2023 NETWORK ADEQUACY METHODOLOGY REPORT FOR SPECIALTY MENTAL HEALTH SERVICES

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

2023 NETWORK ADEQUACY METHODOLOGY REPORT FOR SPECIALTY MENTAL HEALTH SERVICES

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 the network of each MHP. DHCS will make available to the Centers for Medicare and Medicaid Services (CMS), upon request, all documentation collected by the DHCS from the MHPs.

For the 2023 certification year, DHCS published Behavioral Health Information Notice (BHIN) 23-041 which prescribes the MHPs network certification process and submission requirements. DHCS delayed the release of the FY 2023-24 annual network certification (ANC) BHIN in order to incorporate critical updates to timely access reporting requirements for MHPs, as described in Section 2.3 Appointment Wait Time: Timely Access Standards. 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 2023 results, 49 MHPs did not meet one or more network adequacy standards including time or distance standards, network capacity and composition (provider to beneficiary ratios), timely access standards, or a combination thereof. Due to the delayed release of the ANC BHIN, at the time of NAAAR submission DHCS is only able to report on which MHPs are currently out of compliance with ANC requirements. MHPs are required to submit a plan of correction within 30 days to address the deficiency, which is subject to DHCS approval. DHCS will monitor the corrective action plan (CAP) to ensure the MHPs submit required documentation to meet network adequacy standards. NAAAR results currently do not include the number of plans that will go on to promptly resolve CAPs after receiving DHCS technical assistance. Based on experience, many CAPs issued to MHPs are promptly resolved through addressing data reporting issues; such CAPs are not indicative of bona fide network deficiencies. CAP requirements for the MHPs that remain non-compliant are as follows:

- 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

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

unable to comply with annual network certification requirements.
- Participate in technical assistance meetings with DHCS to discuss CAP progress.
- Plans will be periodically required to resubmit their network data until they can demonstrate they have achieved compliance.

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 withholding of funds. In 2022, DHCS issued BHIN 22-045 to provide guidance regarding the MHP sanctions policy.

2. Annual Network Methodology

2.1. Time or Distance Standards – Geographic Access Maps

DHCS prepared geographic access maps for MHPs based on Medi-Cal beneficiary and provider location data submitted to DHCS in Exhibit A-3 of a spreadsheet named the Network Adequacy Certification Tool (NACT) and 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 adults 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

[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

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.

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 three years; 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 Network Capacity and Composition

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) 2021-22. 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.

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[4] 42 CFR Section 438.68(d)(1)
[5] Welfare and Institutions Code (WIC) Section 14197(e)(2)
[6] WIC Section 14197(e)(3)
[7] 42 CFR Section 438.68(d)(2), and Section 438.66(e)(2)(vi)
[8] WIC Section 14197(e)(3)
[9] Prevalence estimates taken from the California Mental Health and Substance Use System Needs Assessment Report (September 2013).

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, 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) 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.

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	1:49
Adult outpatient SMHS	1:85
Children/youth psychiatry	1:267
Adult psychiatry	1:457

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 Provider Network Data. This will ensure MHPs 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, Urgent-Non-Psychiatry, Non-Urgent Psychiatry and Urgent 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 SMHS (not including urgent appointments or psychiatry services). For this purpose, DHCS developed the Timely Access Data Tool (TADT), a spreadsheet which serves as 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.

In a continuous quality improvement process, DHCS continues to strengthen and refine the timely access reporting and analysis methodology for analysis on an annual basis, with the goal of improving the validity of initial and follow-up appointment time data and strengthening DHCS' monitoring and compliance enforcement with network adequacy standards for MHP networks. Consequently, DHCS provides updated templates and reporting guidance for each annual network certification.

For 2023, DHCS included compliance thresholds for new members being offered appointments within established timeframes by age group (0-20 for children/youth and 21+ for adults).

In addition, DHCS made significant updates to the TADT to expand and improve timely access monitoring. These changes included:

- Revisions of terminology and instructions to align with DHCS' CalAIM policy changes and clarify that an array of appointment types should be tracked.
- Replacement of the County Client Numbers (CCNs) with the collection of Client Index Numbers (CINs), which sought to further ensure protection of PHI and facilitate more detailed data analysis by enabling DHCS to perform data matching with demographic data already available to the department.
- Addition of appointment data to align with updates to Senate Bill (SB) 221, which revised California Health and Safety Code §1367.03 to explicitly apply appointment time standards to follow-up appointments with a non-physician mental health provider.
- Addition of out-of-network provider referral appointment data to ensure MHPs are following access to care requirements as specified in the MHP contract.

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 - Indian Health Care Providers

In accordance with Title 42 Code of Federal Regulations, subsection 438.14(b)(1), MHPs are required to demonstrate that there are sufficient Indian Health Care Providers (IHCP), formerly known as American Indian Health Facilities, 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 IHCP in their contracted service area (i.e., county).

The NACT reporting template included the following required elements for each MHP. If an MHP did not have an executed contract with an IHCP, 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 IHCP in the county by comparing reported providers with a list of facilities known to DHCS.

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

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 274 Provider Network Data. This will ensure MHP provider network data submitted to DHCS is consistent, uniform, and aligns with national standards. It

[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)

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:** To comply with the new Final Rule (42 CFR 438.68(f)) by January 2029, DHCS plans to standardize its process to use our independent EQRO to perform validation of timely access, provider network data, and provider network directories 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 specific to timely access.
- **Automation of Timely Access Data Collection.** DHCS is exploring options to automate the collection of timely access data from the MHP counties and providers.

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.

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.

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

	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.