DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

2024 NETWORK ADEQUACY METHODOLOGY REPORT FOR SPECIALTY MENTAL HEALTH SERVICES

Table of Contents

July 2025

1. Overview

This report details the methodology of the Department of Health Care Services (DHCS) 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 county 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 DHCS from the MHPs.

For the 2024 certification year, DHCS published Behavioral Health Information Notice (BHIN) 24-020, which outlines the MHPs network certification process and submission requirements. DHCS transitioned from a manual data collection tool to a standardized, automated system to collect MHP provider network data via the X12 274 Health Care Provider Directory standard, referred to as the 274 in this document. DHCS utilized each MHP's monthly 274 network provider file submission, in addition to the Timely Access Data Tool, to verify MHP compliance. MHPs are required to submit data that demonstrates the capacity to serve the expected enrollment in each service area in accordance with the standards of DHCS 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]

2. Annual Network Methodology

2.1 Time or Distance – Geographic Access Maps

DHCS prepared geographic access maps for MHPs using Medi-Cal members and provider location data submitted through the 274 provider network data and ArcGIS software. Network providers were mapped by service type (e.g., outpatient specialty mental health services [SMHS] or psychiatry) and geographic location, with separate analyses for both adults and children/youth. The mapping process was automated using Environmental Systems Research Institute (ESRI) technology to calculate the precise distance between member and provider addresses.

DHCS allowed MHPs to utilize telehealth services to meet time or distance standards in cases where the MHP can demonstrate it has been unable to contract with an in-person provider, or when its delivery model can still provide the appropriate level of care. Even with this flexibility, at least 85% of members must still reside within the required time and distance standards for each provider type by zip code. Although DHCS permits the use of telehealth to meet time or distance standards, all members have the right to an

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

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.

DHCS notifies MHPs of any deficient zip codes, by provider type, for both adults and children/youth.

2.1.1 Field-Based Services

SMHS[2] are to be provided in the least restrictive setting, consistent with the goals of recovery and resiliency. DHCS considered the availability of services (i.e., when the provider travels to the member and/or a field-based setting to deliver services) when determining compliance with the time or distance standards. For services where the provider travels to the member to deliver services, MHPs are required to ensure services are provided in a timely manner, in accordance with the timely access standards.

2.1.2 Alternative Access Standards Request

The Final Rule permits states to grant exceptions to the time or distance standards.[3] DHCS notified MHPs if they did not meet time or distance standards, and those MHPs were required to submit a request for alternative access standards.[4] Per the statutory requirements, DHCS can grant requests for alternative access standards if the MHP exhausts all other reasonable options to obtain providers to meet the applicable standard or if DHCS determines that the MHP has sufficiently 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.[5]

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 member access on an on-going basis and include the

[2] Mental Health Services, Crisis Intervention, Targeted Case Management and Medication Support
[3] 42 CFR Section 438.68(d)(1)
[4] Welfare and Institutions Code (WIC) Section 14197(e)(2)
[5] WIC Section 14197(e)(3)

findings to CMS in the managed care program annual report required under Title 42 CFR subsection 438.66(e).[6]

DHCS posts all approved alternative access standards on its website.[7]

2.2 Provider to Member 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.[8] Using its Medi-Cal Eligibility Data System, DHCS calculated the average number of enrolled Medi-Cal members in each county during State Fiscal Year (FY) 2022-23. 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 the estimated need for psychiatry services, DHCS further calculated the proportion of members within the existing SMHS population who received Medication Support Services as a part of the member'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 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-member ratios using Short-Doyle/Medi-Cal claims data as reported in its SMHS Performance Dashboard. DHCS established statewide ratios for outpatient SMHS and psychiatry services (i.e., Medication Support

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

Services – psychiatrists, nurse practitioners, and physicians only) for adults and children/youth.

For MHPs 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-member ratio standards:

Table 1: Provider-to-Member 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 successfully transitioned from a manual data collection tool to a standardized, automated system to collect MHP provider network data via the 274 Provider Network Data for the annual network certification (ANC) FY 2024-25. 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, Follow-Up 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 SMHS 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 Timely Access Data Tool (TADT), a spreadsheet that serves as a uniform data collection tool.

DHCS performs analyses utilizing the TADT to calculate county compliance using the date of first contact for new members, as defined by each county, to request services, and the number of days between that date and the assessment appointment first offer

date. 80% of members must have been offered an appointment within the applicable timeframe.

In a continuous quality improvement process, DHCS continues to strengthen and refine the timely access reporting and analysis methodology for analysis, with the goal of improving the validity of initial and follow-up appointment time data and strengthening DHCS's monitoring and compliance enforcement with network adequacy standards for MHP networks.

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 members, including those with Limited English Proficiency (LEP).[9] MHPs are also required to make oral interpretation and auxiliary aids, such as Teletypewriter, Telecommunications Device for the Deaf, and American Sign Language (ASL) services available to members, free of charge, for any language.[10] To demonstrate compliance with these requirements, MHPs must submit subcontracts with interpreters for interpretation and language line services. In addition, MHPs are required to report, in their provider directory and in the 274 network provider file, 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.[11]

2.5 Mandatory Provider Types – Indian Health Care Providers

In accordance with Title 42 CFR, subsection 438.14(b)(1), MHPs are required to demonstrate that there are sufficient Indian Health Care Providers (IHCP) participating in the network of the MHP to ensure timely access to services for American Indian members who are eligible to receive services. As such, MHPs are required to offer to contract with an IHCP in their contracted service area.

The 274 network provider file was used to identify IHCP provider data for all IHCPs that are contracted with the MHP. If an MHP did not have an executed contract with an IHCP, the MHP was required to submit to DHCS an explanation and documentation of the plan's efforts to contract with one or more IHCPs.

DHCS reviewed the MHPs' provider data and submissions and verified the information with approved data sources to ensure compliance. DHCS verified the MHPs' reported

[9] 42 CFR Section 438.206(b)(1)
[10] 42 CFR Section 438.10(h)(1)(vii)
[11] 42 CFR Section 438.10(h)(1)(vii)

efforts to contract with an 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 located in IHCP counties. These MHPs were exempt from the verification process for IHCP validation.

3. Network Adequacy Determinations

DHCS evaluates the data submitted by the MHPs to determine compliance with network adequacy standards and makes the following determination:

- A determination of "Met" means the MHP achieved the required threshold for the assessed standard necessary to be deemed compliant with that standard.
- A determination of "Unmet" means the MHP did not achieve the required threshold for the assessed standard needed to be deemed compliant with that standard.

MHPs that have a designation of "Unmet" for any network adequacy standard or requirement will be issued a Corrective Action Plan (CAP). MHPs are required to submit a plan of correction within 30 calendar days to address the deficiency, which is subject to DHCS approval. DHCS will monitor the CAP to ensure the MHPs submit the required documentation to meet network adequacy standards. The results of the Network Adequacy and Access Assurances Report (NAAAR) currently do not include the number of plans that resolved their CAPs after receiving technical assistance from DHCS. Based on experience, many CAPs issued to MHPs are promptly resolved through addressing data reporting issues. As such, these CAPs are not indicative of bona fide network deficiencies. CAP requirements for the MHPs that remain non-compliant are as follows:

- Provide DHCS with status updates, when requested by DHCS, depending on the nature of the deficiency, that demonstrate progress made by the MHP towards correcting the identified deficiencies;
- Authorize Out-of-Network (OON) access and demonstrate the ability to effectively provide OON access information to its members and ensure that its members' services staff, network providers, and subcontractors receive training on the OON requirements, including the right for members to request OON access for SMHS services and transportation to providers when the MHP is unable to comply with annual network certification requirements.
- Participate in technical assistance meetings with DHCS, when requested, to discuss CAP progress.

- The MHP may, at the discretion of DHCS, be required to submit updated network data until it demonstrates compliance with network adequacy standards.

DHCS is taking steps to strengthen oversight and enforce compliance with network adequacy requirements. Pursuant to WIC section 14197.7, DHCS has the authority to take enforcement actions such as imposing temporary withholds, monetary sanctions, and administrative sanctions on MHPs for network adequacy deficiencies or failure to adhere to annual network certification requirements. In 2025, DHCS issued BHIN 25-023 to outline how it may impose administrative and monetary sanctions and contract terminations with MHPs. DHCS will utilize the enforcement tiers described in this guidance when determining what enforcement action to take against an MHP that fails to meet network adequacy certification requirements.

4. Next Steps for Improvement

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

- **Time or Distance Census Methodology:** DHCS will be updating its time or distance methodology for MHPs to align with the Managed Care delivery system and the Department of Managed Health Care. The updated methodology will utilize population points instead of member addresses.
- **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 and use our independent External Quality Review Organization to perform validation of timely access, provider network data, and provider network directories across all Medi-Cal managed care delivery systems using a third-party secret shopper survey method. 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 and its network providers.

5. Appendices

Psychiatry and Outpatient SMHS Time or Distance Standards[12]

- Up to **15 miles and 30 minutes** from the member'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 member'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 member'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.

Timely Access Standards[13]

Outpatient Non-Urgent Non-Psychiatric SMHS

- Within **10 business days** from request to appointment.

Psychiatry Services

- Within **15 business days** from request to appointment.

Urgent SMHS

- Within **48 hours** without prior authorization**; 96 hours** with prior authorization.

Non-Urgent SMHS Follow-Up

- Within **10 business days** of the prior appointment.

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