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1. Executive Summary

This report details the Department of Health Care Services' (DHCS) methodology description to certify the networks in accordance with Title 42 Code of Federal Regulations (CFR) section 438.207. DHCS reviewed data and information from multiple sources, including network data submissions by the Mental Health Plans (MHPs), to conduct an analysis of the adequacy of each MHP's network. DHCS will make available to Centers for Medicare and Medicaid Services (CMS), upon request, all documentation collected by the State from the MHPs.

DHCS published Behavioral Health Information Notice 22-033 which prescribes the MHPs network certification process and submission requirements. MHPs are required to submit documentation that demonstrates the capacity to serve the expected enrollment in each service area in accordance with DHCS' standards for access to care established under the authority of CMS Medicaid and CHIP Final Rule, CMS-2390-F (Final Rule) Sections 438.68, 438.206, and 438.207.[1]

For the 2022 overall results, 23 MHPs did not meet all network adequacy standards due to deficiencies in relation to time or distance standards, network capacity and composition (provider to beneficiary ratios), timely access standards, or combination thereof. These 23 MHPs are placed on a Corrective Action Plan (CAP) to resolve their network adequacy deficiencies. CAP requirements for the 23 MHPs include:

- Provide DHCS with monthly status updates that demonstrate action steps the MHP is undertaking to correct the CAP deficiency(ies);
- Authorize Out-of-Network (OON) access and demonstrate the ability to effectively provide OON access information to beneficiaries and ensure that its beneficiaries services staff, network providers, and subcontractors are trained on the mandates, including the right for beneficiaries to request OON access for SMHS services and transportation to providers where the MHP is unable to comply with annual network certification requirements.
- Participate in technical assistance meetings with DHCS to discuss DHCS CAP progress.

The majority of MHPs on a CAP (16 out of 23) are due to DHCS establishing a new, heightened standard for compliance with timely access requirements. Specifically, beginning fiscal year 2022-2023, DHCS increased the rate for compliance for appointment wait time standards for non-urgent and non-psychiatric outpatient Specialty Mental Health Services (SMHS).

DHCS is taking steps to strengthen oversight and enforce compliance with MHP network adequacy requirements. DHCS is authorized through Welfare and Institution Code 14197.7 to take enforcement actions, including imposing administrative and monetary sanctions on MHPs plans. If the MHP is not making satisfactory progress toward resolving their deficiency(ies), DHCS may impose administrative and monetary sanctions, including the temporary withhold of funds. In 2022, DHCS issued BHIN 22-045 to provide guidance regarding the MHP sanctions policy.

[1] Managed care Final Rule, Federal Register, Vol. 81, No. 88.

2. Annual Network Methodology

2.1. Time or Distance Standards – Geographic Access Maps

DHCS prepared geographic access maps for MHPs based upon Medi-Cal beneficiary and provider location data submitted in Exhibit A-3 of the Network Adequacy Certification Tool (NACT) using ArcGIS software. DHCS plotted time or distance for all network providers, stratified by service type (e.g., outpatient SMHS or psychiatry) and geographic location, for both adult and children/youth. The mapping process was automated using Environmental Systems Research Institute (ESRI) technology, which determines the precise distance between beneficiary and provider addresses.

DHCS notifies MHPs of deficient zip codes, by provider type, for both adults and children/youth. However, 85% of beneficiaries must reside within the required time and distance standards for provider types by zip code. Although DHCS proposes that telehealth will be permitted to meet time or distance standards, all beneficiaries have the right to an in-person appointment, and telehealth can only be provided when medically appropriate, as determined by the provider and as allowed by the applicable delivery systems' provider manual. Plans are not allowed to restrict in-person appointments in favor of telehealth.

2.1.1. Community Based Services

Rehabilitative Specialty Mental Health Services (SMHS)[2] are to be provided in the least restrictive setting, consistent with the goals of recovery and resiliency, and may be provided anywhere in the community.[3] DHCS considered the availability of services (i.e., when the provider travels to the beneficiary and/or a community-based setting to deliver services) when determining compliance with the time or distance standards. For services where the provider travels to the beneficiary to deliver services, MHPs are required to ensure services are provided in a timely manner, in accordance with the timely access standards and consistent with the beneficiary's individualized client plan.

2.1.2. Alternative Access Standards Requests

The Managed Care Rule permits states to grant exceptions to the time or distance standards.[4] DHCS notifies the MHP in the event they cannot meet the time or distance standards; identified MHPs were required to submit a request for alternative access standards.[5] Per the statutory requirements, DHCS is able to grant requests for alternative access standards if the MHP exhausted all other reasonable options to obtain providers to meet the applicable standard or if DHCS determined that the MHP demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.

[2] Mental Health Services, Crisis Intervention, Targeted Case Management and Medication Support
[3] State Plan, Section 3, Supplement 3 to Attachment 3.1-A, page 2c
[4] 42 CFR Section 438.68(d)(1)
[5] Welfare and Institutions Code (WIC) Section 14197(e)(2)

MHPs were required to include a description of the reasons justifying the alternative access standards. Requests for alternative access standards are approved or denied on a zip code and service type basis.[6]

Requests for alternative access standards may include seasonal considerations (e.g., winter road conditions) when appropriate. As appropriate, MHPs included an explanation about gaps in the county's geographic service area, including information about uninhabitable terrain within the county (e.g., desert, forest land).

Upon notification by DHCS, approved alternative access standards will be valid for one year; however, DHCS will monitor beneficiary access on an on-going basis and include the findings to CMS in the managed care program assessment report required under Title 42 Code of Federal Regulations subsection 438.66(e).[7]

DHCS will post all approved alternative access standards on its website.[8]

2.2. Provider to Enrollee Ratios – Provider Composition and Network Capacity

DHCS determined the anticipated need for SMHS using county-specific Medi-Cal enrollment data and estimates of prevalence of Serious Emotional Disturbance (SED) in children/youth and Serious Mental Illness (SMI) in adults.[9] Using its Medi-Cal Eligibility Data System, DHCS calculated the average number of enrolled Medi-Cal beneficiaries in each county during state fiscal year (FY) 2020-21. DHCS then applied the SED and SMI prevalence estimates to average enrollment for each county. This adjusted Medi-Cal enrollment population represents the anticipated need for SMHS.

DHCS used this same methodology to estimate the need for psychiatry services (i.e., Medication Support Services provided by a psychiatrist). However, to determine estimated need for psychiatry services, DHCS further calculated the proportion of beneficiaries within the existing SMHS population who received Medication Support Services as a part of the beneficiary's individualized treatment plan. DHCS determined that 67% of adults and 29% of children/youth receiving SMHS receive Medication Support Services as a part of their treatment plan.

For each rendering provider who delivers Mental Health Services, and Medication Support Services (for psychiatrists only), the MHP is required to report, by age group (0-20 and 21+), each provider's full-time equivalency (FTE).

DHCS calculated, separately for adults and children/youth, the counts of FTE providers that the MHPs' reported who provide outpatient SMHS and psychiatry (Medication Support Services – psychiatrists only) services. Since outpatient SMHS can be provided by any mental health professional working within their scope of practice, DHCS included all relevant provider types in its calculation of the ratio for outpatient SMHS.

[6] WIC Code Section 14197(e)(3)
[7] 42 CFR Section 438.68(d)(2), and Section 438.66(e)(2)(vi)
[8] WIC Code Section 14197(e)(3)
[9] Prevalence estimates taken from the California Mental Health and Substance Use System Needs Assessment Report (September 2013).

DHCS established statewide provider to beneficiary ratios using Short-Doyle/Medi-Cal claims data as reported in its Performance Outcomes System. DHCS established statewide ratios for outpatient SMHS (i.e., Mental Health Services) and psychiatry services (i.e., Medication Support Services – psychiatrists, nurse practitioners and physicians only) for adults and children/youth.

For MHP's utilizing telepsychiatry and/or Locums Tenens contracts to meet the need for outpatient SMHS or psychiatry services, DHCS calculated the estimated FTE value of the contracts. DHCS divided the total FY budget amount by the highest hourly (i.e., business hours) rate to determine the total number of hours allotted via the contract. DHCS used the number of allotted hours to calculate the estimated FTE value of the contract.

DHCS established the following provider-to-beneficiary ratio standards:

Table 1: Provider-to-Beneficiary Ratio Standards

Certification Category	Ratio Standard
Children/youth outpatient SMHS	**1:43**
Adult outpatient SMHS	**1:85**
Children/youth psychiatry	**1:323**
Adult psychiatry	**1:524**

To strengthen oversight of capacity and composition requirements, DHCS transitioned from a manual data collection tool to a standardized, automated system to collect MHP provider network data via the 274 Health Care Provider Directory standard. This will ensure DMC-ODS provider network data submitted to DHCS is consistent, uniform, and aligns with national standards. It will also support expanded tracking and monitoring of the full array of SMHS and increased frequency of analyses.

2.3. Appointment Wait Time: Timely Access Standards

Non-Urgent Non-Psychiatry

To ensure that MHPs provide timely access to services, DHCS requires each MHP to have a system in place for tracking and measuring timeliness of care, which includes the timeliness to receive a first appointment or first specialty mental health service (not including urgent appointments or psychiatry services). For this purpose, DHCS developed the Timely Access Data Tool (TADT), a uniform data collection tool.

DHCS performs analyses utilizing the TADT to calculate county compliance using the Date of First Contact to Request Services and the number of days between that date and the Assessment Appointment First Offer Date, wherein, 80% of beneficiaries must have been offered an appointment within ten business days.

For 2022, DHCS increased the compliance threshold for beneficiaries being offered an appointment within established timeframes for non-urgent and non-psychiatric outpatient SMHS from a rate of 70% to 80% (meaning, 80% of appointment offers must fall within the appointment wait time standard).

2.4. Language Capabilities

MHPs 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).[10] MHPs are also required to make oral interpretation and auxiliary aids, such as Teletypewriter (TTY), Telecommunications Device for the Deaf (TDD), and American Sign Language (ASL) services available and free of charge for any language.[11] To demonstrate compliance with these requirements, the MHPs must submit subcontracts for interpretation and language line services. In addition, MHPs are required to report, in each MHP's provider directory and in the NACT, the cultural and linguistic capabilities of network providers, including languages (ASL inclusive) offered by the provider or a skilled medical interpreter at the provider's office and whether the provider has completed cultural competence training.[12]

2.5. Mandatory Provider Types - American Indian Health Facilities

In accordance with Title 42 Code of Federal Regulations, subsection 438.14(b)(1), MHPs are required to demonstrate that there are sufficient American Indian Health Facilities (AIHF) participating in the MHP's network to ensure timely access to services for American Indian beneficiaries who are eligible to receive services. As such, MHPs are required to offer to contract with each AIHF in their contracted service area (i.e., county).
The NACT reporting template included the following required elements for each MHP counties. If an MHP did not have an executed contract with an AIHF, the MHP was required to submit to DHCS an explanation and supporting documentation to justify the absence of a contract.

DHCS reviewed the MHPs' submissions and verified the information with approved data sources to ensure compliance. DHCS verified the MHPs' reported efforts to contract with AIHF in the county by comparing reported providers with the Department's list of facilities.

Please note, the not applicable designation applies to MHPs that are not AIHF.

3. Upcoming Methodology Changes

To strengthen monitoring and oversight of MHPs to improve member access to care, DHCS proposes to add additional methodologies for network adequacy monitoring and timely access compliance:

- **Data standardization and integrity:** DHCS is moving to a single standard for plans to submit network and program data to DHCS on a monthly basis using the X12 274 Health Care Provider Directory standard. This will ensure DMC-ODS provider network

[10] 42 CFR Section 438.206(b)(1)
[11] 42 CFR Section 438.10(h)(1)(vii)
[12] 42 CFR Section 438.10(h)(1)(vii)

data submitted to DHCS is consistent, uniform, and aligns with national standards. It will also support expanded tracking and monitoring of the full array of SMHS and increased frequency of analyses.

- **Use of third-party secret shopper surveys for timely access and network validation:** DHCS plans to standardize its process to use our independent EQRO to perform validation of timely and provider network data across all Medi-Cal managed care delivery systems. Until then, DHCS intends to conduct a more limited scope secret shopper process in 2025 for SMHS providers. Additionally, DHCS will be developing additional validation activities to verify the accuracy of MHP provider network directories.

4. Appendices

Table 2: Psychiatry Time or Distance Standards and Timely Access Standards

Timely Access[13]	Within **15 business days** from request to appointment
Time or Distance[14]	Up to **15 miles and 30 minutes** from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Joaquin, San Mateo, and Santa Clara.
	Up to **30 miles and 60 minutes** from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.
	Up to **45 miles and 75 minutes** from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.
	Up to **60 miles and 90 minutes** from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

[13] W&I Code Section 14197(d)(1); Title 28 California Code of Regulations (CCR) Section 1300.67.2.2(c)(5)(D)
[14] W&I Code Section 14197(c)(1), (h)(2)(L)

Table 3: Outpatient SMHS Time or Distance Standards and Timely Access Standards

Timely Access	Within **10 business days** from request to appointment
Time or Distance	Up to **15 miles and 30 minutes** from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Joaquin, San Mateo, and Santa Clara.
	Up to **30 miles and 60 minutes** from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.
	Up to **45 miles and 75 minutes** from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.
	Up to **60 miles and 90 minutes** from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

Effective July 1, 2018, MHPs must comply with the appointment time standards in accordance with 28 CCR Section 1300.67.2.2(c)(1) through (c)(4), and (c)(7).