Frequently Asked Questions

Contents

NACT Reporting & Critical Data 2
MHP Capacity & Composition SPECIFIC 4
DMC-ODS Capacity & Composition SPECIFIC 5
Time or Distance / Alternative Access Standards (AAS) Request 6
Timely Access 8
Telehealth 11
Supplemental Utilization Data (DMC-ODS) 12
Submission Requirements (General) 13
Contracts & Provider Subcontracts 14
Inpatient Hospitalization Contracts 16
Other 18

NACT Reporting & Critical Data

Question: The Exhibit A-3 is a point in time data collection tool for a time period in 21-22, so the contract effective dates in this document reflect the contracts that were live during this time frame, i.e. some of them expired in June 2022. But in Q&A you seemed to suggest that we should overwrite the contract effective dates in A-3 to reflect FY22-23, a later time period than what the A-3 represents. What is the applicable timeframe? What contract dates should we reflect on A3? 21-22 to match our point in time or 22-23 to match contract submission dates?
Answer: "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), must cover the certification year (e.g. valid July 1, 2022, through June 30, 2023). For auto-renewing contracts that have expired or will expire during the certification period, the Plan must submit an attestation on county letterhead that there are no known factors that could preclude the auto- renewal. All auto-renewing contracts must include a distinct, clear auto-renewal clause." – BHIN 22-033, p. 5
Question: Should we add individuals (i.e. Chief Clinical Managers) who don't carry a caseload but can fill in when demand requires?
Answer: "These staff and/or members of leadership can only be included if they have capacity to serve clients on a regular and on-going basis. If an administrative staff employee is needed to function 100% in their administrative role (e.g., director, medical director, quality improvement manager) but could pick up a client on an emergency basis, the employee should not be included as they do not have regular capacity to serve clients. The FTE, if included, should accurately reflect the amount of time the individual can actually be available to directly provide services to a beneficiary over the course of a year. If counties report administrative staff, or other providers, as having ongoing caseloads of zero, they should include information with the submission that explains why the provider does not carry a regular caseload." – BHIN 22-033, p.12

Question:

A) Do you expect for all providers where we mark "Yes" on tab A3 in the field-based services column that we must also include that provider on tab B1? We were previously told a provider could be marked as "Yes" on tab A3 without being included on B1 if all services in the field are provided at a consumer's home.

B) Are you saying services provided in homes are not considered field-based services?

C) Additionally, if we do not have actual street addresses for B-1, is it sufficient to just enter city and zip?

Answer:

A) Yes, if columns BK and BL are indicated as "Yes" on tab A-3 Rendering Service Provider, include the provider on tab B-1 Field Based Services.

B) No, if the services are primarily delivered at the beneficiary's home, then the beneficiary's address should not be reported in Column C under Satellite Address Site, instead report as "N/A – Beneficiary Address"

C) If a specific street address does not exist (i.e., a mobile site) the Plan can report the nearest intersection.

Question:

In one of the earlier presentations, there a reference to age range for up to 20 and 21+ for NACT Critical Data. Our understanding is that the age ranges are 0-17 and 18+. Did I not hear this correctly or was this just for MHP?

Answer:

For MHPs, the age groups are: Children/Youth (0-20), Adult (21+)
For DMC-ODS Plans, the age groups are: Children/Youth (0-17), Adult (18+)

Question:

Do you want us to include our (Short Term Residential Therapeutic Program) STRTPs in the NACT? Those are homes that are for dependents and wards of the court that provide residents with Outpatient SMHS (Case Management, ICC, IHBS, MHS, Med Support, and Crisis Intervention). STRTPs typically serve multiple counties.

Answer:

No, if the served beneficiaries are residents of the STRTP site, and the services are rendered at the STRTP site, do not report the STRTP on the NACT.

MHP Capacity & Composition SPECIFIC

Question:
For FFS providers that are 100% telehealth, we were instructed to use the MHP's administrative offices' address. Since you are using the address for geomapping, is there another option or should we continue to use the admin office address?

Answer:
Yes, the Plans should continue to use the admin office address.

Question:
When you refer to 4:1 ratio regarding nurse practitioners (NPs), you are referring to 4 NPs to 1 psychiatrist (supervision requirement), right?

Answer:
Yes, per BHIN 22-033, “DHCS will evaluate compliance with psychiatry ratios using reported FTE for psychiatrists, psychiatric mental health nurse practitioners (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 must 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”.

Question:
Do we need to include inpatient providers in the C-1 FTEs? If so, how do we get that data if we don't collect inpatient providers on the Rendering Provider tab, we won’t know the FTEs for those facilities for the FTE tab.

Answer:
No, inpatient provider information should not be reported on the NACT.

Question:
We have LVNs supporting medication support, per slide 22 they cannot be a listed FTE for medication support, what should they be listed under?

Answer:
Yes, only providers that are listed as psychiatrists, psychiatric mental health nurse practitioners (PMHNPs) and physicians will count towards FTE for medication support services.

DHCS does not count licensed vocational nurses (LVNs) towards FTE under medication support services; therefore, the Plan will need to identify the applicable service type(s) listed in columns AH-AM of the NACT (not including medication services) for LVNs.

DMC-ODS Capacity & Composition SPECIFIC

Question:

A) Could you please detail where in the NACT (Attachment A.2) ODS plans are to report the number of Residential beds?

B) If a county does not contract for a specific number of beds with our Residential providers, how are counties to report Residential bed numbers?

Answer:

A) DMC-ODS Plan are to report Medi-Cal Residential beds in the A-2 site tab, Column AD – Maximum Number of Medi-Cal Beneficiaries

B) If a specific bed capacity is not stipulated in the contract terms with a DMC-ODS Residential treatment provider, the Plan must report the number of beneficiaries the site is willing to accept at any-given-time.

Question:

Is it possible to get a ratio of providers to beneficiaries for the DMC-ODS providers like there is for the MHP providers?

Answer:

DMC-ODS methodology does not utilize a provider to beneficiary ratio. The methodology used to determine capacity can be found in BHIN 22-033 under the Availability of Services section.

Time or Distance / Alternative Access Standards (AAS) Request

Question: Can this methodology be written out and sent to counties? Your time and distance GIS mapping
Answer: “DHCS prepares geographic access maps for Plans 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 Plan’s network to the address of the furthest Medi-Cal beneficiary in each zip code. The Department determines the beneficiaries to include in the calculation using the most current data available from the MEDS system. DHCS plots time and distance for all network providers, stratified by provider type for MHPs (Psychiatry and Outpatient SMHS) and for DMC-ODS Plans (Outpatient Services and Opioid Treatment Programs), including geographic locations, for both adult and children/youth separately based on the NACT.” – BHIN 22-033, p. 25
Question: For time and distance we used to submit the worksheet along with our Network Adequacy submission since we have extremely rural areas that will always be out of the standard. It looks like the new tool doesn't allow us to send it ahead of time, are there any exceptions to this for frontier counties?
Answer: Plans may submit an Alternative Access Standard (AAS) for zip codes they know will be outside of time or distance standards. Plans may request Attachment C – AAS Request Template by contacting NAOS@dhcs.ca.gov. Please be advised that additional zip codes may be found outside of time/distance standards after our data team analyzes the data Plans reported on the NACT.
Question: What is the timeframe for mapping Medi-Cal eligibles? For each age group and plan, is it eligibles for the full Fiscal Year?
Answer: “DHCS uses the most current data available from the MEDS system.” – BHIN 22-033 p. 25

Question: Are Counties required to submit Geographic Maps with their annual submission?
Answer: No, counties are not required to submit geographic mapping with the annual submission. DHCS conducts the geographic mapping for counties based on the NACT submission.
Question: Can DHCS provide the Geographic Maps rendered by the data team when sending the Findings Report?
Answer: Geographic mapping results are made available by request only.

Timely Access

Question:
For psychiatric appointment request, should request for services be the same day they called to requested Mental health services, even if they did not specify psychiatric services or the date they requested a psychiatric appointment during an assessment?

Answer:
The request for psychiatric services is defined as the moment in which the need for psychiatric services is requested from the beneficiary or legally authorized representative, or when the need for psychiatric services is found during the course other treatment.

Question:

A) Where can we find the definition for urgent requests as this is defining urgent requests as only psychiatric?

B) Please define "Psychiatric Urgent Condition" such as: is this only for new clients accessing SMHS who present with an urgent conditions that require medication services and thus expedited entry is to a psychiatrist, or all new clients who present with an urgent condition requiring expedited entry regardless of needed service to be rendered to address their urgent condition?

Answer:

A) The definition of 'Urgent' and its source is located on the 2nd tab of each Attachment D – Timely Access Data Tool, titled "Timely Access Standards." This definition applies to all new clients accessing SMHS who present with an urgent condition, regardless of which service type they are receiving treatment under.

B) DHCS defines urgent as:
When the beneficiary's condition is such that they faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the beneficiary's life or health or could jeopardize their ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours.*

*28 CCR § 1300.67.2.2, subd. (b)(7); Health & Safety Code § 1367.01, subd. (h)(2)

Question: On the DMC-ODS TADT there is a residential timely access standard of 10 days, is this a new requirement? Instructions say to include residential under the outpatient tab, is this correct?
Answer: No, the residential standard of 10 business days is not new. This can be found in Health and Safety Code (HSC) 1637.03 (a)(5)(e). For FY22-23, Residential services are entered on Tab A) Outpatient Services - SUD of Attachment D2.
Question: Regarding the TADT, can you confirm if the psychiatric appointment request data is for NEW beneficiaries as well?
Answer: Yes, Psychiatric appointment request data is for 'new beneficiaries' only.
Question: Timely Access data for DMC-ODS: where should residential be logged? Only tabs available are for outpatient or OTP.
Answer: Residential Services would be entered on Tab A) Outpatient Services - SUD in the TADT.
Question: Are we just supposed to track Urgent psychiatry on the psychiatry SMHS tab?
Answer: No, all Psychiatric requests, urgent and non-urgent should be entered in on tab B) Psychiatric SMHS.
Question: Our psychiatry initial appointment is very long. They assess and provide treatment in the first appointment. Can we use the same date in the “Assessment start date” and “Treatment start date” columns in the B) Psychiatry SMHS tab?
Answer: Yes, the “Assessment Start Date” and "Treatment Start Date" can be the same date.

Question:
How is request for service defined for psychiatry services, is it all request for a psychiatric appointment? Initial contact at screening? Or requesting the service at Assessment when it was discovered that it is medically necessary?

Answer:
The request for Psychiatric services is defined as the moment in which the need for Psychiatric Services is requested from the beneficiary or legally authorized representative, or when the need for Psychiatric services is found during other SMHS treatment.

Question:
Can a psychiatric appointment be used for “Treatment appointment first offered date” and “treatment start date” in tab A. Non-urgent non-psych SMHS?

Answer:
No, tab A) Non-Urgent Non-Psychiatric Services should not contain any psychiatric appointment data. All Psychiatric requests should be entered on tab B) Psychiatric SMHS.

Question:
How is a psychiatry appointment defined in MH if the scheduled appointment is not kept by client?

Answer:
The definition of a psychiatry appointment does not/will not change, regardless of whether or not a client keeps their appointment. If a client does not keep their psychiatry appointment, or any kind of appointment, it is to be considered as a ‘missed appointment’, and captured as such on the TADT by utilizing the ‘Closure Reasons’ column on each data entry line.

Question:
If we do not collect First Treatment offer date, is it okay to enter the first treatment start date in that field?

Answer:
No; the first treatment offer date must be the actual first treatment offer date. If there are no first treatment offer dates to report, please leave that field blank.

Note: *DMC-ODS Plans will not be placed on a CAP for timely access standards for the FY 22-23 Annual Network Adequacy Certification. However, they will receive findings from DHCS regarding the percentage of requests meeting the standard.*
DMC-ODS Plans who do not meet the timely access standard will receive technical assistance accompanying their findings.

Telehealth

Question: During one of the presentations, it sounded like the presenter said that we could not include telehealth only providers in the NACT for MH. Is that correct?
Answer: No, telehealth providers for Plans can be included in the NACT.

Supplemental Utilization Data (DMC-ODS)

Question:
Is the Supplement Data Tool due monthly? If so, what date of the month is it due?

Answer:
No, the Supplemental Data Tool is not due monthly. If counties are found to be deficient in the initial Network Capacity analysis, then DHCS will request the Plan to complete the Supplemental Data Tool for additional analysis.

Question:
Can Counties submit the Supplement Data Tool with their annual submission?

Answer:
Yes, counties can submit the Supplemental Data Tool with their annual submission. However, counties are not required to submit monthly utilization data with the August 29, 2022 submission. If a county chooses to submit a Supplemental Data Tool, DHCS requires two years' worth of data to perform the analysis.

Submission Requirements (General)

Question:
To confirm one attestation/certification of data letter is required for both MHP and DMC-ODS? This can be either Director or County CAO?

Answer:
MHPs and DMC-ODS Plans must submit a separate 'Certification of Network Adequacy Data' (Attachment E) for each plan type. The Plan's Director, Chief Executive Officer (CEO), or an individual who reports to the Director or CEO with the delegated authority to sign for the Director or CEO may sign.

Question:
Could you please elaborate on what is meant by reserve/staffing contracts?

Answer:
Reserve/staffing contracts are a mechanism that may be used should a MHP have a need to expand (e.g. contracting with a staffing agency) its workforce. MHPs are permitted to use reserve/staffing contracts to meet network adequacy standards and/or as a basis for alternative access requests.

If using reserve/staffing contracts to meet either network adequacy standards or alternative access standards, MHPs must submit:

- a copy of the reserve contract;
- the name and National Provider Identifier (NPI) number of the contracting agency;
- a statement from the county describing the number of FTE that can be available under the contract (if this is not explicit in the contract itself), and;

If applicable, please include budget detail for subcontracts.

Contracts & Provider Subcontracts

Question:
For SMHS contracts, we have a few new providers whose contracts have not yet executed, and they would show as 0 beneficiaries served. Do you want evidence that a contract is in process with them, or not until the contract has executed?

Answer:
If an SMHS provider's contract with the Plan is not fully executed at the time of submission, those providers should not be included on the NACT.

Question:
For contract submissions, if the contract is set to expire in the certification period, can we provide an attestation that the contract is scheduled to be re-procured?

Answer:
Yes; if the Plan has a contract in place that is current at the time of submission, but is set to expire prior to the end of the certification period – in this case, before 6/30/23 – and would still like NAOS to consider that contract during our review of the Plan's annual submission, please include the current contract with its designated contract cover sheet (Attachment I), as well as a signed and dated attestation on County letterhead, indicating that the contract is set to be re-procured on (enter date).

Question:
I heard that the cover sheet should be attached to the contract. However, I see different file naming formats for the cover sheet and the contract itself. Should we be submitting one document? Or two (covers sheet and contract)?

Answer:
Yes; ideally each contract submitted will have its matching coversheet completed with the contract's relevant details, of which is used by NAOS to identify key contract information during our certification review.

If a Plan is unable to electronically attach a contract with its coversheet, it is recommended the Plan submit the contract under the appropriate naming convention based on guidance provided within Attachment G, and separately submit the contract's coversheet utilizing the same naming convention as the contract, but also including a 'CS' at the end as an identifying marker for NAOS to pair the documents together during our certification review.

Example:

Contract file name:
County_FY22-23_Plan_Contract Type_Contract Name_7.1.22

Contract Coversheet file name:
County_FY22-23_Plan_Contract Type_Contract Name_CS_7.1.22

Question:

Can you go over how to indicate contracts are noted to be draft? Is that in the title?

Answer:
No, DHCS does not accept draft contracts. A valid contract is executed and extends through the certification period, which is 6/30/2023.

Question:

Should counties submit their initial contracts plus each of the latest amendments, or just the initial contracts with their respective cover sheets?

Answer:
The original contract plus the latest amendments are required, especially if the amendment contains information like extending the length of the contract or changing the terms (i.e. scope of work, licensure type of contractor) that would be critical to DHCS review.

Question:
Should the Cover Sheet reference pages in the contract that specify the modes of services (i.e., modality/service types) available to each program or to program types that would offer the full array of services?

Answer:
"The Contract Cover Sheet must include the following information:

- Organizational Provider's Name and page number located in the contract;
    - Organizational provider name listed in NACT Exhibit A-1 must match the name of the provider name stated in the contract.
- Contract Term/Length [Start Date – End Date] and page number located in the contract;
- Contract Number and page number located in the contract;
- Modality/Provider Type(s) and page number located in the contract; and
- Age Group(s) Served and page number located in the contract."

– BHIN 22-033 p. 43

Inpatient Hospitalization Contracts

Question:
Regarding Inpatient Hospital Contracts:

A) Do we need to include a Contract Cover Sheet for these contracts as well as attaching the contracts?

B) Are the individual providers of the inpatient contracts to be included in the NACT?

Answer:

A) Yes, please include a Contract Cover Sheet for the inpatient hospital/residential contracts.

B) No, please do not include any inpatient hospital/residential data in the NACT.

"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 for FY21-22, or an executed contract, covering the certification period through June 30, 2023." – BHIN 22-033, p. 13-14

Question:
Are you including Crisis Residential Treatment with Residential Treatment for requiring the contract?

Answer:
Yes, the MHP must provide either an invoice from for FY21-22, or an executed contract, covering the certification period through June 30, 2023. Providers of both crisis residential treatment services and adult residential treatment services must be included.

Question:
Should we also include inpatient electroconvulsive therapy services and residential eating disorder services? I'm not sure if those end up being paid by Medi-Cal.

Answer:
Only Medi-Cal billable services for inpatient hospital/residential facilities contract or invoices must be submitted.

Question: Inpatient Hospital, Residential Treatment Services, and Psychiatry Health Facility Services are only to be submitted if the county operates or has these facilities within their county for which their contract as the host county; is this correct?
Answer: Please submit all contracts within the county or outside the county for inpatient hospital, residential treatment services, and psychiatry health facility including providers of both crisis residential treatment services and adult residential treatment services.
Question: A) Is this only for adult residential treatment services? I wasn't sure. B) For non-contracted facilities, do we only submit one invoice for the facility to show that they provided services to us, or do we submit all their invoices for the fiscal year to show the volume of services they provided? C) Does this include skilled nursing facilities?
Answer: A) No, submission requirements for inpatient hospital/residential facilities encompasses children/youth and adult. B) For non-contracted facilities, please submit all invoices covering FY21-22. C) Submission requirements for inpatient hospital/residential include nursing facilities, if the services are Medi-Cal billable.

Other

Question: How do we learn more about what's "on the radar" so that we can update our NACT tool for providers in preparation for next year? Will counties only be informed about these changes when the BHIN is issued 60 days prior to implementation?
Answer: On-the-radar items are developed in tandem with stakeholder involvement and may be developed in response to mandated state and federal requirements as new and/or updated obligations. Any tools and/or attachments requiring revision will be included along with the draft Behavioral Health Information Notice (BHIN) provided to county Plans as part of initial stakeholder review. The Department of Health Care Services (DHCS) publishes a BHIN for the upcoming Fiscal Year's (FY) Federal Network Certification Requirements following the aforementioned stakeholder review period. The BHIN expands and clarifies Network Adequacy Certification submission requirements for county Mental Health Plans (MHP) and Drug Medi-Cal-Organized Delivery System (DMC-ODS) Plans for the FY.

For county questions, please address them to the NAOS@dhcs.ca.gov mailbox.

In the subject line of your email, please indicate the 1) topic(s), 2) county name, and 3) program (MHP or DMC-ODS) for efficient processing of the inquiry.