneficiary ratios to determine if the current provider network meets the statewide ratio requirement. For an example of this process, see the table below.

Table 2. County Provider Network Adequacy – Example Calculation

State FY 2020-21	Sum Average minutes	Provider productive minutes per year	Statewide ratio requirement	Example County Needs Population	Example County Provider FTE Reported	Example County Ratio	Example Findings
Mental Health Services – Children/Youth	1,536	74,880	74,880/1,536 = 1:49	6,000	70.2	Needs Population / FTE= 1:85	Deficient – Need to add 52.3 FTE
Mental Health Services – Adults	882	74,880	74,880/882 = 1:85	4,000	195.2	Needs Population / FTE = 1:20	Compliant

In the example above, for children/youth mental health services, the county has one FTE per 85 children/youth. This is evidenced by dividing 70.2 FTEs reported into the 6,000 beneficiaries in need of service. To determine how many FTEs are needed to serve 6,000 beneficiaries, divide 49 (required ratio) into 6,000, which equals 122.5 FTEs. By subtracting the reported FTEs (70.2) from the required FTEs (122.5), the deficiency in the example is 52.3 FTEs.

For MHPs utilizing tele-psychiatry and/or locums tenens contracts to meet the need for psychiatry services, DHCS calculates the estimated FTE value of the contracts. DHCS estimates FTEs by dividing the total state FY budget amount by the mean hourly (i.e., business hours) rate to determine the total number of hours allotted via the contract. DHCS will consider alternate proposals from MHPs for estimating FTEs on a case-by-case basis.

Calculating Full-Time Equivalents

A provider may be counted as one (1) FTE position if the individual's full-time job assignment is direct service delivery to Medi-Cal beneficiaries. In the case where an individual is assigned to direct service delivery on a part-time basis, the FTE should be calculated based on the percentage of time the individual could be dedicated to direct service delivery on an ongoing basis over the course of a year. An FTE position is 2,080 hours per year (i.e., 40 hours per week). FTE calculations shall not exceed 40 hours per week, including between service type(s) and age group(s) served. (Please see the section titled "Additional Options to Meet Provider and Capacity Requirements" for instructions on how a Plan may report provider time in excess of 40 hours per week).

Only direct providers of mental health services and psychiatry services should be included. For each rendering provider (an employee or contracted provider), the MHP should report the total FTEs available to directly provide mental health services including IHBS and psychiatry services as evidenced by the contract. Only time available to provide services in outpatient settings should be reported; MHPs should not report FTEs for providers who are only available to work in residential or inpatient settings. Providers who are available to work in both inpatient and outpatient settings can be counted, but their FTEs should be allocated based on time available for the outpatient setting only. For providers that serve more than one age group, the percentage of FTEs allotted to each age group by service type should be listed on a separate line.

Prior to state FY 2021-22, DHCS solely considered psychiatrists/neurologists when calculating psychiatry FTEs due to limitations on claims data for medication support services. After engaging in discussions with internal and external stakeholders, and based on feedback received, DHCS determined that physicians and PMHNPs will be allowed to be reported by MHPs as described below.

DHCS will evaluate compliance with psychiatry ratios using reported FTEs for psychiatrists/neurologists, PMHNPs, and physicians only. PMHNPs will fulfill

requirements for counties in psychiatry ratios as long as the PMHNP ratios do not exceed 4:1 PMHNP/psychiatrist. MHPs shall submit an attestation on county letterhead affirming the rendering provider is a PMHNP and the facility does not exceed the 4:1 PMHNP/psychiatrist ratio requirement.

For outpatient SMHS ratios, DHCS will count reported FTEs for all providers the MHP listed as available to provide outpatient SMHS, including IHBS. This also includes providers who are available to provide other service types in addition to outpatient SMHS. However, DHCS will not count providers who are available only for services other than outpatient SMHS. For example, if a provider is only available to provide targeted case management or crisis stabilization services, the provider should be reported accordingly by the MHP and will not be included in the outpatient SMHS ratio calculation.

For quality and validation purposes, DHCS makes the following adjustments to the data submitted in the NACT:

i. Remove FTEs for providers who were reported with an FTE greater than 100% across service settings and age groups (For further guidance on how to submit an attestation for providers who work over 100%, please see the "Additional Options to meet Provider and Capacity Requirements" section below)
ii. Remove FTEs for medication support services reported for providers that are not psychiatrists/neurologists, PMHNP, or physicians; and,
iii. Remove FTEs for SMHS providers who reported 100% FTE in the SMHS NACT (if no attestation is submitted) and are also reported on the NACT for a DMC-ODS Plan.

The MHP may request further explanation of DHCS about which FTEs were excluded by reaching out to NAOS@dhcs.ca.gov.

Administrative Staff
MHP administrative staff and/or members of leadership can only be included if they have capacity to serve clients on a regular and on-going basis. If an administrative staff employee is needed to function 100% in their administrative role (e.g., director, medical director, quality improvement manager) but could pick up a client on an emergency basis, the employee should not be included as they do not have regular capacity to serve clients. The FTE, if included, should

accurately reflect the amount of time the individual can actually be available to directly provide services to a beneficiary over the course of a year.

If counties report administrative staff, or other providers, as having ongoing caseloads of zero, they should include information with the submission that explains why the provider does not carry a regular caseload.

Reserve/Staffing Contracts
MHPs are permitted to use reserve/staffing contracts to meet network adequacy standards and/or as a basis for an Alternative Access Standard (AAS) request. Reserve/staffing providers shall meet the provider requirements for the applicable SMHS, be enrolled as providers in the Medi-Cal program and be able to comply with state and federal requirements for the Medi-Cal program.

In order to utilize reserve/staffing contracts to meet provider to beneficiary ratios, the provider shall be available to provide services to beneficiaries in the defined service area.

In addition, the physical location where beneficiaries receive services shall meet the State's time or distance standards or an approved AAS request.

If using reserve/staffing contracts to meet either network adequacy standards or an AAS, MHPs shall submit information to DHCS on their reserve/staffing providers during scheduled submission periods. This information should include a copy of the reserve contract, the name and National Provider Identifier (NPI) number of the contracting agency, and a statement from the county describing the number of FTEs that can be available under the contract maximum (if this is not explicit in the contract itself).

Submission Requirements for Residential Treatment Services, Psychiatric Health Facility Services and Inpatient Hospital Services (MHP Only)
For each provider of residential treatment services, psychiatric health facility services, and inpatient hospital services in an MHP's network, the MHP must provide either an invoice from the provider for state FY 2022-23, or an executed contract, covering the certification period through June 30, 2024.

All facilities in the MHP's network that provide Medi-Cal covered services to any age group must be included. This may include inpatient psychiatric settings that are designated as Institutions for Mental Disease but provide Medi-Cal reimbursable services for beneficiaries under 21 or over 65 years of age, as

applicable to the reporting MHP. Providers of both crisis residential treatment services and adult residential treatment services must be included. Providers located outside of an MHP's service area (i.e., county) that are in the MHP's network must be included.

This data is being collected for DHCS review only and counties will not be subject to new standards for inpatient/residential beds in the 2023 certification cycle.

b. DMC-ODS – Availability of Services

Each DMC-ODS Plan is required to provide a list of all network providers as part of their annual network adequacy certification submission. As part of its NACT submission, each DMC-ODS Plan is required to provide a list of all of its network providers and the maximum number of beneficiaries each provider can serve at any given time, separated by age group (i.e., 0-17, and 18+), and by service modality. For providers that serve more than one age group, the DMC-ODS Plan may adjust capacity by age group according to beneficiary needs. Thus (if there is not a specific maximum beneficiary count per age group established by contract) the DMC-ODS Plan should review utilization patterns and trends to determine the best way to allocate the maximum number of beneficiaries per age group.

DMC-ODS Plans shall enter the provider on separate lines in the NACT indicating each age group and maximum number of beneficiaries that the provider can serve. The proportion of maximum capacity allocated to each age group will be at the DMC-ODS Plan's discretion. Additionally, each DMC-ODS Plan is required to report whether each provider is accepting new beneficiaries.

For provider contracts which do not include a limit on the number of beneficiaries the provider can serve, the DMC-ODS Plan must determine and report the maximum number of beneficiaries the DMC-ODS Plan anticipates referring to the provider over the course of the certification period.

DMC-ODS Plans shall contract with a sufficient number of the appropriate types of providers to ensure the provision of all DMC-ODS services covered under its IA with DHCS.

Projected Utilization

DHCS' projected utilization methodology is based on monthly enrollment totals derived from MEDS. Utilizing two state FYs of Medi-Cal enrollment data (e.g., for this certification, DHCS is using state FY 2020-21 and state FY 2021-22), two

sets of projections are produced for each DMC-ODS Plan: one for children and youth (aged 0-17) and one for adults (aged 18 and over).

Monthly enrollment totals are forecasted through the certification period (e.g., for state FY 2023-24 certification the projection is through June 2024).

Utilizing the 2019 National Survey on Drug Use and Health (NSDUH) [8] combined SUD estimates, DHCS applied the percentage of those aged 0-17 (4.55%) and 18+ (9.23%) estimated to be in need of treatment services to the number of individuals eligible to enroll in Medi-Cal through June 2024 for each age group. DHCS then applied a percentage of 10 to the estimated beneficiaries in need of treatment services to estimate the number who will actually seek treatment. The 10% comes from 2018 Edition - Substance Use in California, found on the website of the California Health Care Foundation.

For further validation of expected utilization, DMC-ODS Plans are also required to provide projections of beneficiaries who will seek treatment through the certification period (for state FY 2023-24, this projection is to June 2024) as well as the number of beneficiaries per treatment modality.

Network Capacity
To determine the network capacity and sufficiency to serve the Medi-Cal population of a DMC-ODS Plan, DHCS:

i. Compares the expected utilization (as calculated and reported by DMC-ODS Plans) to the Seeking Treatment Estimate. The Seeking Treatment Estimate is a baseline estimate calculated by DHCS using MEDS data that is specific to each DMC-ODS Plan. It is expected that DMC-ODS Plans reported expected utilization must either meet or exceed this baseline estimate. This comparison results in either of the following 2 scenarios:

1. If the DMC-ODS Plan projects a higher number of beneficiaries expected to utilize services than the Seeking Treatment Estimate generated by DHCS, the DMC-ODS Plan's number is used to determine if the DMC-ODS Plan's network composition is sufficient.
    A. Sufficiency means the maximum number of beneficiaries

[8] Substance Abuse and Mental Health Administration sponsored research evaluates the use of illegal drugs, prescription drugs, alcohol, and tobacco and misuse of prescription drugs; SUDs and substance use treatment major depressive episode and depression care; serious psychological distress, mental illness, and mental health care using data from the National Survey on Drug Use and Health.

that can be served per treatment modality (as reported by the DMC-ODS Plan within the NACT) meets or exceeds the expected utilization.

2. If the DMC-ODS Plan's projections are lower than DHCS' Seeking Treatment Estimate, DHCS applies the percent difference to the DMC-ODS Plan's reported expected utilization (per treatment modality) to increase the estimate to meet or exceed DHCS' seeking treatment estimate. This new figure (new need estimate) is used to determine if the DMC-ODS Plan's network composition is sufficient.
    A. Sufficiency means the maximum number of beneficiaries that can be served per treatment modality (as reported within the NACT) meets or exceeds the new need estimate.

Additional Analysis of Residential Capacity:
Description of Length of Stay (LoS) Analysis:

In prior years, when determining residential capacity, DHCS' methodology only considered the total number of residential beds available to serve Medi-Cal beneficiaries as reported by DMC-ODS Plans and compared the total numbers of beds against the total number of beneficiaries a DMC-ODS Plan expected to serve over the course of a fiscal year. A DMC-ODS Plan could be found deficient when the DMC-ODS Plan's expected utilization exceeded the total number of beneficiaries the DMC-ODS Plan reported it can serve. DHCS' methodology did not take into consideration LoS or the number of times a residential bed could be utilized over the course of a fiscal year. Through stakeholder engagement, DHCS recognized each residential bed could serve multiple beneficiaries within a fiscal year. Therefore, DHCS has developed a methodology utilizing average LoS to determine residential capacity.

Application of LoS Analysis:

If the DMC-ODS Plan's reported point-in-time capacity to provide residential treatment services does not meet or exceed the DMC-ODS Plan's annual expected utilization, DHCS will consider average length of stay in the capacity analysis.

Utilizing the average LoS, DHCS will grow the bed capacity by the average LoS identified in the table below. After growing the bed capacity, DHCS will compare the reported expected utilization of the DMC-ODS Plan to the new bed capacity.

Table 3. Statewide Length of Stay

Age Group	Average # of Days Beneficiaries Stayed in Residential Treatment	Rate of Bed Turnover (365 days per year / Average # of Days Beneficiaries Stayed in Residential Treatment)
Adult	48	8
Youth	36	10

DHCS will not apply the above LoS analysis if the DMC-ODS Plan reports a significant change to the residential provider network and/or is experiencing a delay providing timely access to residential treatment services.

Additional Analysis of Monthly Utilization Data:

If DHCS finds that a DMC-ODS Plan is deficient in the initial network capacity analysis, DHCS also analyzes monthly utilization data as follows:

i. Utilizing the Attachment H – Supplemental Data Tool, the DMC-ODS Plan must report unique beneficiary counts per treatment category for the certification submission's state FY, organized by month and by age group. For validation purposes, DHCS compares this data to the claims data submitted by the DMC-ODS Plan. DHCS recognizes the DMC-ODS Plan may report greater monthly utilization counts than what is evident in the DHCS claims database due to lag in claims processing. However, the monthly utilization counts submitted in the Supplemental Data Tool should not be less than what is in DHCS' claims database. DHCS compares the expected utilization of the DMC-ODS Plan to the annual Seeking Treatment Estimate of DHCS, as discussed in the Network Capacity section above.

1. If the expected utilization of the DMC-ODS Plan is higher than the estimates of DHCS, DHCS uses the monthly utilization of the DMC-ODS Plan to project monthly utilization through the certification year. DHCS then determines sufficient capacity.

A. "Sufficiency" means the maximum number of beneficiaries that can be served per treatment modality (as reported within the

NACT) meets or exceeds the projected monthly utilization for each treatment modality and age group.

2. If the expected utilization of the DMC-ODS Plan is lower than the estimates of DHCS, DHCS uses the monthly utilization of the DMC-ODS Plan to project the monthly utilization through the certification year. DHCS then applies the percent difference between DHCS Seeking Treatment Estimate and the DMC-ODS Plan's expected utilization to the projection of monthly utilization through the certification year to grow it to the appropriate number. DHCS then determines sufficient capacity.

Please note – DMC-ODS Plans are not required to submit monthly utilization data with the annual submission but can submit at their own discretion. DMC-ODS Plans opting to submit monthly utilization data must use the Supplemental Data Tool. The Supplemental Data Tool submission date, and reporting period shall be:

- For state FY 2023-24: annual submission – November 1, 2023 (reporting period: calendar year 2022)

If a DMC-ODS Plan is found deficient in capacity and composition standards, the DMC-ODS Plan shall submit the Supplemental Data Tool as part of the CAP and compliance reassessment data submission on March 20, 2024. (If a DMC-ODS Plan submitted a Supplemental Data Tool at annual submission, an additional tool is not required as part of the reassessment data submission.)

DHCS may refine the methodology for capacity and composition determinations to include additional analyses as it determines necessary. DHCS will communicate any updates to the methodology to the DMC-ODS Plans.

Table 4. DMC-ODS, Estimated Need and the Seeking Treatment Estimate – Example Calculation

Projected Average Medi-Cal Enrollment Ages 0-17	Estimated Population in Need of SUD treatment Ages 0-17 (4.55%)	Estimated Population to Seek SUD treatment Ages 0-17 (10% of total in need)	Projected Average Medi-Cal Enrollment Ages 18+	Estimate in need of SUD treatment Ages 18+ (9.23%)	Estimated Population to Seek SUD treatment Ages 18+ (10% of total in need)
219,775	10,000	1000	1,262,626	116,540	11,654

Table 5a. DMC-ODS, Expected Utilization per Service Modality – Example Calculation

Comparison of DHCS vs. DMC-ODS Plan Estimates			
DHCS Total Expected Utilization (N) Seeking Treatment for the DMC-ODS Plan	DMC-ODS Plan's Actual Total Expected Utilization (N)	Difference	% Difference
1000	750	250	33.3%

DHCS' Seeking Treatment Estimate is used as a baseline that the DMC-ODS Plan must either meet or exceed. In the example above, the DMC-ODS Plan total expected utilization (which is reported in the NACT, exhibit C-1) is 750 beneficiaries, which is less than DHCS' Seeking Treatment Estimate of 1,000 beneficiaries in the children/youth age group (0-17) as shown in Table 5a.

Thus, DHCS calculates the numerical difference between the two estimates and then converts that difference into a percentage.

Table 5b(i). DMC-ODS, Expected Utilization per Service Modality for Outpatient Treatment – Example Calculation

Proportion Expected Utilization for Outpatient Treatment (n)	Applied % Difference	Adjusted Expected Utilization
350	117	467

Table 5b(ii). DMC-ODS, Expected Utilization per Service Modality for Intensive Outpatient Treatment (IOT) – Example Calculation

Proportion Expected Utilization for IOT (n)	Applied % Difference	Adjusted Expected Utilization
200	66	266

Table 5b(iii). DMC-ODS, Expected Utilization per Service Modality for Residential – Example Calculation

Proportion Expected Utilization for RES (n)	Applied % Difference	Adjusted Expected Utilization
150	50	200

Table 5b(iv). DMC-ODS, Expected Utilization per Service Modality for Opioid Treatment Programs (OTP) – Example Calculation

Proportion Expected Utilization for OTP (n)	Applied % Difference	Adjusted Expected Utilization
50	17	67

The percent difference is then applied to the DMC-ODS Plan's expected utilization broken out by service modality (also reported in the NACT, exhibit C-1) to grow those numbers proportionately (adjusted expected utilization) to meet DHCS' Seeking Treatment Estimate.

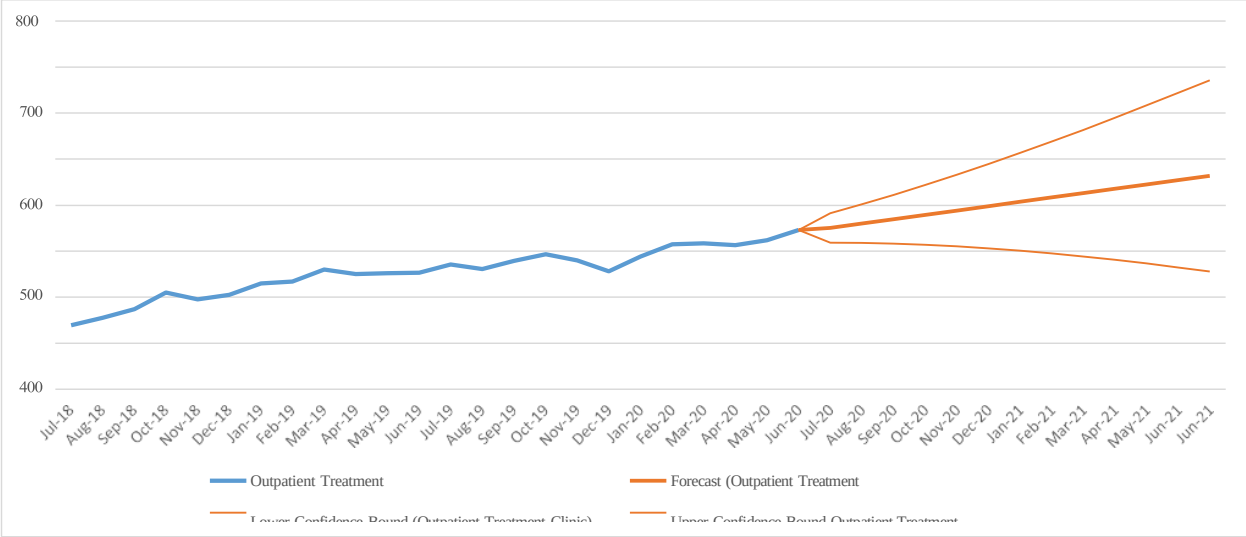
Table 6. DMC-ODS Plan Capacity and Composition Filter – Example

Row	Age Group(s) Served	Modality (DMC-ODS) - Outpatient Treatment Clinic	Modality (DMC-ODS) - Intensive Outpatient Clinic	Modality (DMC-ODS) - Residential	Modality (DMC-ODS) - OTP	Maximum Number of Medi-Cal Beneficiaries
1	18+	Yes	No	No	Yes	70
2	0-17	No	Yes	Yes	No	12
3	0-17	Yes	No	No	Yes	24
4	18+	Yes	No	No	Yes	30
5	18+	Yes	No	No	Yes	245
6	0-17	Yes	No	No	No	300
7	18+	Yes	No	No	Yes	250
8	18+	Yes	Yes	Yes	Yes	100
9	18+	No	Yes	Yes	Yes	59
10	0-17	Yes	No	No	Yes	25
11	0-17	Yes	No	No	Yes	19
12	18+	Yes	No	No	Yes	30
13	0-17	Yes	No	No	Yes	250

In the example above, DHCS filtered the NACT (Exhibit A-2, Site Level Data) by age group, provider type, and maximum number of beneficiaries served.

DHCS uses this filter to determine capacity to serve. For example, for youth (0-17) outpatient treatment services, DHCS can sum the maximum number of Medi-Cal beneficiaries for rows 3, 6, 10, 11, and 13 for a total of 618 maximum capacity. If the expected utilization for youth (0-17) outpatient treatment services, using the examples in Table 6, is 467 beneficiaries, the DMC-ODS Plan has sufficient capacity to meet expected utilization.

Figure 1. DMC-ODS Plan Monthly Utilization Data Projection – Example Projection



In the example above, DHCS uses two state FYs of monthly utilization data (reported by a DMC-ODS Plan, in Attachment H – DMC-ODS Supplemental Data Tool) to project utilization per month through the certification period.

DHCS may use this data to resolve the findings from the annual capacity analysis if DHCS finds a DMC-ODS Plan is noncompliant with capacity and composition standards.

DHCS calculates both annual and monthly estimates to determine the capacity of a DMC-ODS Plan, as there are many variables that affect the range between estimation and actual utilization. For instance, the annual estimation includes beneficiaries currently receiving DMC-ODS services and those that will be new to the system. Utilization data is helpful in understanding the pattern in which services are actually accessed in a DMC-ODS Plan. However, utilization data does not account for those that may have needed services but could not receive it (e.g., inadequate service capacity, obstacles to services, or variation in beneficiaries seeking services) or a growing population that could require services.

The monthly utilization is used as a mediator between the annual estimation and actual monthly utilization for the certification period and can be used to resolve deficiencies. However, DMC-ODS Plans are expected to continually grow the networks to achieve sufficient capacity to serve the annual Seeking Treatment Estimate figure as an eventual benchmark goal.

c. MHPs: Additional Options to meet Provider and Capacity Requirements

DHCS may grant requests for AAS for Capacity and Composition requirements. MHPs may submit an AAS request for Capacity and Composition to DHCS at any time, including at the time the MHP submits its annual certification data. If DHCS denies the request for an AAS it shall provide a written explanation for the denial.

i. DHCS will only consider FTE in excess of 40 hours per week through the AAS process. For Rendering Providers with FTEs in excess of 40 hours per week, MHPs shall not submit the provider's data in the NACT. Rather, MHPs may submit a narrative request (on county letterhead) listing the provider details and FTEs to be considered—including a breakout of FTEs per delivery system, provider service modality, and age group(s) served.
    1. To be considered, the MHP shall also provide an executed provider contract for each provider listed in the narrative and supporting documentation, such as a signed attestation from the MHP explaining the validity of the FTEs if the contract does not state this clearly. If the provider is directly employed by the MHP a contract is not required, however, the MHP must submit an attestation indicating the provider is a county employee.

Time or Distance:

42 CFR Part 438.68(b)(1) requires DHCS to develop quantitative network adequacy standards, such as time or distance standards, for adult and pediatric behavioral health providers. WIC Section 14197(b) and (c) set forth time or distance standards for California. Time means the number of minutes it takes a beneficiary to travel from the beneficiary's residence to the nearest provider site. Distance means the number of miles a beneficiary must travel from the beneficiary's residence to the nearest provider site. Both standards are based on a county's population, and Plans are required to meet either the time standard or distance standard. Time or distance standards for mental health services, psychiatry services, SUD outpatient treatment, and OTP services are specified in Attachment B – Time and Distance Standards.

a. Time or Distance Geographical Maps Methodology

DHCS assesses each BHP's time or distance compliance based on the provider data from the NACT for each of the of the BHP's service areas, for all zip codes, accounting for all current and anticipated beneficiaries.

DHCS prepares geographic access maps for BHPs using ArcGIS software. DHCS applies an enhancement within ArcGIS created by the Environmental Systems Research Institute (ESRI) to run the driving times or driving distances. ESRI utilizes the shortest driving time from each provider in a BHP's network to the address of the furthest Medi-Cal beneficiary in each zip code. The Department determines the beneficiaries to include in the calculation using the most current data available from the MEDS system.

DHCS plots time and distance of the geographic locations of all network providers stratified by service type for MHPs (psychiatry and outpatient SMHS) and service modalities for DMC-ODS Plans (outpatient services and OTPs), for both adult and children/youth separately based on the NACT.
BHPs may request a copy of the access maps by contacting the NAOS mailbox at NAOS@dhcs.ca.gov.

i. MHPs:

1. Exhibit A-3: Rendering Service Provider.
2. Exhibit B-1 (Field Based Services): only needed if field-based services are regularly delivered and are being used to meet time and distance standards.

ii. DMC-ODS Plans:

1. Exhibit A-2: Site

b. AAS – Time or Distance

The Managed Care Rule permits states to grant exceptions to the time or distance standards.[9] If a BHP cannot meet the time or distance standards set forth in this BHIN for all coverage areas where Medi-Cal eligibles reside, DHCS will notify the BHP to submit an Attachment C – AAS Request Template to DHCS within the appropriate timeframe (see

[9] 42 CFR Part 438.68(d)

AAS Validation section below for approval timelines).[10] For each coverage area for which the BHP does not meet the time or distance standards for a provider type, the BHP shall include a description of how the BHP intends to arrange for Medi-Cal beneficiaries who reside in that coverage area to access that provider type.[11] All BHPs are permitted to submit an AAS request with their annual certification package during the annual certification process.

c. Time or Distance AAS Request Template (Attachment – C)
DHCS may grant requests for AAS if the BHP has exhausted all other reasonable options to obtain providers to meet the applicable standard, or if DHCS determines that the BHP has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.[12] If DHCS denies the request for an AAS, it shall provide a written explanation for the denial.

Requests for an AAS will be approved or denied on a zip code and service type basis. Requests for AAS must include a description of the reasons justifying the AAS based on the facts and circumstances applicable to each zip code/service type for which an AAS is requested.[13] Requests may also include seasonal considerations (e.g., winter road conditions) when appropriate. Furthermore, BHPs should, as appropriate, include an explanation about gaps in the county's geographic service area, including information about uninhabitable terrain within the county (e.g., desert, forestland). In determining whether to grant a request, DHCS shall consider whether it is reasonable for a beneficiary to travel the time or distance that would result if DHCS granted the AAS.[14]

Attachment C details the submission requirements for AAS requests. In the AAS request template, a BHP must provide the nearest in-network provider as well as the driving time or distance to that provider from furthest beneficiaries' location in each zip code.

[10] WIC section 14197(f)(3)
[11] WIC section 14197(f)(4)
[12] WIC section 14197(f)(2)
[13] WIC section 14197(f)(4)
[14] WIC section 14197(f)(5)

Exhausted all other reasonable options to contract with providers to meet the applicable standard.
To demonstrate that it has made good-faith efforts to exhaust other reasonable options to obtain providers to meet the applicable standard a BHP must submit evidence of its Out-of-Network (OON) contracting efforts. For each OON provider that a Plan attempted to contract with, the BHP must provide the name of the OON provider, and the driving time/distance from the OON provider to the furthest eligible beneficiary(s) in that zip code; a description of its contracting efforts, including the frequency of the contracting efforts, and the reasons the Plan was unable to contract.

For each zip code/service-type for which a BHP requests an AAS, the BHP must attempt to contract with at least two OON providers.

Alternative Access Standard Validation
In Attachment C, BHPs must detail the name of the two nearest identified OON providers, the date the BHP contacted the providers to discuss contracting with the BHP, and the number of contracting attempts the BHP made. Through the AAS validation, DHCS will request evidence of contracting efforts, which must include documentation demonstrating contracting efforts such as correspondence (via email or letter), scheduled phone calls, notes from negotiations, draft (unexecuted) contracts, marketing materials and advertisements, and correspondence or other evidence of follow-up attempts after initial contract efforts or outreach.

If a BHP is unable to contract with a specific provider due to a quality-of-care issue, the BHP must submit supporting documentation detailing the BHP's concern with the provider's quality of care. A quality-of-care issue may include, but is not limited to, a provider having insufficient credentials or being suspended from participation in the Medi-Cal program by DHCS, CMS, or the Office of the Inspector General for Health and Human Services.

The evidence of contracting efforts shall reflect contracting efforts conducted since the BHP's last annual network adequacy certification submission. The supporting documentation submitted shall be dated prior to the AAS request in question taking effect.

DHCS approves or denies an AAS request on a zip code/ service type basis.[15] The review process includes 1) verifying the AAS Request is submitted on time, 2) verifying if the AAS request is complete, and 3) verifying the BHP's efforts to identify the nearest in-network and OON providers.

Additionally, DHCS compares the identified providers submitted by the BHP to the NACT and to other resources.

DHCS reviews the AAS request and all supporting documentation to assess the facts and circumstances provided by the BHP. BHPs shall maintain documentation of their efforts to contract with the nearest OON providers and must provide all documentation to DHCS upon request. DHCS may request additional evidence of contracting efforts if DHCS identifies more than two nearer OON providers during the review process.

The use of clinically appropriate telehealth may be considered in determining compliance with the applicable standards and/or for the purpose of approving an AAS request.[16] However, BHPs cannot require a beneficiary to access services via telehealth only, per BHIN 23-018. BHPs shall inform the beneficiary about options for accessing covered non-emergency medical transportation to an in-network provider within time or distance and timely access standards for medically necessary services, when an in-person visit is requested by a beneficiary.

On an annual basis and at DHCS' request, the BHP shall demonstrate how it arranges for the delivery of services such as Medi-Cal covered transportation or telehealth, if beneficiaries needed services from a provider or facility located outside of the time or distance standards specified in WIC section 14197(c).[17]

DHCS will approve or deny an AAS request within 90 days of submission by the BHP. DHCS may stop the 90-day timeframe on one or more occasions, as necessary, in the event of an incomplete submission, or to obtain additional information from the BHP requesting

[15] WIC section 14197(f)(3)
[16] WIC section 14197(e), (f)(1), (6)
[17] WIC section 14197(g)(1), (2)

the AAS.[18] Upon submission of sufficient additional information to the department, the 90-day timeframe shall resume where previously stopped, except if there is less than 30 days remaining in which case the department shall approve or deny the request within 30 days of submission of sufficient additional information.[19] Upon notification by DHCS, an approved AAS will be valid for three years.[20] DHCS will annually reassess a BHP's compliance with time or distance standards and provide the BHP with updates for zip codes that are deficient, by age group and provider type, that are not part of the approved three-year AAS. If a zip code is identified as being deficient during the three-year period, the BHP will be required to submit a revised AAS for the newly identified zip code(s) and services type. DHCS will monitor beneficiary access to the service type covered by the AAS on an on-going basis and report DHCS' findings to CMS.[21]

For all approved AAS requests, DHCS will monitor beneficiary access to the service type covered by the AAS request on an on-going basis and report DHCS' findings to CMS. If DHCS rejects a request for AAS, DHCS shall inform the BHP of the reason for rejecting the request. DHCS will post approved AAS requests on the DHCS website.[22]

d. Additional Options to Meet Time or Distance Standards Field Based Services

SMHS and DMC-ODS services are to be provided in the least restrictive setting, consistent with the goals of recovery and resiliency. DHCS will consider providers traveling to the beneficiary or a field-based setting to deliver services in its time or distance methodology. For services where the provider travels to the beneficiary to deliver services, the BHP must ensure services are provided in a timely manner.

[18] WIC section 14197(f)(4)
[19] WIC section 14197(f)(4)
[20] WIC section 14197(f)(3)(C)
[21] 42 CFR Part 438.66(e) requires DHCS to submit a report to CMS annually on each managed care program the Department administers. 42 CFR Part 438.68(d)(2) and 438.66(e)(2)(vi) require the Department to include the results of the monitoring in that report.
[22] WIC section 14197(e)(3)

i. MHP Only

MHPs requesting to use field-based providers to meet the time or distance standards must submit information to DHCS on the availability and provision of field-based or mobile services on the Attachment A.1 – MHP NACT: Exhibit A-3. – Rendering Service Provider tab, and Exhibit B-1. – Field Based Services tab. MHPs should include in the B-1. tab fixed-location community settings (e.g., school, community center) or field-based, mobile services (e.g., mobile units, satellite sites, community centers) used to deliver services to beneficiaries in community-based settings, not the home of the beneficiary.

ii. DMC-ODS Only

DMC-ODS plans requesting to use field-based providers to meet the time or distance standards shall submit information to DHCS on the availability of providers who will travel to deliver services on the Attachment A.2, Exhibit A-3. – Rendering Service Provider tab.

Telehealth Services

BHPs are permitted to use the synchronous mode of telehealth services to meet network adequacy standards, and/or as a basis for an AAS request.[23] However, 85% of beneficiaries must reside within the required time and distance standards for provider types by zip code. For example, if 100 Medi-Cal beneficiaries reside in zip code 95814, 85 of those beneficiaries must have an on-site provider available within time and distance standards.

Although DHCS proposes that telehealth will be permitted to meet time or distance standards, all members have the right to an in-person appointment. Telehealth can only be provided when medically appropriate, as determined by the provider and as allowed by the applicable delivery systems' provider manual. For further information regarding telehealth requirements, please reference BHIN 23-018.

In accordance with the terms and conditions of either the Intergovernmental Agreement with DHCS or the MHP contract, BHPs must coordinate transportation with the local Managed Care Plan (MCP) for a beneficiary to a network provider and meet timely access standards for medically necessary services when a beneficiary is

[23] WIC, section 14197(f)(6).

offered a telehealth visit but requests an in-person visit. If a BHP is unable to arrange for an in-person visit with a network provider, the BHP must authorize OON services and coordinate transportation with the local MCP for the beneficiary to travel to the appointment as needed. Telehealth services must comply with BHIN 23-018 and DHCS' Medi-Cal Provider Manual telehealth policy.[24]

In order to utilize telehealth to fulfill network adequacy requirements for time or distance standards, telehealth services must be provided to beneficiaries in the defined service area. In addition, the physical location where beneficiaries receive telehealth services must meet the State's time or distance standards or approved AAS.

If using telehealth to meet either network adequacy standards or AAS, BHPs must submit information to DHCS on their telehealth providers. However, BHPs cannot require a beneficiary to access services via telehealth only.[25] BHPs must inform the beneficiary about options for accessing covered non-emergency medical transportation to a provider within time or distance and timely access standards for services, when an in-person visit is requested by a beneficiary.

Telehealth providers for BHPs must be included in the NACT, in the appropriate exhibit, as follows:

i. MHPs:

1. Exhibit A-3: Rendering Provider

ii. DMC-ODS Plans:

1. Exhibit A-3: Rendering Provider

Timely Access:

42 CFR Part 438.206(c)(1), Availability of Services, requires BHPs to meet State standards for timely access to care and services, taking into account the urgency of the need for services. WIC section 14197 (d) sets forth timely access standards for MHPs and DMC-ODS Plans; it requires them to comply with the appointment time standards set forth in Health and Safety Code (HSC) section 1367.03 and Title 28, California Code of Regulations (CCR), section 1300.67.2.2. The specific appointment time

[24] WIC, section 14197(e)(4); Medi-Cal Provider Manual. "Medicine: Telehealth."
[25] WIC section 14197(f)(6); Business and Professions Code section 2290.5(b)

standards for which the Department is currently collecting data are set forth in the Timely Access Data Tool (TADT) Attachments D.1 (MHP) and D.2 (DMC-ODS).

a. Timely Access Data Tool (TADT): Attachment – D.1 and D.2

To ensure that BHPs provide timely access to services, DHCS requires each BHP to have a system in place for tracking and measuring timeliness of care, which includes the timeliness to receive the first SMHS appointment, or DMC-ODS appointment, and timeliness of the first follow-up appointment for beneficiaries who begin treatment while waiting or are in the process of completing a clinical assessment. For this purpose, DHCS developed the TADT, a uniform data collection tool. Effective at the time of this publication, data submissions to the DHCS Client and Services Information (CSI) Assessment Record requirement is superseded and no longer required.

Reporting Requirements

Annual 2023 submission: BHPs must use the TADT for new beneficiaries who request SMHS, any new or established beneficiary requests for psychiatric services, or new beneficiaries requesting DMC-ODS services during the reporting period. The reporting period is July 1, 2022, through March 31, 2023.

March 2024 CAP and compliance reassessment data submission: BHPs must use the TADT for new beneficiaries who request services during the reporting period. The reporting period is April 1, 2023, through June 30, 2023. BHPs must use the TADT to submit timely access data for new beneficiaries who request services during the reporting period.

Beginning with FY 2023-24, BHPs must report on the timeliness of care for OON providers if the BHP is unable to arrange for an appointment for a beneficiary with a network provider that meets the timely access standard. For additional information, please reference BHIN 21-008 for MHPs and MHSUDS IN 19-024 for DMC-ODS Plans.

b. Methodology for Determining BHP Compliance with Timely Access Standards

DHCS calculates compliance using the Date of First Contact to Request of Services and the number of business days between that date and the date of the first available appointment that qualifies as a

billable service. For example, if a beneficiary requests an initial appointment for an outpatient SMHS service or an outpatient DMC-ODS service on the first of the month and is offered an appointment on the 11th of the month, the BHP would be considered to have met the 10-business day standard. For a BHP to be in compliance with timely access standards, 80% of beneficiaries must have been offered an appointment within the applicable time frame.

Timely Access Standards for MHPs

Service Type	Standard*
Outpatient Non-Urgent Non-Psychiatric Specialty Mental Health Services	Offered an appointment within 10 business days of request for services.
Psychiatric Services	Offered an appointment within 15 business days of request for services.
All SMHS Urgent Appointments	Urgent:** 48 hours without prior authorization. 96 hours with prior authorization.
Non-urgent Follow-up Appointments	Offered a follow-up appointment with a non-physician within 10 business days of the prior appointment.[26]
*The above standards are applicable, unless otherwise provided in 28 CCR section1300.67.2.2(c)(5)(G) and (H) ** DHCS defines urgent as: When the beneficiary's condition is such that they faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the beneficiary's life or health or could jeopardize their ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours.[27]	

[26] HCS section 1357.03 (a)(5)(F), (H)
[27] 28 CCR section 1300.67.2.2 (b)(7); HSC section 1367.01 (h)(2)

Timely Access Standards for DMC-ODS Plans

Modality Type	Standard
Outpatient Services – Outpatient Substance Use Disorder Services	Offered an appointment within 10 business days of request for services.
Residential	Offered an appointment within 10 business days of request for services.
Opioid Treatment Program*	Within three business days of request
Non-urgent Follow-up Appointments with a Non-Physician	Offered an appointment within 10 business days of the request for services.[28]
*For OTP patients, the OTP standards apply equally to both buprenorphine and methadone where applicable. Buprenorphine is not specified in several areas of the current regulations, so we default to the federal regulations. (For example, with take-home medication, time in treatment requirements are not applicable to buprenorphine patients.) DHCS defines urgent as: When the beneficiary's condition is such that they faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the beneficiary's life or health or could jeopardize their ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours.[29]	

All entries submitted in the TADT shall be for new beneficiaries only. The definition of what constitutes a new beneficiary is at the discretion of the BHP. The data will be used to determine compliance with timely access standards.

Furthermore, if the BHP is determined not to meet network adequacy requirements and the provider network is unable to provide timely access to necessary services, the BHP shall adequately and timely cover these services OON for the beneficiary. The BHP must permit OON access for as long as the BHP's provider network is unable to

[28] HSC section 1357.03 (a)(5)(F), (H)
[29] 28 CCR section 1300.67.2.2 (b)(7); HSC section 1367.01 (h)(2)

provide the services in accordance with the standards. For further guidance please see BHIN 21-008 and MHSUDS IN 19-024.

MHPs are required to submit timely access data for:

i. An urgent or non-urgent appointment with a non-physician mental health care provider of an outpatient SMHS;[30]
ii. An urgent or a non-urgent appointment with a provider of psychiatry.
iii. Non-urgent follow-up appointments with a non-physician mental health care provider; and,
iv. OON provider referrals.

DMC-ODS Plans are required submit timely access data for:

i. Outpatient SUD services.
ii. Residential treatment.
iii. OTP.
iv. Non-urgent follow-up appointments with a non-physician SUD provider; and,
v. OON provider referrals

Language Assistance Capabilities:
BHPs shall submit to DHCS subcontracts with interpreters for interpretation and language line services. In addition, BHPs are required to report, in the BHP's provider directory[31] and in the NACT, the cultural and linguistic capabilities of network providers, including languages offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.

a. Language Capacity
BHPs are required to maintain and monitor a network of providers that is supported by written agreements and is sufficient to provide adequate access to all covered services for all beneficiaries, including those with Limited English Proficiency (LEP).[32] BHPs are also required to make oral interpretation and auxiliary aids, such as TTY/TDY and American Sign Language (ASL), available to beneficiaries, free of charge, for any language.[33]

[30] HSC section 1367.03(a)(5); BHIN 22-016
[31] 42 CFR Part 438.10(h)(1)(vii)
[32] WIC section 14197(d)(1)(A); Title 28, CCR section 1300.67.2.2(c)(5)(D)
[33] 42 CFR Part 438.10(h)(1)(vii)

i. While DHCS does not require a fixed number of language subcontracts from BHPs, regardless of quantity, the BHP's language assistance subcontracts shall cover—whether within a singular contract or several—the following types of language assistance services at a minimum:
    1. Oral Interpretation – services offered for spoken language processed in real time, whether in-person, via video call, phone, or other medium.
    2. Written Translation – services offered for written language content, often processed separately from the time of the request for assistive language services.
    3. ASL – services offered for a spoken language processed in real time, whether in-person or via video call.

b. Language Line Encounters Report

BHPs shall submit a report detailing language service encounters. The report shall detail the utilization of language line interpretation services to provide language access to beneficiaries in non-English languages. For each of the following, BHPs must report, by language, the total number of encounters for which the language line services were requested:

i. 24/7 access line encounters.
ii. Face-to-face service encounters; and
iii. Other telehealth service encounters.

BHPs shall submit a report of language line encounters. DHCS has developed a standardized tool for collecting such encounters: Attachment G – Language Line Encounter Template. To submit language line encounters (LLE), BHPs shall complete the Attachment G and provide all required encounter information from July 1 through March 31 on an annual basis.

BHPs shall submit through the BHIS folder. MHPs are to use the "DHCS-NAOS-MHP" root folder and navigate to the folder with the name of their county for documentation submission. DMC-ODS Plans are to use the "DHCS-NAOS-DMC-ODS" root folder and navigate to the folder with the name of their county for documentation submission.

If the BHP did not have any language line encounter requests for the reporting period, please enter "No service requests were received during this reporting period" in the report.

Mandatory Provider Types:
BHPs shall demonstrate compliance with federal regulations addressing protections for American Indians and American Indian Health Services provided within a managed care system (42 CFR Part 438.14).

a. American Indian Health Facilities
American Indians and American Indian Health Facilities (AIHFs) are not required to contract with BHPs; however, BHPs shall document good-faith efforts to contract with all AIHFs in the BHP's service area (i.e., county). If a BHP does not have a contract with any of the AIHFs in the BHP's County, the BHP shall submit an explanation to DHCS that includes supporting documentation, to justify the absence of the mandatory provider type in the BHP's network. Please see Attachment – A NACT:

i. MHP NACT – Attachment – A.1
   1. Exhibit B-2

ii. DMC-ODS NACT – Attachment – A.2
   1. Exhibit B-1

DHCS will review the Plan's submission to determine compliance.

b. Mandatory Provider Type – ICC and IHBS Providers (MHP Only)
Per the MHP Contract,[34] MHPs are required to provide, or arrange for the provision of, all covered SMHS, including ICC, and IHBS. Each MHP's network must include providers responsible for delivering ICC and IHBS. ICC and IHBS providers should be included in NACT Exhibit A-3.

Continuity of Care and Transition of Care Reports:
Per MHSUDS IN 18-059 (MHP) and MHSUDS IN 18-051 (DMC-ODS Plan), BHPs are required to report to DHCS all continuity of care (CoC) and transition of care (ToC) requests. DHCS has developed a standardized tool for collecting CoC and ToC requests (see Attachment F – Continuity-Transition of Care Report Template). It is

[34] MHP Contract, Att. 11, section 3, E.

mandatory for Plans to submit their CoC/ToC data utilizing the Attachment F report template.

This data is considered Protected Health Information and must be submitted using the Secure Data Portal BHIS. Submission of the report by email or through another method will constitute a breach of the federal privacy rules and DHCS will report it to the DHCS Privacy Office as a breach.

If the BHP does not have any data to report for any of the data requirements during the reporting period, the BHP can submit a statement on county letterhead, or on the report template, stating "No service request for the reporting period."

System Infrastructure:
Each BHP shall also submit the following additional supporting documentation on an annual basis unless noted otherwise:

a. Grievance and Appeals

BHPs are required to submit qualitative data regarding grievances and appeals, including complaints, related to the following:

i. Services not available,
ii. Services not accessible,
iii. Timeliness of services,
iv. 24/7 Toll-free access line,
v. Linguistic services,
vi. Other access issues,
vii. Authorization delay notices, and/or
viii. Timely access notices.

The BHP's submission shall include a copy of the initial grievance, appeal, or complaint; the acknowledgement of receipt of each grievance, appeal, or complaint; any information gathered and used in determining the outcome of the grievance, appeal, or complaint; and the written notice of the resolution of the grievance, appeal, or complaint. The reporting period for the 2023 Certification Period is July 1, 2022, through March 31, 2023. If a BHP did not receive any grievances or appeals during the reporting period, the BHP shall include an attestation indicating that no grievances or appeals were received during the reporting period.

b. Organizational Provider Contract Submission Requirements

In order to streamline the validation process of network provider contracts, DHCS will send a pre-populated list of the provider contracts required for validation purposes to each BHP following BHP submission and DHCS review of the NACT. BHPs will have a minimum of 10 business days to submit the required contracts. Each list compiled by DHCS will be reflective of each BHP's designated sample size of provider contracts.

Sample size requirements are detailed in Tables 7 and 8.

Table 7a. DMC-ODS Service Provider Contract Submission Requirements

County Size	Outpatient Treatment Adult and Youth, IOT Adult and Youth, and OTP Adult and Youth	Residential *Adult and Youth*
Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, Tuolumne ***Per WIC section 14197(c)(4)(A)(iii)*	DHCS will request between 3-5 contracts to cover an array of services for state FY 2023-24.	Please submit all current contracts.
Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa, Barbara, Sutter, Tulare, Yolo, Yuba ***Per WIC section 14197(c)(4)(A)(iii)*	DHCS will request between 6-10 contracts to cover an array of services for state FY 2023-24.	Please submit all current contracts.

Table 7b. DMC-ODS Service Provider Contract Submission Requirements

County Size	Outpatient Treatment Adult and Youth, IOT Adult and Youth, and OTP Adult and Youth	Residential *Adult and Youth*
Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, Ventura ***Per WIC section 14197(c)(4)(A)(ii)*	DHCS will request between 11-15 contracts which cover an array of services for state FY 2023-24.	DHCS will request three contracts
Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, Santa Clara ***Per WIC section 14197(c)(4)(A)(i)*	DHCS will request between 16-20 contracts which cover an array of services for state FY 2023-24.	DHCS will request three contracts
**WIC section 14197(a) It is the intent of the Legislature that the department implement and monitor compliance with the time and distance requirements set forth in 42 CFR Parts 438.68, 438.206, and 438.207 and this section, to ensure that all Medi-Cal managed care covered services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as those standards were enacted in May 2016.		

Table 8a. MHP Service Provider Contract Submission Requirements

County Size	Psychiatry and SMHS**	ICC	IHBS
Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, Tuolumne ***Per WIC section 14197(c)(3)(D)*	DHCS will request between 3-5 contracts to cover an array of services (psychiatry and outpatient services) for state FY 2023-24.	DHCS will request at least one ICC contract.	DHCS will request at least one IHBS contract
Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa, Barbara, Sutter, Tulare, Yolo, Yuba ***Per WIC section 14197(c)(3)(C)*	DHCS will request between 6-10 contracts which cover an array of services (psychiatry and outpatient services) for state FY 2023-24.	DHCS will request at least one ICC contract.	DHCS will request at least one IHBS contract

Table 8b. MHP Service Provider Contract Submission Requirements*

County Size	Psychiatry and SMHS**	ICC	IHBS
Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, Ventura ***Per WIC section 14197(c)(3)(B)*	DHCS will request between 11-15 contracts which cover an array of services (psychiatry and outpatient services) for state FY 2023-24.	DHCS will request at least one ICC contract.	DHCS will request at least one IHBS contract.
Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, Santa Clara ***Per WIC section 14197(c)(3)(A)*	DHCS will request between 16-20* contracts which cover an array of services (psychiatry and outpatient services) for state FY 2023-24. *If the MHP has fewer than 16 contracts the MHP shall submit all contracts.	DHCS will request at least one ICC contract.	DHCS will request at least one IHBS contract.

*A single contract *may be sufficient to* adequately satisfy the requirement if the contract covers more than one service type and/or age group.

**WIC section 14197(a) It is the intent of the Legislature that the department implement and monitor compliance with the time and distance requirements set forth in 42 CFR Parts 438.68, 438.206, and 438.207 and this section, to ensure that all Medi-Cal managed care covered services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as those standards were enacted in May 2016.

For auto-renewing contracts that have expired or will expire during the certification period, the BHP must submit an attestation on county letterhead that there are no known factors that preclude the auto renewal. All auto-renewing contracts must include language pertaining to the auto-renewal.

Note: The contract terms and conditions must align with data reported in the NACT Exhibit A-2: Site. DHCS may request additional contracts during the annual network adequacy certification process.

c. Policies and procedures addressing the following topics:

- Network adequacy monitoring - submit policies and procedures related to the BHP's procedures for monitoring compliance with the network adequacy standards;
- OON access - submit policies and procedures related to beneficiary access to OON providers;
- Timely access - submit policies and procedures addressing appointment time standards and timely access requirements;
- Service availability - submit policies and procedures addressing requirements for appointment scheduling, routine specialty (e.g., psychiatry) referrals, and access to medically necessary services 24/7;
- Physical accessibility - submit policies and procedures regarding access for beneficiaries with disabilities pursuant to the Americans with Disabilities Act of 1990;
- Telehealth services - submit policies and procedures regarding use of telehealth services to deliver covered services;
- 24/7 Access Line requirements - submit policies and procedures regarding requirements for the MHP's 24/7 Access Line; and,
- 24/7 language assistance - submit policies and procedures for the provision of 24-hour interpreter services at all provider sites.

If any of the required policies and procedures have not been updated since the last time, they were submitted to DHCS, the BHP may submit a statement listing those policies and procedures that remain the same as the version on file.

Non-Compliance with Network Adequacy Standards:
DHCS must certify the adequacy of every BHP's provider network to CMS on an annual basis. DHCS has the authority, in accordance with WIC section 14197.7, to sanction BHPs that are out-of-compliance with the submission requirements, including completeness, accuracy, and timeliness or lack of submission.

If DHCS determines that a BHP does not meet the network adequacy standards, or a DHCS approved AAS, the BHP will be required to submit a CAP to DHCS demonstrating steps the BHP will take to come into compliance with the standards and may be subject to immediate monetary sanctions. DHCS will monitor the BHP's corrective actions and require updated information from the BHP on a monthly basis until the BHP meets the applicable standards.

If the BHP is not making satisfactory progress toward resolving their CAP or coming into compliance with applicable standards, DHCS may impose monetary sanctions.

DHCS may impose sanctions on BHPs pursuant to subdivisions (e) and (f) of WIC section 14197.7. The bases for imposition of administrative and/or monetary sanctions include, but are not limited to, the following:

- Failure to comply with network adequacy standards, including, but not limited to, time or distance, timely access, and provider to beneficiary ratio requirements pursuant to standards and formulae that are set forth in federal or state law, regulation, state plan or contract, and that are posted in advance to DHCS' internet website.[35]
- Failure to demonstrate that the BHP has an adequate network to meet anticipated utilization.[36]
- Failure to submit timely and accurate network provider data.[37]

For further information regarding sanctions for BHPs, please see BHIN 22-045.

Furthermore, if the BHP is determined not to meet network adequacy requirements because the provider network is deficient in capacity and composition or is unable to provide timely access to necessary services, including meeting the applicable time and distance standards or an approved AAS request, the BHP shall adequately and timely cover these services OON for the beneficiary. The BHP shall permit OON access for as long as the BHP's provider network is unable to provide the services in accordance with the standards. For additional guidance on OON providers, please see BHIN 21-008 for MHPs and MHSUDS IN 19-024 for DMC-ODS Plans.

[35] WIC section 14197.7(e)(6)
[36] WIC section 14197.7(e)(5)
[37] WIC section 14197.7(e)(8)

Network Adequacy Monitoring:
Significant Change to Network

Each BHP shall submit data and documentation any time there has been a change in the BHP's operations that would affect the adequacy and capacity of services. DHCS defines a significant change in the network of a BHP as any of the following:

- any decrease of the provider network, or a specific providers capacity to serve in a service type/modality, and/or demographic;
- Changes in the composition of, or payments to the plan's provider network;
- a change in benefits;
- a change in geographic service area;
- enrollment of a new population, or;
- any significant change to the BHP's operations that would cause the BHP to become noncompliant with any of the requirements outlined in this BHIN.

A significant change may occur because of contract terminations, suspensions, or the decertification of a network provider or subcontractor. Additionally, any decrease in administrative staffing of a BHP that significantly impacts the BHPs operations and would cause the BHP to be out of compliance with any of the requirements outlined in this BHIN, is considered a significant change.

For example, a decrease in services may occur as a result of a provider reducing the number or types of services offered at a provider site (e.g., a DMC-ODS service provider no longer offers IOT services, or a SMHS provider reduces the number of days the site offers Day Rehabilitative services).

Significant Change Disclosure Form

BHPs must use the Attachment J – Significant Change Disclosure Form to notify DHCS of any significant changes, as defined in the section "Significant Change to Network" above within 10 business days of the change. The Significant Change Disclosure Form must be emailed to NAOS@dhcs.ca.gov.

Upon notification of a significant change, DHCS will communicate with the BHP regarding next steps. BHPs found out of compliance with these requirements are subject to administrative and/or monetary sanctions as specified in BHIN 22-045.

Annual Attestation Reporting Requirement
If a BHP does not report a significant change to its network pursuant to the two immediately preceding paragraphs during the attestation period listed below, the BHP must attest to DHCS there are no significant changes to their network annually. The attestation due date and reporting period are as provided in Table 9, below:

Table 9. Annual Attestation Due Date

Submission Due Date	Attestation Period
March 20, 2024	January 1, 2023, to December 31, 2023

BHPs must utilize the Attachment I – Significant Change Attestation template to report that there have been no significant changes to their provider network during the attestation period. Failure to submit the attestation each fiscal year may result in sanctions as specified in BHIN 22-045.

Beginning with state FY 2024-25, if there has been a significant decrease in a BHP's provider network, DHCS will require the BHP to adhere to an Enhanced CAP Monitoring, which includes, but is not limited to, additional technical assistance and more frequent contact.

DHCS will monitor compliance with network adequacy standards on an ongoing basis. Network adequacy monitoring activities include, but are not limited to, the following:

- Annual NACT data submissions for BHPs;
- Triennial reviews of each MHP;
- Annual reviews of each DMC-ODS Plan;
- Annual program assessment reports submitted to CMS in accordance with 42 CFR Part 438.66;
- MHP performance dashboards;
- Corrective action monitoring and follow-up; and
- Any other monitoring activities required by DHCS.

In addition, WIC section 14197.05 requires DHCS' external quality review organization to annually gather data and assess whether each BHP's network met the network adequacy requirements set forth in WIC section 14197 during the preceding 12 months.

DHCS will post network adequacy documentation for each BHP on its website, including any approved AAS, in accordance with WIC section 14197.

For questions regarding this BHIN, please contact the Medi-Cal Behavioral Health – Oversight and Monitoring Division at NAOS@dhcs.ca.gov.

Sincerely,

Original signed by

Michele Wong, Chief
Medi-Cal Behavioral Health Division – Oversight and Monitoring Division

Attachments
- Attachment A.1 – MHP NACT
- Attachment A.2 – DMC-ODS NACT
- Attachment B – Time or Distance Standards
- Attachment C – Alternative Access Standards Request Template
- Attachment D.1 – Timely Access Data Tool (MHP)
- Attachment D.2 – Timely Access Data Tool (DMC-ODS Plan)
- Attachment E – Certification of Network Adequacy Data
- Attachment F – Continuity-Transition of Care Report Template
- Attachment G – Language Line Encounter Template
- Attachment H – Supplemental Data Tool
- Attachment I – Significant Change Attestation Template
- Attachment J – Significant Change Disclosure Template