DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
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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: 2024 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 state fiscal year (FY) 2024-25 certification period

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

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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 authorizes the Department of Health Care Services (DHCS) to interpret and implement those standards by information notice. (WIC § 14197(j)) 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§ 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 monitor and 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. DHCS' submission to CMS shall also include an analysis that supports the assurance of the adequacy of each BHP's provider network.[1] DHCS has the authority, in accordance with WIC section 14197.7, to sanction BHPs that are out-of-compliance with the submission requirements, including accuracy, and timeliness or lack of submission.

BHPs shall submit documentation and data to DHCS, in a format specified by DHCS, annually, each time there has been a significant change in the BHP's operations, and upon the request of DHCS.[2]

The documentation shall demonstrate compliance with the State's standards for access to services, including network adequacy and timely access standards; that the BHP offers an appropriate range of services that is adequate for the anticipated number of members for the service area of the BHP; and that the BHP maintains a network of providers operating within their scopes of practice under State law that is sufficient in

[1] 42 CFR §438.207(d)
[2] 42 CFR § 438.207(c); WIC §14197(g)(1)

number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area of the BHP.[3]

The documentation and data shall demonstrate compliance for adult and children/youth services separately.

I. Network Certification Requirements:

DHCS is required to monitor BHPs' compliance with the network adequacy requirements set forth in WIC section 14197 and 42 CFR Parts 438.68, 438.206, and 438.207 to ensure that all Medi-Cal managed care covered services are available and accessible to members of the BHPs.

Each MHP is required to provide, or arrange for the provision of, all SMHS covered in its MHP contract, and its network must include providers responsible for delivering all those SMHS. MHPs shall report information regarding which network providers deliver which SMHS in the monthly 274 file.

Each DMC-ODS Plan is required to provide, or arrange for the provision of, all DMC-ODS services covered in its Intergovernmental Agreement with DHCS, and its network must include providers responsible for delivering all those DMC-ODS services. DMC-ODS Plans shall report information regarding which network providers deliver which services in the Network Adequacy Certification Tool (NACT) Exhibit A-2 Site tab.

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

i. The anticipated Medi-Cal enrollment;
ii. The expected utilization of services;
iii. The characteristics and health care needs of the Medi-Cal population;
iv. The numbers and types (in terms of training, experience, and specialization) of network providers required to furnish contracted Medi-Cal services;
v. The numbers of network providers who are not accepting new Medi-Cal beneficiaries;
vi. The geographic location of network providers and Medi-Cal beneficiaries, considering distance, travel time, and the means of transportation ordinarily used by Medi-Cal beneficiaries;
vii. The ability of network providers to communicate with limited English proficient beneficiaries in their preferred language(s);
viii. The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medi-Cal beneficiaries with physical or mental disabilities; and,
ix. The availability of triage lines or screening systems, as well as the use of tele- medicine, e-visits, and/or other evolving and innovative

[3] WIC §14197(g)(1); 42 CFR § 438.207(a), (b)

technological solutions.

II. BHP Submission Requirements:

For the state FY 2024-25 network adequacy certification period, BHPs shall submit the NACT (DMC-ODS Plans), 274 file (MHPs), and all requested and necessary supporting documentation no later than August 1, 2024.

Effective state FY 2024-25, DHCS has discontinued provider data reporting through the NACT for MHPs. DHCS will utilize each MHP's monthly 274 file submission to verify the MHP's compliance with the required Provider-to-Member ratios, mandatory provider types, and time or distance standards. DHCS will inform the MHPs which monthly 274 file will be used for Annual Network Certification as part of the Annual Network Certification documents package that will be emailed to the MHPs. DHCS will also utilize the MHP's 274 file submission if the MHP is required to resubmit documentation due to errors identified during the initial and re-assessment review process. If an MHP submits its 274 file late, or the file is incomplete or inaccurate, the MHP may be subject to the imposition of a Corrective Action Plan (CAP) and/or other enforcement actions. For detailed information on how to submit the 274 file, please see BHIN 22-032.

MHPs should submit 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.

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 DMC-ODS Plan's discretion.

DMC-ODS Plans 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.

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.

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 2024-25_DMC-ODS_NACT_2024-XX-XX
- Napa_FY 2024-25_MHP_Language_Line_Attestation_2024-XX-XX

BHPs are required to submit supporting documentation, such as 1) Timely Access data, 2) Grievances and Appeals, 3) Language Line Encounters, and 4) Continuity of Care Requests, by August 1, 2024. For state FY 2024-25 the reporting period is July 1, 2023, through March 31, 2024.

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, 2024, through June 30, 2025). For auto-renewing contracts that would expire during the certification period but for the auto-renewing clause, 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.

III. 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 Medicaid payments.[4]

a. MHP Network Capacity and Composition: Provider to Member 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 members within their county, including those with limited English proficiency, or physical or mental disabilities.[5] MHPs shall meet or exceed network capacity requirements and proportionately adjust the number of network providers to support any anticipated changes in enrollment.

[4] 42 CFR §438.600(b)
[5] 42 CFR §438.206(b)(1)

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

i. 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.).

ii. 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 member population was 51.6%. The median percentage of medication support services billed by psychiatrists, neurologists, or PMHNPs for the children/youth member population was 78.1%.

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

iii. 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.[6]

Table 1. Provider-To-Member 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

iv. 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 has compared these estimates to other prevalence estimates for 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 youth and adult members likely to need SMHS. These estimates represent the anticipated need for SMHS among youth and adult Medi-Cal eligibles in each county.

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 members within the existing

[6] State FY 2020-21 Short-Doyle claims data.

SMHS population who received psychiatry services as a part of the member's individualized treatment plan. DHCS determined that 67% of adults and 27% of children/youth receiving SMHS receive psychiatry services as a part of their treatment. Thus, to estimate the proportion of members that may need psychiatry services, the estimated population needing SMHS was adjusted by these percentages, respectively.

v. Evaluation of County Provider-Member Ratios

DHCS calculates each MHP's current provider-to-member ratio using FTE provider counts (numerator) and the anticipated SMHS and psychiatry needs population (denominator). DHCS then evaluates the MHP's provider-to-member 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 members in need of service. To determine how many FTEs are needed to serve 6,000 members, 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.

vi. 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 eligibles. 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).

vii. Direct Providers of Outpatient Services

Only direct providers of mental health services and psychiatry services should be included in the 274 file. For each rendering provider (an employee or contracted provider), the MHP should report the total FTEs available to directly provide mental health services including psychiatry services as evidenced by the contract.

MHP s should only report FTE for outpatient settings and not report FTE 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.

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 MHPs to receive credit for SMHS outpatient ratios, they must select mental health services in the 274 file. This also includes providers who are available to provide other service types in addition to mental health services. However, if a rendering provider is contracted for additional service delivery, then the MHP should select all other appropriate service types in the 274 file.

For quality and validation purposes, DHCS makes the following adjustments to the data submitted in the 274 file:

1. 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);
2. Remove FTEs for medication support services reported for providers that are not psychiatrists/neurologists, PMHNP, or physicians; and,
3. Remove FTEs for SMHS providers who reported 100% FTE in the SMHS 274 file (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.

viii. 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 member 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.

ix. 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 member ratios, the provider shall be available to provide services to members in the defined service area.

In addition, the physical location where members 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 maximum number of FTEs that can be available under the contract (if this is not explicit in the contract itself).

x. MHPs: Additional Options to meet Capacity and Composition Requirements

DHCS may grant requests for Alternative Access Standards (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.

1. 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 274 file. 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.

(a) 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.

xi. 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 2023-24, or an executed contract, covering the certification period through June 30, 2025. The executed contract and or invoice is due on August 1, 2024, with the Network Adequacy Submission.

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 members under 21 or over 65 years of age 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 2025 certification cycle.

b. DMC-ODS – Availability of Services

Each DMC-ODS Plan shall maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to Substance Use Disorder (SUD) services for all members within their county, including those with limited English proficiency, or physical or mental disabilities.[7] DMC-ODS Plans shall meet or exceed network capacity requirements and proportionately adjust the number of network providers to support any anticipated changes in enrollment. Each DMC-ODS Plan is required to

[7] 42 CFR § 438.206(b)(1)

provide a list of all its network providers as part of its annual network adequacy certification submission. Each NACT shall also include the maximum number of members 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 member needs. Thus (if there is not a specific maximum member 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 members per age group.

DMC-ODS Plans shall enter the provider on separate lines in the NACT indicating each age group and maximum number of members 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 members.

For provider contracts that do not include a limit on the number of members the provider can serve, the DMC-ODS Plan must determine and report the maximum number of members 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.

i. 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 2021-22 and state FY 2022-23), 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 2024-25 certification the projection is through June 2025).

Utilizing the 2019 National Survey on Drug Use and Health (NSDUH) [8] combined SUD estimates, DHCS applied the

[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.

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 2025 for each age group. DHCS then applied a percentage of 10 to the estimated members in need of treatment services to estimate the number who will actually seek treatment. The 10% comes from America's Need for and Receipt of Substance Use Treatment in 2015; this report uses data from the NSDUH and can be found on the Substance Abuse and Mental Health Services Administration's website. These numbers are referred to as the "Seeking Treatment" estimates in this BHIN.

For further validation of expected utilization, DMC-ODS Plans are also required to provide projections of members who will seek treatment through the certification period (for state FY 2024-25, this projection is to June 2025) as well as the number of members per treatment modality.

ii. Network Capacity

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

1. 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 (see above). 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:
   (a) If the DMC-ODS Plan projects a higher number of members 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.
   (b) Sufficiency means that the maximum number of members 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 that the maximum number of members that can be served per treatment modality (as reported within the NACT) meets or exceeds the new need estimate.

iii. 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 eligibles as reported by DMC-ODS Plans and compared the total numbers of beds against the total number of members 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 available residential beds. 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 members 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 Members Stayed in Residential Treatment	Rate of Bed Turnover (365 days per year / Average # of Days Members Stayed in Residential Treatment)
Adult	48	8
Youth	36	10

DHCS will not apply the above LoS analysis in scenarios where comparing capacity to projected utilization over time is inapplicable. For example, if the DMC-ODS Plan reports a significant change to the residential provider network and/or is currently failing to provide timely access to residential treatment services, accounting for bed turnover in order to estimate annual service capacity would be inappropriate.

iv. 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:

1. Utilizing the Attachment H – Supplemental Data Tool, the DMC-ODS Plan must report unique member 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.
   (a) 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.

(i) "Sufficiency" means that the maximum number of members 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.

(b) 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 2024-25: annual submission – August 1, 2024 (reporting period: calendar year 2023).

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. (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 members, which is less than DHCS' Seeking Treatment Estimate of 1,000 members 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

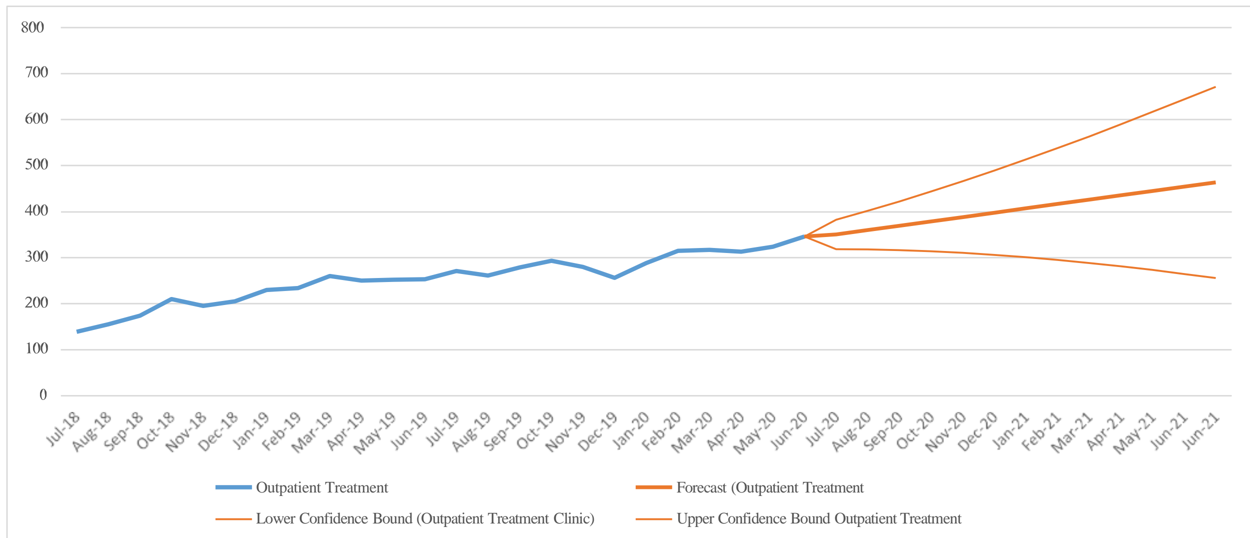
Row	Age Group(s) Served	Modality (DMC-ODS) - Outpatient Treatment Clinic	Modality (DMC-ODS) - Intensive Outpatient Clinic	Modality (DMC-ODS) - Residential	Modality (DMC-ODS) - OTP	Maximum Number of Medi-Cal Members
1	18+	Yes	No	No	Yes	70
2	0-17	No	Yes	Yes	No	12
3	0-17	Yes	No	No	Yes	24
4	18+	Yes	No	No	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 members 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 members 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 members, 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 members 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 members 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. 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 member to travel from the member's residence to the nearest provider site. Distance means the number of miles a member must travel from the member's residence to the nearest provider site. Both standards are based on a county's population density, 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.

i. Time or Distance Geographical Maps Methodology

DHCS assesses each BHP's time or distance compliance based on the provider data from the NACT (DMC-ODS Plans) or 274 file (MHPs) for each of the BHP's service areas, for all zip codes, accounting for all current and anticipated members.

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 eligibles in each zip code. The Department determines the members 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 BHP's reported provider data. DHCS evaluates BHP compliance with time or distance standards by age group (adults, and children/youth).

BHPs may request a copy of the access maps by contacting the NAOS mailbox at NAOS@dhcs.ca.gov.

1. **MHPs:**
   - 274 File: Provider detail
2. **DMC-ODS Plans:**
   - Exhibit A-2: Site

- Exhibit A-3: Rendering Service Provider

ii. 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 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 service type, the BHP shall include a description of how the BHP intends to arrange for Medi-Cal eligibles who reside in that coverage area to access that service type.[11] All BHPs are permitted to submit an AAS request with their annual certification package during the annual certification process.

iii. 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 member to travel the time or distance that would result if DHCS granted the AAS.[14]

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[9] 42 CFR §438.68(d)
[10] WIC §14197(f)(3)
[11] WIC §14197(f)(4)
[12] WIC §14197(f)(2)
[13] WIC §14197(f)(4)
[14] WIC §14197(f)(5)

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 the furthest members' location in each zip code.

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 member(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.

iv. 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 (DMC-ODS Plans) or 274 file (MHPs), 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 member to access services via telehealth only, per BHIN 23-018. BHPs shall inform the member 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 member.

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 members 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

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[15] WIC §14197(f)(4)
[16] WIC §14197(e), (f)(1), (6)
[17] WIC §14197(g)(2)

the BHP requesting 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 member 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 member access to the service type covered by the AAS request on an on-going basis and report DHCS' findings to CMS. [22] 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.[23]

v. 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 member or a field-based setting to deliver services in its time or distance methodology. For services where the provider travels to the member to deliver services, the BHP must ensure services are provided in a timely manner.

1. **MHP Only**
   MHPs requesting to use field-based or mobile providers to meet the time or distance standards must submit information to DHCS on the availability and provision of field-based or mobile services in the 274 file.

[18] WIC §14197(f)(4)
[19] WIC §14197(f)(4)
[20] WIC §14197(f)(3)(C)
[21] 42 CFR §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] 42 CFR § 438.68(d)(2)
[23] WIC §14197(f)(4)

2. **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.

vi. 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.[24] However, 85% of members must reside within the required time and distance standards for provider types by zip code. For example, if 100 Medi-Cal eligibles reside in zip code 95814, 85 of those members 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 DMC-ODS Intergovernmental Agreement or the MHP contract, BHPs must coordinate transportation with the local Managed Care Plan (MCP) for a member to a network provider and meet timely access standards for medically necessary services when a member is 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 member to travel to the appointment as needed per BHIN 21-008. Telehealth services must comply with BHIN 23-018 and DHCS' Medi-Cal Provider Manual telehealth policy.[25]

In order to utilize telehealth to fulfill network adequacy requirements for time or distance standards, telehealth services must be provided to members in the defined service area. In addition, the physical location where members 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

[24] WIC, §14197(e), (f)(1), (6).
[25] WIC, §14197(e); Medi-Cal Provider Manual. "Medicine: Telehealth."

DHCS on their telehealth providers.

Telehealth providers for BHPs must be reported in the BHP's provider data as follows:

1. **MHPs:**
   - 274 File

2. **DMC-ODS Plans:**
   - Exhibit A-3: Rendering Provider

d. 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) requires MHP and DMC-ODS Plans 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 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 Plans).

i. 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 members who begin receiving services while waiting for, or are in the process of completing, a clinical assessment. For this purpose, DHCS developed the TADT, a uniform data collection tool.

ii. Reporting Requirements

BHPs must use the TADT to report data on new members who request a non-psychiatry SMHS; any new or established member requests for psychiatric services; new members requesting a DMC-ODS service; and the first follow-up appointment offered after the initial service appointment. The reporting period for the Annual Network Certification is July 1, 2023, through March 31, 2024. The reporting period for reassessment (if required) will be dependent on the CAP timelines outlined for individual BHPs.

For state FY 2025-26, DHCS plans to update TADT reporting requirements and may include additional appointment types. DHCS will provide further guidance to BHPs. BHPs will be required to report data on the TADT for the reporting period of July 1, 2024, through March 31, 2025.

FY 2023-24 was a technical advisement year for follow-up appointment reporting for all BHPs. Beginning with state FY 2024-25, all BHPs will be subject to corrective action for failure to comply with timely follow-up appointment standards.

Timely access data reported on the TADT must represent the entire provider network, which includes county operated facilities/providers and contracted facilities/providers. Additionally, BHPs must disclose to DHCS on the TADT if the data is or is not inclusive of all providers in the BHP's network.

The data will be used to determine compliance with timely access standards. DHCS will no longer report compliance for the collective "all ages" group. DHCS will determine compliance by service type (see lists below) and age group, i.e., will assess compliance separately for adults and youth.

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 member. The BHP must permit OON access for as long as the BHP's provider network is unable to provide the services in accordance with the standards. For further guidance please see BHIN 21-008 and MHSUDS IN 19-024.

Additionally, BHPs must report on the timeliness of care for OON providers if the BHP is unable to arrange for an appointment for a member 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.

MHPs are required to submit timely access data for:

1. An urgent or non-urgent appointment with a non-physician mental health care provider of an outpatient SMHS;
2. An urgent or a non-urgent appointment with a provider of psychiatry;
3. Non-urgent follow-up appointments with a non-physician mental health care provider; [26] and,
4. Appointments with OON providers (in cases where appointments with network providers are not available within timely access standards).

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

1. Urgent and non-urgent appointments for Outpatient SUD services;
2. Urgent and non-urgent Residential treatment;
3. Withdrawal Management (all WM is considered urgent);
4. Urgent and non-urgent appointments for OTP;

[26] HSC § 1367.03(a)(5); BHIN 22-016

5. Non-urgent follow-up appointments with a non-physician SUD provider; and,
6. Appointments with OON providers (in cases where appointments with network providers are not available within timely access standards).

iii. Methodology for Determining BHP Compliance with Timely Access Standards

DHCS calculates compliance using the Date of First Contact to Request 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 member 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 members 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 Care:** 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.[27]
*The above standards apply unless the waiting time for an appointment is extended pursuant to HCS 1367.03(a)(5)(H) or 28 CCR section1300.67.2.2(c)(5)(H). ** Urgent care means health care provided to a member when the member's condition is such that the member 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 member's life or health or could jeopardize their ability to regain maximum function..[28]	

[27] HCS §1367.03 (a)(5)(B), (D), (E) and (F)
[28] HSC §1367.03(e)(7); 28 CCR §1300.67.2.2 (b)(21))

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.[29]
*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.) Urgent care means health care provided to a member when the member's condition is such that the member 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 member's life or health or could jeopardize their ability to regain maximum function.[30]	

e. **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 (DMC-ODS) and 274 file (MHP), 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.

i. **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 members, including those with Limited English Proficiency (LEP).[32] BHPs are also required to make oral interpretation and

[29] HSC §1357.03 (a)(5)(B), (D), (E) and (F)
[30] HSC §1367.03(e)(7); 28 CCR §1300.67.2.2 (b)(21)
[31] 42 CFR §438.10(h)(1)(vii)
[32] 42 CFR § 438.206(b)(1); WIC §14713(a)

auxiliary aids, such as TTY/TDY and American Sign Language (ASL), available to members, free of charge, for any language.[33]

1. 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 single contract or several—the following types of language assistance services at a minimum:
   (a) Oral Interpretation – services offered for spoken language processed in real time, whether in-person, via video call, phone, or other medium.
   (b) Written Translation – services offered for written language content, often processed separately from the time of the request for assistive language services.
   (c) ASL – services offered for a spoken language processed in real time, whether in-person or via video call.

ii. 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 members 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:

1. 24/7 access line encounters;
2. Face-to-face service encounters; and,
3. 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, 2023, through March 31, 2024, on an annual basis.

State FY 2023-24 was a technical advisement year for LLE reporting for all BHPs. Beginning with state FY 2024-25, all BHPs may be subject to corrective action for failure to comply with LLE reporting.

BHPs shall submit through the BHIS folder. MHPs are to use the "DHCS-NAOS-MHP" root folder and navigate to the folder with

[33] 42 CFR §438.10(d)(4); MHP Contract, Att. 11, section 3, E.

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.

f. 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).

i. Indian Health Care Providers (IHCP)
Indian Health Care Providers (IHCPs) are not required to contract with BHPs; however, BHPs shall document good-faith efforts to contract with all IHCPs in the BHP’s service area (i.e., county). If a BHP does not have a contract with any of the IHCPs 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. If a Contractor is unable to contract with an IHCP, Contractor must allow eligible Members to obtain services from out-of-network IHCP in accordance with 42 CFR section 438.14.

1. **MHP**
   Attestation on county letterhead including an explanation to DHCS to justify the absence of the mandatory provider type for IHCP in the MHP’s network.

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

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

g. Continuity of Care (CoC) and Transition of Care (ToC) 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 mandatory for Plans to submit their CoC/ToC data utilizing the Attachment F report template. FY 2023-24 was a technical advisement year for DMC-ODS Plans. Beginning with FY 2024-25, DMC-ODS Plans will be subject to corrective action for failure to comply with ToC reporting.
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."

h. System Infrastructure:

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

i. Grievance and Appeals

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

1. Services not available;
2. Services not accessible;
3. Timeliness of services;
4. 24/7 Toll-free access line;
5. Linguistic services;
6. Other access issues;
7. Authorization delay notices; and/or
8. 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 2024 certification period is July 1, 2023, through March 31, 2024. 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.

i. 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 within 60 days of BHP submission and DHCS review of the NACT (DMC-ODS Plans) and 274 file (MHPs). 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.

FY 2023-24 was a technical advisement year for provider contract

submissions, (DMC-ODS Residential ASAM LOC 31., 3.3, & 3.5; MHP Service Types). Beginning with FY 2024-25, all BHPs will be subject to corrective action for failure to comply with provider contract submission requirements.

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 2024-25.	DHCS will request up to three 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 2024-25.	DHCS will request up to three 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 2024-25.	DHCS will request up to 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 2024-25.	DHCS will request up to 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 2024-25.	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 2024-25.	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 2024-25.	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 2024-25. *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 would expire during the certification period but for the auto renewal provision, 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 (DMC-ODS Plans), and 274 file (MHPs). DHCS may request additional contracts during the annual network adequacy certification process.

j. **Requirements for Submission of Policies and Procedures:**

i. Network adequacy monitoring - submit policies and procedures related to the BHP's procedures for monitoring compliance with the network adequacy standards;

ii. OON access - submit policies and procedures related to member access to OON providers;

iii. Timely access - submit policies and procedures addressing appointment time standards and timely access requirements;

iv. 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;

v. Physical accessibility - submit policies and procedures regarding access for members with disabilities pursuant to the Americans with Disabilities Act of 1990;

vi. Telehealth services - submit policies and procedures regarding use of telehealth services to deliver covered services;

vii. 24/7 Access Line requirements - submit policies and procedures regarding requirements for the MHP's 24/7 Access Line; and,

viii. 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.

IV. Non-Compliance with Network Adequacy Standards:

a. Corrective Action Plans

If a BHP is found to be deficient for one or more network standards, the BHP shall develop a corrective action plan (CAP), to address the deficiencies, and submit the CAP for DHCS approval.
DHCS' review of each CAP will consider the steps the BHP proposes to take to come into compliance with the standards. Upon CAP approval the BHP is required to begin submitting supporting data and documentation needed to demonstrate compliance with the CAP, including but not limited to a NACT (DMC-ODS Plans) or 274 file (MHPs) when applicable. The submission deadlines for data and documentation are dependent on the actions and steps detailed in the approved CAP. Additionally, if a DMC-ODS Plan is found to be deficient in capacity and composition standards, the DMC-ODS Plan shall submit the Supplemental Data Tools as part of their CAP data submission.
Submission requirements for the CAP process are:

- **i.** Submission due date – Will be communicated to the BHP's 30 days prior to the submission due date.
  1. Reporting period: Based on details of the approved CAP

Dependent on the approved CAP, DHCS may require subsequent submission(s) of additional documentation and/or data to demonstrate CAP compliance. If DHCS determines that a BHP is not making satisfactory progress toward resolving their CAP or coming into compliance with applicable standards, the BHP may be subject to monetary sanctions. DHCS will monitor the BHP's corrective actions and require updated information from the BHP monthly until the BHP meets the applicable standards.

V. Monetary Sanctions

DHCS may impose monetary sanctions on a BHP pursuant to subdivisions (e) and (f) of WIC section 14197.7 and may temporarily withhold funds from a BHP pursuant to subdivision (o). The bases for imposition of monetary sanctions include, but are not limited to, the following:

- i. Failure to comply with network adequacy standards, including, but not limited to, time or distance, timely access, and provider to member

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.[34]

ii. Failure to demonstrate that the BHP has an adequate network to meet anticipated utilization in the county.[35]

iii. Failure to submit timely and accurate network provider data.[36]

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

Furthermore, if a BHP is unable to meet network adequacy requirements because its provider network is deficient in capacity and composition, is unable to provide timely access to necessary services, or is unable to meet the applicable time and distance standards or secure approval of an AAS, the BHP shall adequately and timely cover these services OON for the member. 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.

VI. Network Adequacy Monitoring:

a. 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 of capacity and services[37]. DHCS defines a significant change in the BHP's operations as any of the following:

- **i.** Any decrease of the provider network, or a specific provider's capacity to serve in a service type/modality, and/or demographic;
- **ii.** Changes in the composition of, or payments to the plan's provider network;
- **iii.** A change in benefits;
- **iv.** A change in geographic service area;
- **v.** Enrollment of a new population; or,
- **vi.** 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.

[34] WIC §14197.7(e)(6)
[35] WIC §14197.7(e)(5)
[36] WIC §14197.7(e)(8)
[37] 42 CFR § 438.207(c)(3)

Additionally, any decrease in administrative staffing of a BHP that significantly impacts the BHP's 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).

Additionally, DHCS may initiate a significant change inquiry based upon information or reports received from sources other than the BHP.

When a significant change inquiry is initiated during the ANC process, DHCS will utilize new information and/or data from the BHP to determine, or redetermine, compliance with ANC requirements.

b. 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.

c. Semi-Annual Attestation Reporting Requirement

If a BHP does not report a significant change to its operations during the attestation period listed below, the BHP must attest to DHCS that there are no significant changes to their network semi-annually. The attestation due dates and reporting periods are in Table 9, below:

Table 9. Semi-Annual Attestation Due Dates

Submission Due Date	Attestation Period
August 1, 2024	January 1, 2024, to June 30, 2024
January 1, 2025	July 1, 2024, to December 31, 2024

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 attestations may result in sanctions as specified in BHIN 22-045.

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.

d. Ongoing Monitoring:

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

- **i.** Provider data submissions for BHPs;
- **ii.** Annual County Monitoring Activities for BHPs;
- **iii.** Annual program assessment reports submitted to CMS in accordance with 42 CFR Part 438.66;
- **iv.** Corrective action monitoring and follow-up; and,
- **v.** 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,

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

- 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