FISCAL YEAR (FY) 2025-26 FEDERAL NETWORK CERTIFICATION REQUIREMENTS FREQUENTLY ASKED QUESTIONS

For County Behavioral Health Plans and Delivery Systems

Network Adequacy Oversight Section

June 4, 2025

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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TIMELY ACCESS

Question: Are these new templates posted online anywhere or can we only get them by emailing in and requesting them?

Answer: No, the new Timely Access Data Tool (TADT) templates are not publicly posted to the DHCS website. However, all TADT templates are available by accessing the county BHP's 'NAOS MHP and/or DMC-ODS' root folders within MOVEit. If a County BHP staff member does not have access to their Plan's NAOS root folder(s) within MOVEit, please reach out to NAOS@dhcs.ca.gov for the appropriate steps to be taken by your Plan's NAOS liaison to further assist you.

Question: I see the DHCS state holidays observed list doesn't include Juneteenth, which our county has off. Does that mean that date will be counted as a business day since it's not on this list, even though we are not open because of the holiday?

Answer: Correct. DHCS would consider this event a regular business day. As was presented as an example during the webinar, while the State of CA and DHCS recognize Juneteenth as a holiday, it is not an observed state holiday, meaning State employees do not have the day off. Therefore, DHCS would not take an extra business day into consideration unless the county BHP notated this event/holiday as being a county-observed holiday within the 'Notes' column of any/all appointment data directly impacted by the date in question.

Question: TADT Reporting period is 07.01.2024 - 03.30.2025 right?

Answer: For FY 2025-26 Annual Network Certification(ANC) reporting of Timely Access, the Timely Access Data Tool (TADT) Reporting Period is: 7/1/2024 - 3/31/2025.

The associated reporting periods for ANC, Corrective Action Plan (CAP, Significant Change requests, etc... can also be located within the TADT templates' 'Standards' tabs.

Question: Do MAT(Medication Assisted Treatment) services fall under Outpatient Treatment Program or Opioid Treatment Program for DMC-ODS counties?

Answer: Medication Assisted Treatment (MAT) services and Opioid Treatment Programs (OTP) are not synonymous, as MAT can also refer to non-opioid withdrawal treatment (i.e., Naltrexone). The Timely Access standards NAOS applies to a county BHP's DMC-

related TADT are specific to Opioid medications; therefore, MAT services that are not providing Opioid medications should not be captured within the TADT's OTP tab.

Question: Will there be allowances for the Regional Model as Partnership submits our TDAT for DMC-ODS only? Our network for the Regional Model covers 7 counties. We will never be able to meet Network Adequacy in each county alone.

Answer: The Regional Model is evaluated as a single plan. It is the responsibility of each county BHP, Regional Model partner, and/or county delivery system's responsibility to adhere to the Timely Access standards set forth in Welfare and Institution Code (WIC) 14197.

Should a county BHP, Regional Model partner, and/or county delivery system be unable to meet the applicable timely access standards using its available network of providers, it is the plan's responsibility to obtain Out-of-Network (OON) services for all impacted members.

Question: How exactly does DHCS calculate the days between the first request and the first offer? Is it a formula you use in excel?

Answer: DHCS calculates timeliness based on the number of business days elapsed from date of request to the date of the first offered appointment based on the applicable timely access standards (i.e., 10 business days, etc..) per WIC 14197, excluding all observed state holidays, which can be located within the 'Standards' tab of each TADT template.

Question: Will DHCS be offering another webinar to focus on the completion of TADT and understanding what data is required in the new forms? If not, whom can we contact for clarification of the data expected?

Answer: NAOS will consider the request and provide future guidance. If a county requires technical assistance (TA) prior to DHCS issuing the guidance, the county can contact DHCS NAOS@dhcs.ca.gov mailbox to request a TA call.

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Question: So, for the resubmission on the TADT, counties will get 2 business days to do corrections?

Answer: Correct

Question: Do you have suggestions on how to cut and paste into the TADT template without Excel inserting a ' character at the beginning of each field? I've tried pasting values (as we were instructed previously) and not specifying to paste values and both ways it generates a ' that isn't visible at the beginning of every field.

Answer: To prevent Excel from adding a single quote (') when pasting, use the "Paste Special" option and select "Values" or "Text". Alternatively, you can use the shortcut Ctrl+Alt+V, then choose "Values" (V) or "Text" (T). If you continue to have functionality issues, it is recommended you work with your IT Department to troubleshoot.

Question: Are there exclusions from the TADT compliance rate calculations? For example if a client has no first offer date but the closure date is marked as 07 - Unable to contact, would that count against the county as non-compliant?

If so, can we get a full list of exclusions?

Answer: No. DHCS does not have a list of exclusions for Timely Access appointment data. If a county BHP does not have a record of a member's "Date of First Offered Appointment", please ensure the member's "Date of First Request for Services" is complete and include a "Closure Date" and "Closure Reason" for that member's particular data entry line on the TADT.

'Closure Reason 07 = Unable to Contact' entries will not count against the county as being non-compliant; however, if the BHP's TADT shows a large number of entries reflecting the inability to make contact with the member, NAOS may reach out to the BHP for additional information on this matter via a Technical Assistance call.

Question: On the TADT, when reporting on members who requested services (either psych or non-psych) at the end of the reporting period, should we report appointments that are offered and/or rendered after the end of the reporting period?

Example (not an example of specific member, example dates only): Member requested services on March 25, 2025, First Appointment Offered 3/28/25. First Appt. Rendered 3/28/25. First Follow-Up offered 4/5/25. First Follow-Up Rendered 4/8/25.

Would the dates on or after 4/1/2025 be reported on the TADT?

Answer: For members requesting services toward the end of the reporting period, county BHPs are required to report all applicable timely access appointment data available through the end of the specified reporting period, at minimum.

Should a BHP have any appointment data available beyond the reporting period that is applicable to the data entered on the TADT, those dates of service do not fall under the reporting requirement.

Example: A member requested Non-Urgent Non-Psych SMHS services on 3/31/2025 - the last day of the FY 25-26 Annual Network Certification (ANC) reporting period for Timely Access. **-->** The BHP must include the 'Date of First Request for Services' on their TADT, which is 3/31/25 in this case. If the 'Date of First Offered Appointment' was 4/4/25, this date is not required; however, BHPs are still encouraged to include the data if the information is available, as NAOS has purposely built in a 90-day buffer for reporting data to ensure BHPs are able to report the most accurate data it has on file in a given certification period.

Question: I have a CAP because the ATT D.1 was an "unauthorized template" and I knew nothing about any updated version. So is DHCS saying that we should check the instructions to determine the most updated version of these attachments?

Answer: Correct. If a County BHP has been placed on a Corrective Action Plan (CAP) for utilizing an unauthorized TADT template, NAOS' email notifying the BHP of its findings will always include the correct and applicable TADT template that is needed for CAP resolution purposes.

Question: Can you please confirm/ clarify that the requirement to schedule the follow-up appointment within 10 days for a new member applies to non-psychiatry only, not psychiatry appointments?

Answer: Correct. Follow-up appointment data does not apply to Psychiatry services and will not have any associated columns for follow-up data within the Psychiatry tab of the TADT.

Question: Can you clarify that last statement on new member for psychiatry? We report all new requests for psychiatry, not just those that are new members to the entire BHP network (in other words, they may already be receiving non-psychiatry services) but would report as new for the purpose of the psychiatry request.

Answer: The Plan is correctly reporting Timely Access data for Psychiatry Services.
All entries submitted for Psychiatry appointments shall be for all requests for Psychiatry services, not just new service requests, as is the case for Non-Psychiatry related SMHS. A 'new service' is a service that a member has never received in the past or they are not currently receiving to date. All BHPs must continue to report on service requests from both new and established members seeking psychiatric services.

Question: How soon after the NA submission would we expect to hear about the TADT errors? I understand that counties are expected to turn the information around within 2 days of being notified, but when can we expect to be notified?

Answer: County BHPs can anticipate receiving notifications from NAOS regarding any FY 2025-26 TADT errors starting in late July 2025. Should a county BHP receive an email notifying them of any TADT errors, NAOS has had a long-standing protocol in place of permitting two (2) full business days to make any necessary corrections identified and resubmit the corrected TADT to NAOS for analysis.

Question: Does DHCS have guidance on when to start the "timeliness clock" for referrals that are submitted on behalf of members from other agencies? (ie. a written referral on behalf of a beneficiary when the beneficiary may not have requested the services themselves)? Also, how should counties handle these types of requests for members that may still be in hospitals or in jails, and are not yet able to schedule an appointment date due to not knowing when they will be released?

Answer: The "timeliness clock" for referrals submitted on behalf of members from other agencies (i.e., justice referrals, inpatient hospitals, etc...) is when the county BHP has assumed full responsibility for providing SMHS, Psychiatry, Outpatient Substance Use Disorder Services (SUDS), and/or Opioid Treatment Program (OTP) services.
BHPs are not required to report timely access data for members still in the hospital, or are justice-involved within the TADT.

Question: Will the VBA code used to calculate elapsed days be thrown off by the (') character that Excel is inserting? It isn't causing the date fields to turn yellow, indicating a validation error

Answer: The VBA code utilized by DHCS' Data Team to analyze TADTs will not be interrupted by the erroneous apostrophe (') that often appears when copying/pasting data into the TADT templates. Additionally, to prevent Excel from adding a single quote (') when pasting, use the "Paste Special" option and select "Values" or "Text". Alternatively, you can use the shortcut Ctrl+Alt+V, then choose "Values" (V) or "Text" (T). If you continue to have functionality issues, it is recommended you work with your IT department to troubleshoot.

Question: The MHS D.1 Tool Closer Date column appears to is highlighted yellow on all for the Outpatient / Non-phy. is this really a required field even for appointment scheduled but client did not show 02. Can we use the appointment offer day as the close date?

Answer: Yes, it is a required field. DHCS requires county BHPs to submit a complete TADT, which should include a 'Closure Date' and associated 'Closure Reason', when applicable. If a member does not show up to a requested service appointment, the BHP must include the date in which the member's access record was closed as the "Closure Date", as well as the associated closure reason for a complete entry.

Question: I didn't see this clarification in the recent BHIN. Can you confirm that the standard time frame is based on business days (Monday through Friday), and that the urgent time frame is based on business hours (Monday through Friday)? Or is it based on the days the program is open (e.g., if the program is open 24/7 then weekends would be included)?

Answer: NAOS is referring to the traditional Monday through Friday calendar/timeframe when "business days", and/or "Hours Elapsed" for urgent appointments are referenced within BHIN 25-013.

Due to the nature of healthcare facilities, hospitals, etc... operating on a different schedule by providing 24/7 services to meet healthcare needs, for administrative purposes, a standard business day might still apply to processing paperwork and non-emergency consultations during regular office hours.

Question: Pg. 33: Can this be further flushed out further and with examples provided?

"…new members who request a non-psychiatry SMHS; any new or established member requests for psychiatric services; new members requesting a SUD service; and the first follow-up appointment offered after the initial service appointment."

- Would this be a member who has never received SMSH/DMC-ODS services and is not "open to our EHR? Basically, our electronic health record has no record of this member.
- How is a new member defined?
- So, if a new member is asking for psychiatry services, then this would be tracked. If an existing member has been receiving, let's say mental health services (i.e. rehabilitation and case management), for the last 6 months and then requests psychiatry services, then this would be tracked. Is this correct?
- What if a member received a psychiatry service in the past, for example, over a year ago and then requests psychiatry services again, would this be tracked? Does psychiatry service have an "expiration date" to when tracking must be completed or should all psychiatry requests be tracked regardless of if the member received a psychiatry service in the past?

Answer: DHCS has left the definition of what constitutes a new member to the discretion of the Plan.

Additionally, all entries submitted for Psychiatry appointments shall be for ALL requests for Psychiatry services. BHPs, IBHPs and DMC-IBHDS' are required to utilize the applicable TADT template to document service requests from members seeking new SMHS or DMC-ODS services.

Question: Can you please describe and provide examples for closure reason 03 = Member attended initial appointment but did not complete assessment process?

Answer: Closure Reason 03 = Member attended initial appointment but did not complete the assessment process is equivalent to a person attending an initial appointment and then never scheduled, attended, or completed their assessment [i.e., a member had an initial appointment and was never seen/heard from regarding the requested service(s).

274 REPORTING

Question: We have a new member who needs to be added to the NAOS e-mail list. What is the preferred method for them to request to be added to the e-mail distribution list?

Answer: Please email the NAOS@dhcs.ca.gov inbox requesting to add a contact person from your County to the NAOS Contact List. Please provide the name, title, email address and identify the program type (MHP or DMC-ODS) of the contact person.

Question: Question for the earlier slide "274 Provider Data Submission" regarding the bullet point for "Service Validation". Which Monthly quality check/tab(s) is this in reference to? Is this the required type of service field or something else?

Answer: Yes, this is the data quality check that occurs after the 10th of the month. For instance, for July 2025 reporting period all submissions are due on August 10th for ANC FY 25-26. After the submission is completed, DHCS conducts data quality checks and notifies the Plans by August 22, 2025. The Plans must correct and resubmit the 274 file within 5 business days.

Question: For "DMC ODS 274 Reporting Requirements: Capacity". In that slide, it references the datapoint "site licensed capacity". I don't see a datapoint on the companion guide that matches this terminology exactly. Can you confirm which datapoint this is?

Answer: "Licensed Capacity" refers to the site capacity that the Plan is required to report by age group and modality for each site.

Question: Shouldn't Attachment E be submitted once the 274 File data is due to DHCS as final confirmation of NACT submission.

Answer: No. Attachment E is representative of a county's entire ANC submission. Therefore, the county must submit Attachment E July 1, 2025. Furthermore, Attachment E is due to DHCS anytime the County is required to submit data, such as annual certification, CAP resolution, and significant change submission that includes data and documentation. Attachment E does not need to be submitted each month with the 274 file data.

Question: On slide 11 "The sum of individual age group capacity cannot exceed site licensed capacity. Sites reported above the licensed capacity will be excluded from Plan network data." – was this statement specific to Res and OTPs only? Which data point is "site licensed capacity"?

Answer: Licensed Capacity is specific to Residential Treatment Services and OTP Services.

Site licensed capacity is not a data point the county reports in the 274. The licensed capacity is assigned to a provider site as part of licensure/certification.

BH INTEGRATION

Question: Calaveras would like to clarify guidance provided in BHIN 25-013 in reference to the new reporting requirements for integrated BHP's. Calaveras would be considered a DMC-IBHDS as referenced on page 3 of the BHIN and having gone live 1/1/2025.

Can you please confirm if the BHIN is considering counties integrated for the reporting period of 7/1/2024-3/31/2025 regardless of the integrated contract start date if they have a current signed contract?

We want to make sure we complete the appropriate materials.

Answer: Yes, Integrated BHPs and DMC-IBHDS counties will be required to report their data using the same reporting period 7/1/2024-3/31/2025 regardless of the integrated contract start date. Next week, on Wednesday, June 11, at 2pm, NAOS will host a webinar for our Integrated Behavioral Health Plans and Delivery Systems, where we will cover Annual Certification Requirements.

GRIEVANCES AND APPEALS

Question: Are the Grievance categories on slide 43 sub-categories used after filtering the grievances for Access to Care?

Answer: Yes, NAOS will only use the categories as reflected in the BHIN 25-013 for Access to care.

Question: In the Network Adequacy webinar in which Kalila Holmes said that NAOS would be reaching out to Plans to request grievances & appeals after cross references the 1915b Waiver reports – so now I'm confused again.

Do we, or do we NOT submit grievances and appeals that we received during the reporting period (or an attestation) forboth plans that are related to these areas?
- services not available,
- services not accessible,
- timeliness of services,
- 24/7 toll-free access line,
- linguistic services,
- authorization delay notices,
- geographic access, and/or timely access notices

Answer: Grievances and Appeals packages are not due on July 1, 2025. NAOS will reach out with further instructions at a later date. BHPs are still required to submit the 1915(b) waiver, which remains a statewide mandate. Further information on quarterly grievance and appeal reporting can be found in BHIN 23-062. Following the receipt of these

submissions, NAOS will contact the respective BHPs to request the Grievances and Appeals packages in accordance with the documentation requirements outlined in 42 CFR 438 Subpart F and BHIN 25-014.

INPATIENT HOSPITALS

Question: Please clarify if the BHIN language below means that we have an option for contracted facilities to either submit the contract or an invoice or if the requirement remains the same as it has been in the past - contracts for contracted facilities and invoices for noncontracted facilities.

Also, is the August 1 due date for this, which is one month after the Network Adequacy submission is due, correct, or is that an error due to the change in the due date for this year?

"xi. Submission Requirements for Residential Treatment Services, Psychiatric Health Facility Services, and Inpatient Hospital Services (MHP Only) All Medi-Cal certified and inpatient residential facilities must continue submitting data monthly through the 274 file. 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 2024-25, or an executed contract, covering the certification period through June 30, 2026. The executed contract and or invoices is due on August 1, 2025, with the Network Adequacy Submission."

Answer: Yes, the BHIN language means that the requirement remains the same. MHPs must provide an executed contract for contracted facilities and invoices for non-contracted facilities.

Additionally, NAOS is confirming that documentation for Residential Treatment Services, Psychiatric Health Facility Services and Inpatient Hospital Services is due on **August 1, 2025**, with the Network Adequacy Submission.

Question: If we contract with a residential facility to pay for the outpatient services only, but an entity outside of Behavioral Health pays for the person's residential costs, do we include that facility as a residential provider?

Answer: No. The Plan is not contracted with the provider for residential services.

Question: I was reviewing BHIN 25-013 and noticed that on page 14 (MHP Residential Treatment, PHF, and Inpatient Hospital) the due date for executed contracts and/or invoices is listed as August 1, 2026. (please see below)

Since our certification period runs through June 30, 2026, I wanted to confirm whether this due date is accurate.

For reference, in the FY2023–24 ANC, which covered the certification period through June 30, 2025, these documents were due by August 1, 2024.

Based on that, I wanted to verify if the correct due date for the current certification period should be August 1, 2025, instead of 2026.

I would appreciate it if you could confirm the correct due date.

Answer: Confirming that the correct due date for the current certification should be **August 1, 2025,** not 2026.

CAPACITY & COMPOSITION

Question: Pg. 8: Does the 60% calculate holidays and staff time off? Does this percentage take into account holidays, staff time off, mandatory meetings, required trainings, etc. By taking into account other activities, would the 60% be an accurate representation direct billable service?

Answer: Correct, based on surveyed feedback provided from our stakeholder meetings, DHCS determined that the 60% productivity rate appropriately captured billable services delivered.

The established productivity rate takes into account work duties that fall outside of the scope of direct treatment services such as meetings, conferences, and other non-service-related activities.

PROVIDER CONTRACT VALIDATION

Question: We do not expect our provider contracts to be ready by July 1. Can we include them once they execute as part of a corrective action plan?

Answer: NAOS current policy regarding contract submissions does consider the expressed concern. The process for determining compliance with contract validation occurs later in the certification year to allow for counties to provide executed contracts.

IHCP

Question: We have consistently attempted to engage with our sole Indian Health Care Provider, who has stated they are not interested in contracting to bill Medi-Cal. Given this, we would like clarification on the expectations for the recertification submission:

Would four documented outreach attempts (via phone calls and emails) made in 2023 be considered a sufficient good faith effort to contract? Or are we expected to make additional outreach efforts prior to submission and include updated documentation of those attempts?
Language as referenced in the BHIN 25-013 regarding the requirement on page 43-44:

Mandatory Provider Types
BHPs, IBHPs and DMC-IBHDS' 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)
IHCPs are not required to contract with BHPs, IBHPs and DMCIBHDS'; however, BHPs, IBHPs and DMC-IBHDS' shall document good-faith efforts to contract with all IHCPs in the BHP's County. If a BHP, IBHP, or DMC-IBHDS has a valid contract with an IHCP in the BHP's, IBHP's and DMC-IBHDS' County, the BHP, IBHP and DMC-IBHDS shall submit a copy of the contract with their annual submission and complete the MHP and DMC-ODS 274 data fields corresponding with IHCP.

If a BHP, IBHP, or DMC-IBHDS does not have a contract with any of the IHCPs in the BHP's, IBHP's and DMC-IBHDS' County, the BHP, IBHP and DMC-IBHDS shall submit to DHCS an attestation on county letterhead including an explanation to DHCS to justify the absence of an IHCP in the BHP's, IBHP's, or DMC-IBHDS' provider network. The BHP, IBHP, or DMC-IBHDS must also submit supporting documentation. If a BHP, IBHP and DMCIBHDS is unable to contract

with an IHCP, BHP, IBHP, and DMCIBHDS must allow eligible Members to obtain services from out-of-network IHCP in accordance with 42 CFR section 438.14.
DHCS will review the BHP's, IBHP's and DMC-IBHDS' submission to determine compliance.

Answer: No, any contracting efforts within 2023 would not be accepted. The contracting efforts should be between July 1, 2024-June 30, 2025. If your County is an IHCP County, that County must provide a good-faith effort of contracting efforts such as emails, letters, meeting agendas etc.. BHPs that are unable to contract with an IHCP must submit an attestation on their county letterhead in alignment with the 274 submissions along with evidence of contracting efforts.

LANGUAGE CAPABILITIES

Question: Language Line slide says Attachment G is due August 1, 2025 - was this a typo?

Answer: Attach G.1 or G.2, Language Line Encounters report template, is Due July 1, 2025. Language Line/Interpretation contracts are due August 11, 2025.

Question: Placer is a BHP (not an IHBP). Are we to submit one Language Line Encounter template, Attachment G.1, containing all the language line utilization data for both DMC-ODS and MHP members combined?

Answer: No, Two (2) separate LLEs would need to be submitted separately. Per BHIN 25-013 (pg 42), BHP, IBHPs, and DMC-IBHDS' are required to submit in Language Line Encounter (LLE) Template- Attachment G.1 and/or G.2.

Question: As of now, Imperial County Behavioral Health Services does not have an integrated contract in place. Can you confirm whether, in that case, we are required to complete the attachments titled 'BHP'?
G.1- Language line encounter template (BHP)
G.2 language line encounter template (IBHP)

Answer: Two separate LLEs would need to be submitted separately. Per BHIN 25-013 (pg 42), BHP, IBHPs, and DMC-IBHDS' are required to submit in Language Line Encounter (LLE) Template- Attachment G.1 and/or G.2.

SANCTIONS

Question: If the sanctions BHIN is not finalized until after the July 1 deadline for TADT submission, does that mean counties will not be held to sanctions for this reporting period?

Answer: BHIN 25-023 has been recently published. Beginning with the reporting period FY 2023-24, DHCS may impose administrative and/or monetary sanctions on counties that fail to meet network adequacy certification requirements. Please see BHIN 25-023, along with Attachment A and B regarding enforcement actions DHCS may impose.

SIGNIFICANT CHANGE

Question: Question on Significant Change Disclosure: Is Residential WM 3.2 a Modality that Plans are required to report on?

Answer: Yes.

OTHER

Question: Can you clarify the use of "mhp" "dmc-ods" and "bhp" sometimes all of which appear in the same document? Are they being used interchangeably, or should we understand that if mhp or dmc-ods is called out separately, that we're supposed to submit separately, but not if bhp is being used?

Answer: Correct. When MHP or DMC-ODS is specifically called out in the BHIN, that section and submission requirement is specific to the identified program. When BHP is singularly referenced in the BHIN, the section and submission requirement is specific to both programs, MHP and DMC-ODS.

Question: Can you please provide more clarification on what the upcoming "Transition of Care/ Continuity of Care" BHIN will entail?

Answer: The upcoming Transition of Care/Continuity of Care BHIN will combine the guidance from MHSUDS IN 18-059 and MHSUDS IN 18-051 into one single BHIN.