State of California—Health and Human Services Agency

Department of Health Care Services

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DATE: May 24, 2021

Behavioral Health Information Notice No: 21-023
Supersedes: MHSUDS IN 18-011 & BHIN 20-012

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: 2021 Federal Network Certification Requirements for County Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery Systems (DMC-ODS).

PURPOSE: To expand and clarify Network Adequacy Certification submission requirements for county MHP and DMC-ODS Plans

REFERENCE: Supersedes IN 18-011, and BHIN 20-012

BACKGROUND:
On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program Managed Care Final Rule (Managed Care Rule), which revised 42 Code of Federal Regulations (C.F.R.). These changes aimed to align Medicaid managed care regulations with requirements of other major sources of coverage. MHPs and DMC-ODS Counties (referred to as "Plans") are classified as Prepaid Inpatient Health Plans under federal law and must therefore comply with federal managed care requirements (with some exceptions). Three parts of the Managed Care Rule comprise the majority of network adequacy standards: 42 C.F.R. part 438.68 Network adequacy standards; part 438.206 Availability of services; and part 438.207 Assurance of adequate capacity and services. Welfare and Institutions

Code (W&I) Section 14197 includes time and distance and timely access standards and subdivision (i) authorizes DHCS to interpret and implement section 14197 by information notice.

REQUIREMENTS

DHCS is required to monitor Plans' compliance with the network adequacy requirements set forth in section 14197 and 42 C.F.R. parts 438.68, 438.206, and 438.207 to ensure that all Medi-Cal managed care covered services are available and accessible to beneficiaries of the Plans in accordance with timely access and time and distance standards.[1] In accordance with 42 C.F.R. part 438.68(c)(1), the standards specified in this BHIN take into consideration the following elements:

1) The anticipated Medi-Cal enrollment;
2) The expected utilization of services;
3) The characteristics and health care needs of the Medi-Cal population;
4) The numbers and types (in terms of training, experience and specialization) of network providers required to furnish contracted Medi-Cal services;
5) The numbers of network providers who are not accepting new Medi-Cal beneficiaries;
6) The geographic location of network providers and Medi-Cal beneficiaries, considering distance, travel time, and the means of transportation ordinarily used by Medi-Cal beneficiaries;
7) The ability of network providers to communicate with limited English proficient beneficiaries in their preferred language(s);
8) The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medi-Cal beneficiaries with physical or mental disabilities; and
9) The availability of triage lines or screening systems, as well as the use of tele-medicine, e-visits, and/or other evolving and innovative technological solutions.

NETWORK DATA AND DOCUMENTATION REPORTING REQUIREMENTS

The Managed Care Rule, as set forth in 42 C.F.R. part 438.207, requires each Plan to submit documentation to DHCS annually[2] to demonstrate its compliance with the State's standards for access to services, including network adequacy and timely access standards. Additionally, Part 438.207, assurances of adequate capacity and services, requires each Plan to submit documentation to DHCS, in a format specified by DHCS, to demonstrate that it complies with the following requirements:

[1] W&I § 14197 (2020); See Also . § 14197(f) (2020); 42 C.F.R. §§ 438.68(a) (2020), 438.206(a),(c)(1)(i) (2020); See Also § 438.207 (2020).
[2] Plans are also required to submit documentation at any time there has been a significant change in the Plans operations that would affect the adequacy of the Plans capacity and services. 42 C.F.R. § 438.207(c) (2020).

- Offers an appropriate range of services that is adequate for the anticipated number of beneficiaries for the service area (i.e., county); and
- Maintains a network of providers operating within the scope of practice under State law, that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the service area (i.e. county).[3]

The Final Rule also required DHCS to implement regulations related to network adequacy standards and certification, and established requirements for Plans network certification that expanded on previous provider network monitoring efforts and contractual provider network requirements. The Final Rule required that states not only meet the federal requirements of 42 C.F.R. Sections 438.68, 438.206(c), and 428.207, but also establish state specific network adequacy standards to ensure that Plans are meeting the current needs of the beneficiaries and projected future beneficiaries.

To assure compliance with established federal and State standards, the Final Rule requires DHCS to submit to CMS an annual network certification of the Plans. Additionally, DHCS must submit a network certification anytime there has been a significant change as defined by DHCS in the Plans operations that would affect the adequacy of capacity and services, including changes in Plan services, benefits, geographic service area, composition of, or payments to its provider network; or enrollment of a new population in the Plan.

As set forth in 42 C.F.R. parts 438.68 and 438.206, Plans must submit the required documentation and submit an assurance of compliance to CMS on an annual basis, confirming that each Plan meets the State's requirements for the availability of services. Each Plan's documentation serves as the basis for the State's assurance that the Plan is compliant. The submission to CMS must include documentation of an analysis that supports the assurance of the adequacy of each Plan's provider network.[4]

W&I Section 14197, subdivision (f)(1) also requires that the Plan, on an annual basis and on DHCS's request, demonstrate (separately for adult and pediatric services) the Plan's compliance with the time and distance and appointment time standards in the section.[5] Furthermore, on an annual basis and on DHCS's request, the Plan shall demonstrate (separately for adult and pediatric services) how it arranged for the delivery of services, such as through Medi-Cal covered transportation or telehealth, if

[3] 42 C.F.R. § 438.207 (2020).68(d)(1)
[4] 42 C.F.R. § 438.207, subd. (d) (2020); See Also W&I, § 14197, subd. (f)(3),(4) (2020).
[5] W&I, § 14197, subd. (f)(1) (2020).

beneficiaries needed services from a provider or facility located outside of the time and distance standards specified in section 14197(c).[6]

In addition, W&I Section 14197.05 requires DHCS' external quality review organization to annually gather data and assess whether each Plan's network met the network adequacy requirements set forth in W&I Section 14197 during the preceding 12 months.

SUBMISSION REQUIREMENTS

For the Fiscal Year (FY) 2021/2022 certification and subsequent FYs, Plans shall submit the Network Adequacy Certification Tool (NACT) and supporting documentation no later than July 1, or the next business day if the 1st day of the month falls on a weekend or holiday. The submission of the NACT provides point-in-time data in regards to the composition of the Plan's provider network. Supportive documentation such as the provider directory and organizational charts should also be point in time.

Supporting Documentation submissions such as 1) Timely Access Data, 2) Grievance and Appeals, 3) Language Line Encounters, and 4) Continuity of Care, must comply with the reporting periods below. The December-February reporting period will be used for annual submissions until further notice:

- For State FY 2021/2022: Annual Certification - July 1, 2021(reporting period: December 1, 2020 – February 28, 2021)

All executed agreements with contracted network providers and subcontractors (including agreements and policies and procedures pertaining to interpretation, language line, telehealth services, timely access, accessibility, and reserve/staffing contracts documentation) must cover the certification FY. For auto-renewing contracts (that have expired or will expire during the certification period), the Plan must submit an attestation there are no known factors that could preclude the auto renewal.

Any county that is found deficient and placed on a Corrective Action Plan (CAP) must submit the NACT and any supporting documentation required to address the CAP by March 1st to demonstrate compliance. The submissions must comply with the reporting periods below. The September – November reporting period will be used for annual CAP submissions until further notice:

- For State FY 2021/2022: CAP County submission - March 1, 2022 (reporting period: September 1, 2021 – November 30, 2021)

[6] W&I, § 14197, subd. (f)(2) (2020).

In addition, MHPs and DMC-ODS plans are required to notify DHCS by email to MHSDFinalRule@dhcs.ca.gov or ODSSubmissions@dhcs.ca.gov, respectively, within 10 business days, any time there has been a significant change in the Plan's operations that would render the Plan non-compliant with standards for network adequacy and capacity including, but not limited to, the composition of the Plan's provider network.[7]

Network Adequacy Certification Tool (NACT) – Attachments A.1 and A.2
Plans are required to complete all exhibits in the NACT.

MHP:
- Attachment A.1 is available by contacting MHSDFinalRule@dhcs.ca.gov

DMC-ODS:
- Attachment A.2 is available by contacting ODSSubmission@dhcs.ca.gov

Utilizing the NACT and supporting documentation, DHCS will review each Plan's compliance in the following areas:

I. Network Capacity and Composition:
   a. MHP – Beneficiary to Provider Ratios;
   b. DMC-ODS – Availability of Services; and
   c. Additional Options to meet Provider and Capacity Requirements.

II. Time and Distance Standards:
   a. Geographic Maps Methodology;
   b. Alternative Access Standard;
   c. Alternative Access Standard Request Template; and

III. Additional Options to meet Time and Distance Standards.
Timely Access:
   a. Timely Access Data Tool (TADT) (Distinct from CSI data and required for MHPs only until further notice; please see Section III of this Notice, beginning on p. 20).

IV. Language Assistance Capabilities:
   a. Language Capacity;
   b. Telephonic language Line Encounters Analysis.

V. Mandatory Provider Types:
   a. American Indian Health Facilities;
   b. Intensive Care Coordination and Intensive Home Based Services.

VI. Transition of Care/Continuity of Care as described in: IN 18-051 and IN 18-059; and

VII. System infrastructure.

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[7] 42 C.F.R., § 438.207(c)(3) (2020)

I. Network Adequacy Standards – Capacity and Composition

a. MHP – Beneficiary to Provider Ratios

Each MHP must maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to SMHS, for all beneficiaries within their county, including those with limited English proficiency or physical or mental disabilities.[8] MHPs must meet or exceed network capacity requirements and proportionately adjust the number of network providers to support any anticipated changes in enrollment.

The process by which DHCS determines if an MHP meets or exceeds network capacity pertaining to Outpatient SMHS and Psychiatry Services includes 1) Provider Productivity Calculation, 2) Average Minutes Calculation, 3) Provider Ratio Calculation, 4) Anticipated Need for Specialty Mental Health Services and Psychiatry Services, and 5) Evaluation of County Provider-Beneficiary Ratios.

Productivity Calculation

DHCS assumed that each full-time equivalent (FTE) provider can work a maximum of 2,080 hours (or 124,800 minutes) per year (assumptions: 52 weeks × 40 hours per week). DHCS assumes a 60% productivity rate (i.e., time spent on direct billable services) to determine the total productive minutes (i.e., 74,880) per State Fiscal Year (SFY) for each FTE Specialty Mental Health Service (SMHS) provider. The 60% productivity rate was established after convening internal and external stakeholder meetings which confirmed that, on average, most providers spend about 60% of their time providing treatment services directly while the remaining 40% is spent on administrative or other non-service related professional activities (e.g., attending conferences, participating in professional events, etc.).

Average Minutes Calculation

Using SMHS claims data (as claimed by all qualified providers listed in the California State Plan), DHCS calculated the average number of minutes claimed statewide for Mental Health Services parsed into adults and children/youth for the FY 2017/2018.

For Psychiatry Services (because DHCS was developing a ratio specific to psychiatrists), each county's medication support services were isolated into only those claimed under a psychiatrist/neurologist provider taxonomy code. Then the minutes were averaged for the FY by county and age group. The averages were divided into quartiles representing all 56 county MHPs. Then, DHCS used the median value to stabilize the billing pattern variations across the counties. The

[8] 42 C.F.R. § 438.206(b)(1) (2020)

median percentage of medication support services billed by psychiatrists or neurologists for the adult beneficiary population was 50.6%. The median percentage of medication support services billed by psychiatrists or neurologists for the children/youth beneficiary population was 71.8%. DHCS adjusted the statewide average of medication support services by these percentages to create a proportionate psychiatry provider ratio.

Provider Ratio Calculation

To calculate statewide ratios for Mental Health Services, DHCS divided the total **productive minutes** per year by the total **average SMHS service minutes** billed for adults and/or children/youth.

To calculate statewide ratios for Psychiatry Services, DHCS divided the total **productive minutes** per year by the percentage of **psychiatry-billed medication support minutes** calculated (as described above). The results of the provider ratio calculation are presented in Table 1.

Table 1. Provider-To-Beneficiary Ratio Standards

Measurement Category	Ratio Standard
Psychiatry – Adults	1:524
Psychiatry – Children/Youth	1:323
Mental Health Services – Adults	1:85
Mental Health Services – Children/Youth	1:43

Anticipated Need for Specialty Mental Health Services (SMHS) and Psychiatry Services

DHCS based SMHS need on the Serious Emotional Disturbance in children/youth and Serious Mental Illness in adults (SED/SMI) prevalence estimates calculated for the *Bridge to Reform Waiver*, developed by the Technical Assistance Collaborative (TAC) and the Human Services Research Institute (HSRI). The TAC and HSRI report is available at: http://www.dhcs.ca.gov/provgovpart/Documents/CABridgetoReformWaiverServicesPlanFINAL9013.pdf). While these estimates were published in 2013, they are the only available prevalence estimates specific to the SED/SMI population within Medi-Cal. However, DHCS compared prevalence estimates over time and determined that prevalence rates within the population do not vary greatly over time.

Using the Medi-Cal Eligibility Data System (MEDS), DHCS calculates the average number of eligible Medi-Cal beneficiaries in each county during the most recent FY. DHCS then applies the SED and SMI prevalence estimates to the average eligibles per county and age group to determine the proportion of

beneficiaries likely to need SMHS. This adjusted Medi-Cal enrollment population represents the anticipated need for SMHS.

DHCS uses this same methodology to estimate the need for psychiatry services (i.e., provided specifically 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 psychiatry 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 psychiatry services as a part of their treatment plan. Thus, to estimate the proportion of beneficiaries that may need psychiatry services, the estimated population to seek SMHS was adjusted by this percent.

Evaluation of County Provider-Beneficiary Ratios

DHCS will calculate each MHP's current provider-to-beneficiary ratio using FTE provider counts (numerator) and the anticipated SMHS and Psychiatry needs population (denominator). DHCS will then evaluate the MHP's provider-to-beneficiary ratios to determine if the current provider network meets the statewide ratio requirement. For an example of this process, see Table 2.

Table 2. County Provider Network Adequacy – Example Calculation

FY 17/18	Sum Average minutes	Provider productive minutes per year	Statewide ratio requirement	Example County Needs Population	Example County Provider FTE Reported	Example County Ratio	Example Findings
Mental Health Services – Children /Youth	1,733	74,880	74,880/1,733 = 1:43	6,000	70.2	Needs Population/ FTE= 1:85	Deficient – Need to add 69.3 FTE
Mental Health Services – Adults	882	74,880	74,880/882 = 1:85	4,000	195.2	Needs Population/ FTE= 1:20	Compliant

In the example above, for Children/Youth Mental Health Services, the county has one FTE per 85 children. This is evidenced by dividing 70.2 FTE reported into the 6,000 beneficiaries in need of service. To determine how many FTE are needed to serve 6,000 beneficiaries, divide 43 (required ratio) into 6,000, which equals 139.5 FTE. By subtracting reported FTE (70.2) from required FTE (139.5), the deficiency in the example is 69.3 FTE.

For MHPs utilizing tele-psychiatry and/or locums tenens contracts to meet the need for psychiatry services, DHCS will calculate the estimated FTE value of the contracts. DHCS estimates FTE by dividing the total FY budget amount by the mean hourly (i.e., business hours) rate to determine the total number of hours allotted via the contract. DHCS will consider alternate proposals from MHPs for estimating FTE on a case-by-case basis.

Calculating Full-Time Equivalents

A provider may be counted as one FTE position if the individual's full-time job assignment is direct service delivery to Medi-Cal beneficiaries. In the case where an individual is assigned to direct service delivery on a part-time basis, the FTE should be calculated based on the percentage of time the individual could be dedicated to direct service delivery on an ongoing basis over the course of a year. A FTE position is 2,080 hours per year (i.e., 40 hours per week). FTE calculations shall not exceed 40 hours per week; including between service type and age group served (Please see the section titled "Additional Options to Meet Provider and Capacity Requirements" on p. 14 for instructions on how a Plan may report provider time in excess of 40 hours per week).

Only direct providers of Mental Health Services and Psychiatrist Services should be included. For each rendering provider (an employee or contracted provider), report the total FTE (capacity) available to directly provide Mental Health Services including Intensive Home Based Services (IHBS) and Psychiatrist Services as evidenced by the contract. Only report time available to provide services in outpatient settings; do not report FTE for providers who are only available to work in inpatient or residential settings. Providers who are available to work in both inpatient and outpatient settings can be counted, but their FTE should be allocated based on time available for the outpatient setting only. The NACT only allows for the selection of one age group per provider listed. Thus, for providers that serve more than one age group, the percentage of FTE allotted to each age group by service type should be listed on a separate line. In addition, if a percentage of FTE is telehealth, it should be listed on a separate line and indicated by selecting “yes” in the telehealth column (MHP NACT, Exhibit A-3, column BJ).

DHCS will evaluate compliance with psychiatry ratios using reported FTE for psychiatrists only. Psychiatric nurse practitioners (NPs) may fulfill requirements for counties with deficiencies in psychiatry ratios, as part of a CAP, as long as the nurse practitioner ratios do not exceed 4:1 NP/psychiatrist (for more detail please see p. 14).

For outpatient specialty mental health ratios, DHCS will count reported FTE for all providers the MHP has listed as available to provide outpatient mental health services (including IHBS). This includes providers who are available to provide other service types in addition to outpatient mental health services. However, DHCS will not count providers who are available only for services other than outpatient mental health services. For example, if a provider is only available to provide targeted case management or crisis stabilization services, the provider should be reported accordingly by the MHP and will not be included in the outpatient ratio calculation.

Administrative Staff

These staff and/or members of leadership can only be included if they genuinely 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 actual 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 briefly explains why the provider does not carry a regular caseload.

Reserve/Staffing Contracts

MHPs are permitted to use reserve/staffing contracts to meet network adequacy standards and/or as a basis for Alternative Access Standard (AAS) request. Reserve/staffing providers must meet the provider requirements for the applicable SMHS, be enrolled as providers in the Medi-Cal program, and be able to comply with state and federal requirements for the Medi-Cal program.

In order to utilize reserve/staffing contracts to meet provider to beneficiary ratios, the provider must be available to provide services to beneficiaries in the defined service area. In addition, the physical location where beneficiaries receive services must meet the State's time and distance standards or an approved AAS request.

If using reserve/staffing contracts to meet either network adequacy standards or AAS, MHPs must submit information to DHCS on their reserve/staffing providers during scheduled submission periods. This information should include a copy of the reserve contract, the name and National Provider Identifier (NPI) number of the contracting agency, and a statement from the county describing the number of FTE that can be available under the contract maximum (if this is not explicit in the contract itself).

b. DMC-ODS – Availability of Services

Each DMC-ODS plan is required to provide a list of contracted facilities as part of their annual submission. To verify the network composition for the DMC-ODS plan, DHCS analyzes the list of submitted facilities, and each facility's maximum number of beneficiaries separated by age group (i.e., 0-17, 18-20, and 21+) and service modality that can be served at any given time, as reported by the county.

DMC-ODS plans must contract with the following provider types or facilities based on contractual, state, or federal requirements:

- Outpatient substance use disorder services provided by DMC-certified outpatient and intensive outpatient facilities.
- Opioid use disorder services provided by DMC-certified Narcotic Treatment Program/Opioid Treatment Program facilities.
- Residential substance use disorder services provided by DMC-certified, state-licensed, and American Society of Addiction Medicine (ASAM) designated residential facilities. At least one ASAM level of service must be

available at initial implementation and all ASAM levels of care (e.g., 3.1, 3.3, 3.5) must be available within three years of implementation.

Projected Utilization

DHCS' projected utilization methodology is based on monthly enrollment totals derived from MEDS. Utilizing two FYs of Medi-Cal enrollment data (e.g., for this certification, DHCS is using state FY 2018-19 and 2019-20), two sets of projections are produced for each county: one for children and youth (aged 12-17) and one for adults (aged 18 and over). Monthly enrollment totals are forecasted through the certification period (e.g., for FY 2021/2022 certification the projection is through June 2022).

Utilizing the 2019 National Survey on Drug Use and Health[9] combined SUD estimates, DHCS applied the percentage of those aged 12-17 (4.55%) and 18+ (9.23%) estimated to be **in need of treatment services** to the Medi-Cal enrollment projections through June 2022 for each age group. DHCS then applied a percentage of 10 to the estimated beneficiaries **in need of treatment services** to estimate the number **who will actually seek treatment**. The 10% comes from the California-Specific 2018 Edition — Substance Use in California - California Health Care Foundation (chcf.org).[10]

For further validation of expected utilization, DMC-ODS plans are also required to provide projections of beneficiaries who will seek treatment through the certification period (for FY 2021/2022, this projection is to June 2022) as well as the number of beneficiaries per treatment modality.

Network Capacity

To determine DMC-ODS plans' network capacity and sufficiency to serve the Medi-Cal population, DHCS:

1. Compares the **expected utilization** (as calculated and reported by DMC-ODS plans) and the **Seeking Treatment Estimate** (as calculated by DHCS).
    a. If the DMC-ODS plan projects a **higher** number of beneficiaries **expected to utilize** services than the **Seeking Treatment Estimate** generated by DHCS, the plan's number is used to determine if the DMC-ODS plan's network composition is sufficient.

[9] Substance Abuse and Mental Health Administration sponsored research evaluates the use of illegal drugs, prescription drugs, alcohol, and tobacco and misuse of prescription drugs; substance use disorders and substance use treatment major depressive episode and depression care; serious psychological distress, mental illness, and mental health care using data from the National Survey on Drug Use and Health.

[10] The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California.

i. Sufficiency means the maximum number of beneficiaries that can be served per treatment modality (as reported by the DMC-ODS plan within the NACT) meets or exceeds the **expected utilization.**

b. If the DMC-ODS plan's projections are **lower** than DHCS' **Seeking Treatment Estimate**, DHCS utilizes the **Seeking Treatment Estimate** to determine if the DMC-ODS plan's network composition is sufficient.
   i. Sufficiency means the maximum number of beneficiaries that can be served per treatment modality (as reported within the NACT) meets or exceeds the **Seeking Treatment Estimate**
   ii. When determining sufficiency based on the seeking treatment, the percent difference between the DMC-ODS total **expected utilization** and the **Seeking Treatment Estimate** is applied to increase the number of beneficiaries per treatment modality to the appropriate number.

Additional Analysis of Monthly utilization Data:

If counties are found deficient in the initial Network Capacity Analysis described above, then, DHCS also analyzes monthly utilization data as follows:

1. Utilizing the Supplemental Data Tool, counties may submit unique beneficiary counts per treatment category for the certification submission's FY, by month and by age group. For validation purposes, DHCS compares this data to the DMC-ODS' claims data submitted. DHCS understands that counties may report more monthly utilization than what is evident in the DHCS claims database, due to normal claim lag; however, the monthly utilization submitted in the Supplemental Data Tool should not be less than what is in DHCS's records.
2. DHCS compares the county's **expected utilization** to DHCS's annual **Seeking Treatment Estimate** (as discussed in Sections A & B above).
   a. If the county's expected utilization is **higher than DHCS' estimate**, DHCS uses the county's monthly utilization to project monthly utilization through the certification year. Then, DHCS determines sufficient capacity. Sufficiency means the maximum number of beneficiaries that can be served per treatment modality (as reported within the NACT) meets or exceeds the projected monthly utilization for each treatment modality and age group.
   b. If the county's expected utilization is **lower than DHCS' estimate**, DHCS uses the county's monthly utilization to project the monthly utilization through the certification year, then applies the percent

difference between DHCS **Seeking Treatment Estimate** and the county's **expected utilization** to the projection of monthly utilization through the certification year in order to grow it to the appropriate number. Then, DHCS determines sufficient capacity. Sufficiency means the maximum number of beneficiaries that can be served per treatment modality (as reported within the NACT) meets or exceeds the projected monthly utilization (with applied growth) for each treatment modality and age group.

Please note - Counties are **not** required to submit monthly utilization data with the July 1st submission but can submit at their own discretion. The submission is required on March 1st if the county is placed on a CAP for Capacity and Composition.

Table 3. DMC-ODS, Estimated Need and the Seeking Treatment Estimate – Example Calculation

Projected Average Medi-Cal Enrollment Ages 12-17	Estimated Population in Need of SUD treatment Ages 12-17 (4.55%)	Estimated Population to Seek SUD treatment Ages 12-17 (10% of total in need)	Projected Average Medi-Cal Enrollment Ages 18+	Estimate in need of SUD treatment Ages 18+ (9.23%)	Estimated Population to Seek SUD treatment Ages 18+ (10% of total in need)
219,775	10,000	1000	1,262,626	116,540	11,654

Table 4. DMC-ODS, Expected Utilization per Service Modality – Example Calculation

Comparison of DHCS vs. County Estimates				Outpatient Drug Free (ODF)			Intensive Outpatient Treatment (IOT)			Residential (RES)			Opioid Treatment Programs (OTP)		
DHCS Seeking Treatment	County's Total Expected Utilization (N)	Difference	% Diff	Proportion Expected Utilization for **ODF** (*n*)	Applied % Diff	New Need	Proportion Expected Utilization for **IOS** (*n*)	Applied % Diff	New Need	Proportion Expected Utilization for **RES** (*n*)	Applied % Diff	New Need	Proportion Expected Utilization for **OTP** (*n*)	Applied % Diff	New Need
1000	750	250	33.3%	**350**	117	467	**200**	66	266	**150**	50	200	**50**	17	67

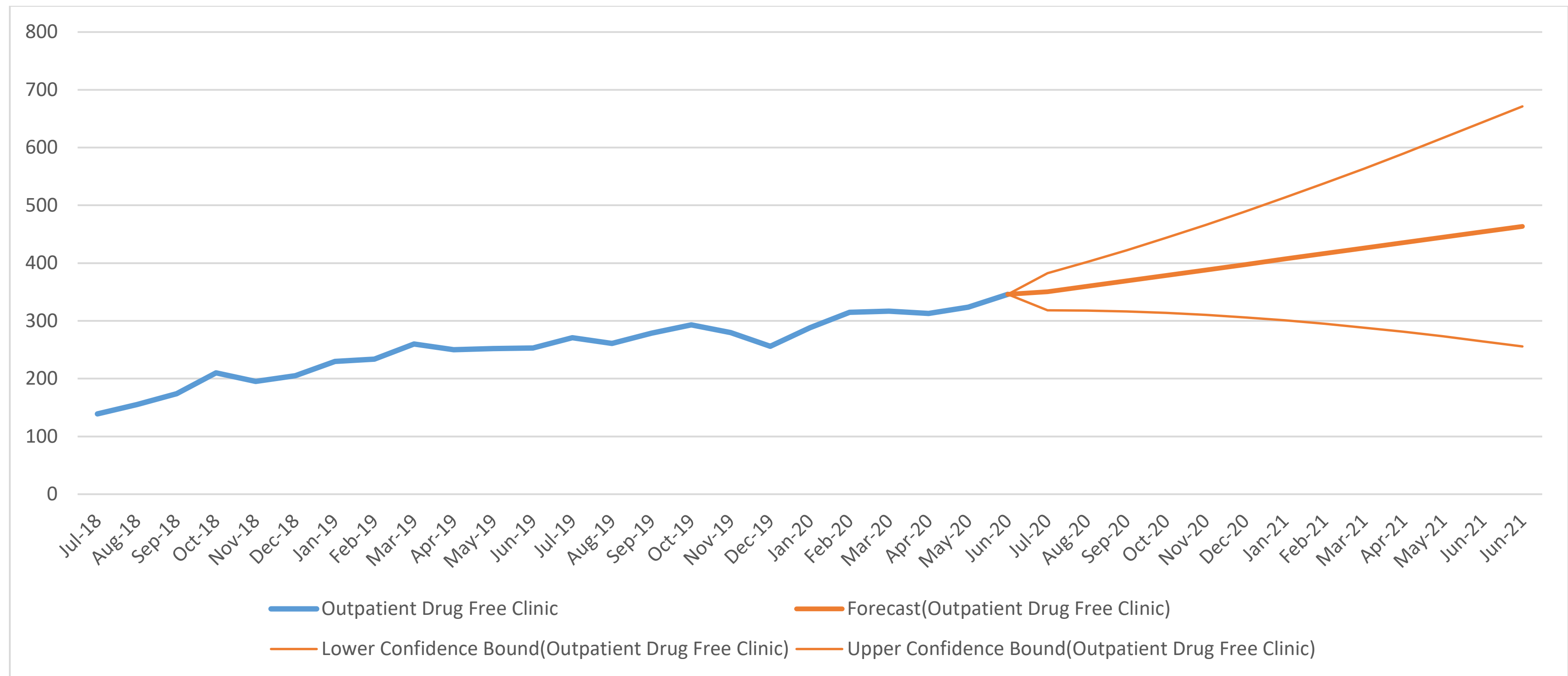
In the example above, the county's total **expected utilization** (which is reported in the NACT, exhibit C-1) is 750 beneficiaries, which is less than DHCS's **Seeking Treatment Estimate** of 1,000 beneficiaries in the children/youth age group (0-17), as shown in Table 3. DHCS's **Seeking Treatment Estimate** is used as a baseline that the county must either meet or exceed. Thus, DHCS calculates the numerical difference between the two estimates and then converts that difference into a percentage. The percent difference is then applied to the county's **expected utilization** broken out by service modality (also reported in the NACT, exhibit C-1) to grow those numbers proportionately to meet DHCS's **Seeking Treatment Estimate.**

Table 5. DMC-ODS Capacity and Composition Filter – Example

Row	Age Group (s) Served	Modality (DMC-ODS) - Outpatient Drug Free Clinic	Modality (DMC-ODS) - Intensive Outpatient Clinic	Modality (DMC-ODS) - Residential	Modality (DMC-ODS) - Opioid Treatment Program	Maximum Number of Medi-Cal Beneficiaries
1	18+	Yes	No	No	Yes	70
2	0-17	No	Yes	Yes	No	12
3	0-17	Yes	No	No	Yes	24
4	18+	Yes	No	No	Yes	30
5	18+	Yes	No	No	Yes	245
6	0-17	Yes	No	No	No	300
7	18+	Yes	No	No	Yes	250
8	18+	Yes	Yes	Yes	Yes	100
9	18+	No	Yes	Yes	Yes	59
10	0-17	Yes	No	No	Yes	25
11	0-17	Yes	No	No	Yes	19
12	18+	Yes	No	No	Yes	30
13	0-17	Yes	No	No	Yes	250

In the example above, DHCS filtered the NACT (Exhibit A-2, Site Level Data) by age group, provider type, and maximum number of beneficiaries served. DHCS uses this filter to determine capacity to serve. For example, for Children/Youth (0-17) Outpatient Drug Free services, DHCS can sum the Maximum Number of Med-Cal Beneficiaries for rows 3, 6, 10, 11, and 13 for a total of 618 maximum capacity. If the **expected utilization** for Children/Youth (0-17) Outpatient Drug Free services (using the example in Table 4) is 467 beneficiaries, the county has sufficient capacity to meet **expected utilization.**

Table 6. DMC-ODS Monthly Utilization Data Projection – Example Projection



In the example above, DHCS uses two FYs of monthly utilization data (reported by a county, in the Supplemental Data Tool) to project utilization per month through the certification period. This data can be used to resolve the findings from the annual capacity analysis.

DHCS calculates both annual and monthly estimates to determine a DMC-ODS plan's capacity, as there are many variables that affect the range between estimation and actual utilization. For instance, the annual estimation includes beneficiaries currently receiving DMC-ODS services and those that will be new to the system. Utilization is helpful in understanding the pattern in which services are actually utilized in a county; however, utilization does not account for those that may have needed services but could not receive it (e.g., inadequate service capacity, obstacles to services, or variation in beneficiaries seeking services) or a growing population that could require services. The monthly utilization is used as a mediator between the annual estimation and actual monthly utilization for the certification period and can be used to resolve CAPs. However, counties are expected to continually grow the networks to eventually achieve the annual **Seeking Treatment Estimate**.

c. Additional Options to meet Provider and Capacity Requirements

DHCS may grant requests for AAS for MHP Provider Ratio and DMC-ODS Capacity and Composition requirements.

- For MHP, Rendering Providers with FTE in excess of 40 hours per week, counties **must not** submit the provider's data in the NACT. Rather, counties may submit a narrative request (on county letterhead), listing the provider details and FTE to be considered (including breakout of FTE per delivery system if the provider works in both MHP and DMC-ODS, service modality, and age group served).
    - To be considered, the county must also provide an executed provider contract for each provider listed in the narrative **and** supporting documentation, such as a signed attestation from the county explaining the validity of the FTE if the contract does not state this clearly.
- For Psychiatry ratios, counties may submit psychiatric nurse practitioners (NP) to meet the alternate access standard, as long as the ratio of NPs per Psychiatrist does not exceed 4:1.
- For Non-Psychiatry, Medication Support only Provider FTE, counties **must not** submit the provider's data in the NACT. Rather, counties may submit a narrative request (on county letterhead), listing the provider details and FTE to be considered (including breakout of FTE per delivery system if the provider works in both MHP and DMC-ODS, service modality, and age group served)
    - To be considered, the county must also provide an executed provider contract for each provider listed in the narrative **and** supporting documentation such as a signed attestation from the county explaining the validity of the FTE if the contract does not state this clearly.

- For DMC-ODS Capacity and Composition gaps in service providers, counties may submit a Corrective Action Plan Resolution Proposal which outlines how the Plan proposes to ensure access to those services while working to add providers. The Resolution Proposal should also include a long-term plan which describes the steps (including timelines) that the county will take to obtain a provider in each required service modality. If approved, the county will have established an AAS for Capacity for the certification period only (through June 2022). DHCS will monitor the timeline submitted for the long-term resolution. It is critical that Plans adhere to timelines stated within the DHCS approved CAP resolution, and submits required documentation as proof of progress in a timely manner.

II. Network Adequacy Standards – Time and Distance Standards (Attachment B)

42 C.F.R., part 438.68 (2020), Network Adequacy Standards, requires states to develop time and distance standards for adult and pediatric behavioral health providers. Time means the number of minutes it takes a beneficiary to travel from the beneficiary's residence to the nearest provider site. Distance means the number of miles a beneficiary must travel from the beneficiary's residence to the nearest provider site. Based on technical assistance DHCS received from CMS, the Plans must meet both time and distance standards, not time **or** distance. Both standards are based on a county's population density, and counties are required to meet both standards. Time and distance standards for Mental Health Services, Targeted Case Management, Crisis Intervention, Psychiatrist Services, Substance Use Disorder outpatient, and Opioid Treatment Program services are specified in Attachment B.

a. Time and Distance Geographical Maps Methodology

DHCS prepares geographic access maps for Plans. DHCS applies ArcGIS Enterprise (DHCS Online Portal) to run the driving times and driving distances by utilizing the shortest driving time from the Plan to the furthest Medi-Cal eligible's address. The eligible(s) impacted is based on the most recent data available from the MEDS data for all Medi-Cal eligibles in the zip code.

DHCS plots time and distance for all network providers, stratified by provider type for MHP (Psychiatry and Outpatient SMHS), for DMC-ODS (Outpatient Services and Opioid Treatment Programs) and geographic locations, for both adult and children/youth separately based on the NACT.

MHP:

- Exhibit A-3: Rendering Service Provider
- Exhibit B-1 (Field Based Services): only needed if field-based services are regularly delivered and are being used to meet time and distance standards.

DMC-ODS:

- Exhibit A-2: Site

b. Alternative Access Standard

The Managed Care Rule permits states to grant exceptions to the time and distance standards.[11] If a Plan cannot meet the time and distance standards set forth in this BHIN for all coverage areas where Medi-Cal eligibles reside, DHCS will notify the Plan to submit an AAS request (Attachment C) to DHCS within 30 days.[12] For each coverage area for which the Plan does not meet the time and distance standards for a provider type, the Plan shall include a description on how the Plan intends to arrange for Medi-Cal beneficiaries who reside in that coverage area to access that provider type, as specified in W&I Section 14197, subdivision (c).[13]

c. Alternative Access Standard Request Template: Attachment C

DHCS may grant requests for AAS if the Plan has exhausted all other reasonable options to obtain providers to meet the applicable standard, or if DHCS determines that the Plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access. [14]

Requests for AAS must include a description of the reasons justifying the AAS based on the facts and circumstances surrounding a ZIP Code or Provider Type.[15] Requests may also include seasonal considerations (e.g. winter road conditions), when appropriate. Furthermore, Plans should, as appropriate, include an explanation about gaps in the county's geographic service area, including information about uninhabitable terrain within the county (e.g., desert, forestland). In determining whether to grant a request, DHCS shall consider whether it is reasonable for a beneficiary to travel the time and distance that would result if DHCS granted the AAS.[16]

[11] 42 C.F.R. § 438.68(d)(1) (2020).
[12] W&I, § 14197, subd. (e)(2) (2020).
[13] W&I, § 14197, subd. (e)(3) (2020).
[14] W&I, § 14197, subd. (e)(1) (2020).
[15] W&I, § 14197, subd. (e)(3) (2020).
[16] W&I, § 14197, subd. (e)(5) (2020).

Attachment C details the submission requirements for AAS requests. In the AAS request template, a Plan must provide the nearest in-network provider as well as the driving time/distance to that provider.

To demonstrate that it has exhausted all other reasonable options to obtain providers to meet the applicable standard a Plan must submit evidence of its Out-of-Network (OON) contracting efforts. For each OON provider that a Plan attempted to contract with, the Plan must provide the name of the OON provider, including at minimum two OON provider(s) and driving time/distance from the OON provider(s) to the furthest eligible(s) in that zip code. In addition, Plans must provide reasons for inability to contract with OON provider and description of its contracting efforts, including the frequency of the contracting efforts, and the reasons the Plan was unable to contract. Plans must attempt to contract with at least two OON providers.

Plans are required to submit evidence of OON contracting efforts, including narrative detailing the name(s) of the OON provider(s) that the Plan attempted to contract with and the frequency of the contracting efforts. Plans must include documentation demonstrating contract efforts via email/letter, scheduled phone calls, good faith negotiations, contract records, marketing materials and advertisements, and follow-up attempts after initial contract efforts or outreach.

If a Plan is unable to contract with a specific provider due to a quality of care issue, the Plan must submit supporting documentation detailing the Plan’s concern with the provider’s quality of care. A quality of care issue may include, but is not limited to, a provider having insufficient credentials or being suspended from participation in the Medi-Cal program by DHCS, CMS, or the Office of the Inspector General for Health and Human Services.

Alternative Access Standard Validation

In Attachment C, Plans must detail the name of the two nearest identified OON providers, the date the Plan contacted the providers to discuss contracting with the Plan and the number of contracting attempts the Plan made. Through the AAS validation, DHCS will request evidence of contracting efforts, which must include supporting documentation demonstrating contract efforts via email/letter, scheduled phone calls, good faith negotiations, contract records, marketing materials and advertisements, and follow-up attempts after initial contract efforts or outreach. The evidence of contracting efforts must reflect contracting efforts conducted since the Plan’s last annual submission. DHCS will focus on validating AAS requests that have potential contracting options. The supporting

documentation submitted must be dated prior to the AAS request being requested.

DHCS approves or denies an AAS request on a zip code and provider type basis.[17] The review process includes 1) verifying the AAS Request is submitted on time, 2) verifying if the AAS request is complete, and 3) verifying the Plan's efforts to identify the nearest in-network and OON providers. Additionally, DHCS compares the identified providers submitted by the Plan to the NACT and to other resources.

DHCS reviews the AAS request and all supporting documentation to assess the facts and circumstances provided by the Plan. Plans must maintain documentation of their efforts to contract with nearer OON providers and must provide all documentation to DHCS upon request. DHCS may request additional evidence of contracting efforts if DHCS identifies more than two nearest OON providers during the review process.

The use of clinically appropriate telehealth may be considered in determining compliance with the applicable standards and/or for the purpose of approving an AAS request. However, Plans cannot require a beneficiary to access services via telehealth only. Plans must inform the beneficiary about options for accessing covered non-emergency medical transportation to an in-network provider within time and distance and timely access standards for medically necessary services, when an in-person visit is requested by a beneficiary.

DHCS will make a decision to approve or deny a request within 90 days of submission by the Plan. DHCS may stop the 90-day timeframe on one or more occasions, as necessary, in the event of an incomplete submission or to obtain additional information from the Plan requesting AAS.[18] Upon submission of sufficient additional information to the department, the 90-day timeframe shall resume at the same point in time it was previously stopped, except if there is less than 30 days remaining in which case the department shall approve or deny the request within 30 days of submission of sufficient additional information.[19] Upon notification by DHCS, approved AAS will be valid through the certification period (for FY 2021/2022 that is through June 2022). DHCS will monitor beneficiary

[17] W&I § 14197, subd. (e)(3) (2020).
[18] W&I § 14197, subd. (e)(3) (2020).
[19] W&I § 14197, subd. (e)(3) (2020).

access to the service type covered by the AAS on an on-going basis and report DHCS's findings to CMS.[20]

For all approved AAS request, DHCS will monitor beneficiary access to the service type covered by the AAS request on an on-going basis and report DHCS's findings to CMS.[21]
If DHCS rejects a Plan's request for AAS, DHCS shall inform the Plan of the reason for rejecting the request. DHCS will post any approved AAS request on its website.[22]

d. Additional Options to Meet Time and Distance Standards

Field Based Services (MHP Only)

SMHS are to be provided in the least restrictive setting, consistent with the goals of recovery and resiliency.[23] DHCS will consider a substitute standard, other than time and distance, when the provider travels to the beneficiary and/or a community-based setting to deliver services. For services where the provider travels to the beneficiary to deliver services, the MHP must ensure services are provided in a timely manner in accordance with the timely access standards and consistent with the beneficiary's individualized client plan. MHPs requesting a substitute standard must submit information to DHCS on the availability and provision of community-based or mobile services on Attachment A.1, Exhibit B-1, Field Based Services. This includes fixed-location community settings (e.g., school, community center) and/or field-based, mobile, and/or community-based services (e.g., mobile units, satellite sites, community centers) to deliver services to beneficiaries in community-based settings (not including a beneficiary's home).

Telehealth Services

Plans are permitted to use telehealth services to meet network adequacy standards, including the provider ratios for both outpatient SMHS and psychiatry services, and/or as a basis for an AAS request.[24] However, 90% of beneficiaries must reside within the required time and distance standards for provider types by zip code. For example, if 100 Medi-Cal beneficiaries reside in zip code 95814, 90 of those beneficiaries should have an on-site provider available within time and

[20] 42 C.F.R. section 438.66 (e) requires DHCS to submit a report to CMS annually on each managed care program the Department administers. 42 C.F.RN. sections 438.68(d)(2) and 438.66(e)(2)(vi) require the Department to
include the results of the monitoring in that report.
[22] W&I, § 14197, subd. (e)(3) (2020).
[23] State Plan, Section 3, Supplement 3 to Attachment 3.1-A, page 2c; W&I Code section 14713, subd. (a) (2020).
[24] W&I, § 14197, subd. (e)(4) (2020).

distance standards. Recently, due to the COVID-19 pandemic, the coverage requirement for beneficiaries in rural areas is 85%.

Although DHCS proposes that telehealth will be permitted to meet time and distance standards, all members 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. Telehealth services must comply with DHCS' Medi-Cal Provider Manual telehealth policy.[25]

In order to utilize telehealth to fulfill network adequacy requirements for time and distance standards, telehealth services must be provided to beneficiaries in the defined service area. In addition, the physical location where beneficiaries receive telehealth services must meet the State's time and distance standards or approved AAS.

If using telehealth to meet either network adequacy standards or AAS, Plans must submit information to DHCS on their telehealth providers. However, Plans cannot require a beneficiary to access services via telehealth only.[26] Plans must provide transportation, when requested by a beneficiary, to an in-network provider within time and distance and timely access standards for medically necessary services.
Telehealth providers for Plans must be included in the NACT, in the appropriate exhibit, as follows:

MHP

- Exhibit A-3: Rendering Provider Detail

DMC-ODS

- Exhibit A-2: Site

III. Network Adequacy Standards – Timely Access

42 C.F.R. Part 438.206(c)(1), Availability of Services, requires Plans to meet State standards for timely access to care and services, taking into account the urgency of the need for services.

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[25] W&I, § 14197, subd. (e)(4) (2020); Medi-Cal Provider Manual. "Medicine: Telehealth." https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf
[26] W&I § 14197, subd. (e)(4); Health & Saf. Code, §2290.5, subd. (b) (2020).

a. Timely Access Data Tool (TADT): Attachment D (MHP Only)

To ensure that MHPs provide timely access to services, DHCS requires each MHP to have a system in place for tracking and measuring timeliness of care, which includes the timeliness to receive a first appointment or first specialty mental health service. For this purpose, DHCS developed the TADT, a uniform data collection tool. For additional guidance, please see IN 19-020 and BHIN 20-062E.

Please note, the TADT is separate from the DHCS Clinical Services Information (CSI) Assessment Record submission requirement, although the data elements are in alignment. As explained in BHIN 20-062E, DHCS intends to use the TADT to analyze timely access until the CSI Assessment Record data is robust and accurate enough to be used as a sole source for timeliness analysis.

Implementation

July 2021 submissions: Due to the COVID-19 public health emergency, the submission period for the TADT was extended from April 1 to July 1 (reporting period December 1, 2020 through February 28, 2021). MHPs must use the TADT to submit timely access data for beneficiaries who requests services in the reporting period. For the July submission, only Phase One CSI data elements are required because the reporting period falls before the Phase Two data elements became mandatory in March 2021.

March 2022 CAP submissions: Due to the COVID-19 public health emergency, the submission period for timely access CAP resolution is extended from January 1 to March 1 (reporting period September 2021 through November 2021). MHPs must use the TADT. Counties on a CAP will be required to submit data for both Phase One and Phase Two data elements.

Methodology for Determining County compliance with Timely Access Standards

MHPs must provide Medi-Cal beneficiaries a non-urgent non-psychiatry mental health appointment within ten business days of the beneficiary's request.[27] MHPs must provide Medi-Cal beneficiaries a non-urgent psychiatry appointment within 15 business days of the beneficiary's request.[28] At this time, the TADT data elements cannot determine the nature of a request (e.g., psychiatric vs non-psychiatric), thus we are asking that counties submit data for all beneficiaries "new" to the Plan that are requesting an SMHS and that data will be used to determine timeliness in accordance with the standard for non-urgent, non-psychiatry specialty mental health service Assessment Appointments only. The

[27] W&I § 14197, subd. (d)(1)(A) (2020); Cal.Code Regs., tit. 28 § 1300.67.2.2(c)(5)(E) (2021).
[28] W&I § 14197, subd. (d)(1)(A) (2020); Cal.Code Regs., tit. 28 § 1300.67.2.2(c)(5)(D) (2021).

definition of what constitutes a new beneficiary is at the discretion of the Plan. DHCS calculates 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, 70% of beneficiaries must have been offered an appointment within ten business days (for example, when a client calls on the 1st of the month and is offered an appointment on the 11th of the month, the client was offered an appointment within 10 days).

DHCS does not issue deficiency findings for the percentage of beneficiaries that attend the Assessment Appointment Start Date. When that percentage is below 50%, DHCS will use Phase Two data elements (e.g., closure reason) to determine the cause. Because Phase Two data elements are optional at this time, if a county does not use them to form a comprehensive picture of the path to services, DHCS will also contact the county to determine the cause for the low attendance rate.

IV. Language Assistance Capabilities

Plans must submit subcontracts for interpretation and language line services. In addition, Plans are required to report, in the Plan's provider directory and in the NACT, the cultural and linguistic capabilities of network providers, including languages, including American Sign Language (ASL) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.[29]

a. Language Capacity

Plans 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).[30] Plans are also required to make oral interpretation and auxiliary aids, such as TTY/TDY and ASL, available to beneficiaries, free of charge, for any language.[31]

b. Telephonic Language Line Encounters Analysis

Plans must submit an analysis of monthly telephonic language line encounters. The analysis must detail the utilization of telephonic (i.e., language line) interpretation services to provide language access to beneficiaries in non-English languages. For each of the following, Plans must report, by language, the total number of encounters for which the telephonic language line was used:

[29] 42 C.F.R. § 438.10(h)(1)(vii) (2020).
[30] 42 C.F.R, § 438.206(b)(1) (2020).
[31] MHP Contract, Att. 11, section 3, E.

- 24/7 access line encounters;
- Face-to-face service encounters; and
- Other telehealth or telephone service encounters.

Telephonic language line utilization should be reported for all network providers in relevant categories. **Language Line Utilization for 24/7 Access Line**	**Language Line Utilization for Face-to-Face Service Encounters**	**Language Line Utilization for Telehealth or Telephonic Service Encounters**
Exhibit Name: Language Line Utilization	Exhibit Name: Language Line Utilization	Exhibit Name: Language Line Utilization
MHP Name	MHP Name	MHP Name
Reporting Period	Reporting Period	Reporting Period
Total # encounters requiring language line services	Total # encounters requiring language line services	Total # encounters requiring language line services
# of encounters requiring language line services, stratified by language	# of encounters requiring language line services, stratified by language	# of encounters requiring language line services, stratified by language
Reason services could not be provided by bilingual provider/staff or contracted interpreter	Reason services could not be provided by bilingual provider/staff or via face-to-face interpretation	Reason services could not be provided by bilingual provider/staff or via face-to-face interpretation

V. Mandatory Provider Type

Plans must demonstrate compliance with federal regulations addressing protections for American Indians and American Indian Health Services provided within a managed care system (42 C.F.R. part 438.14).

a. American Indian Health Facilities

American Indians and American Indian Health Facilities (AIHF) are not required to contract with Plans; however, Plans must document good-faith efforts to contract with all AIHFs in the Plan’s service area (i.e., county). If a Plan does not have a contract with any of the AIHFs in the Plan’s county, the Plan must submit an explanation to DHCS that includes supporting documentation, to justify the absence of the mandatory provider type in the Plan’s network. Please see Attachment A NACT:

MHP NACT – Attachment A.1
- Exhibit B-2

DMC-ODS NACT – Attachment A.2
- Exhibit B-1

DHCS will review the Plan's submission to determine compliance.

b. Mandatory Provider Type – Intensive Care Coordination and Intensive Home Based Services Providers (MHP Only)

Per the MHP Contract,[32] MHPs are required to provide, or arrange for the provision of, all covered SMHS, including Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS). Each MHP's network must include providers responsible for delivering ICC and IHBS. ICC and IHBS providers should be included in NACT Exhibit A-3.

VI. Continuity of Care Report

MHPs are required to report to DHCS all requests, and approvals, for continuity of care. The continuity of care report must include the following information:

- The date of the request;
- The beneficiary's name;
- The name of the beneficiary's pre-existing provider;
- The address/location of the provider's office;
- Whether the provider has agreed to the MHP's terms and conditions; and
- The status of the request, including the deadline for making a decision regarding the beneficiary's request.

If an MHP does not provide a Continuity of Care Report, the MHP must provide an attestation to the fact that there were no requests.

VII. System Infrastructure:

Each Plan must also submit the following additional supporting documentation on an annual basis unless noted otherwise:

[32] Exhibit E, Attachment 2.

- <u>MHP and DMC-ODS:</u>
  Grievances and appeals related to:
    - Access to care
    - Availability of services
    - Accessibility of services
    - Timeliness of services

  If none were received during the reporting period, Plans must include attestation indicating so.

- <u>MHPs only:</u>
    - **Please note** - Grievances should correspond with the following Annual Beneficiary Grievance and Appeal Report (ABGAR) categories:
        - Services not available
        - Services not accessible
        - Timeliness of services
        - 24/7 Toll-free access line
        - Linguistic services
        - Other access issues
        - Authorization delay notices
        - Timely access notices
    - **Provider Directory**. In addition to the paper directory, the MHP should include the website URL for online searchable directories, as applicable.
    - **Organizational Chart** detailing the MHP's clinical teams, including identification of deputy directors, clinical managers/supervisors, clinicians and staff.
- <u>All Plans</u>
    - Executed provider agreements with contracted network providers and the Plan's provider contract boilerplate.
    - Executed agreements with subcontractors, including agreements pertaining to interpretation, language line, telehealth services, and reserve/staffing contracts (please include budget detail for subcontracts).
    - All executed agreements must cover the certification period. For auto-renewing contracts (that have expired or will expire during the certification period), the Plan must submit an attestation there are no known factors that could preclude the auto renewal.
    - Policies and procedures addressing the following topics:
        - Network adequacy monitoring - submit policies and procedures related to the Plan's procedures for monitoring compliance with the network adequacy standards;

- OON access - submit policies and procedures related to beneficiary access to OON providers;
- Timely access - submit policies and procedures addressing appointment time standards and timely access requirements;
- Service availability - submit policies and procedures addressing requirements for appointment scheduling, routine specialty (e.g., psychiatry) referrals, and access to medically necessary services 24/7;
- Physical accessibility - submit policies and procedures regarding access for beneficiaries with disabilities pursuant to the Americans with Disabilities Act of 1990;
- Telehealth services - submit policies and procedures regarding use of telehealth services to deliver covered services;
- 24/7 Access Line requirements - submit policies and procedures regarding requirements for the MHP's 24/7 Access Line; and,
- 24/7 language assistance - submit policies and procedures for the provision of 24-hour interpreter services at all provider sites.

If the Plans do not have any data to report for any of the data requirements during the reporting period, Plans can submit a statement on County Letterhead stating, "**No data for the reporting period."**

CERTIFICATION OF NETWORK ADEQUACY DATA AND DOCUMENTATION SUBMISSION

The Plan's Director, Chief Administrative Officer, or equivalents, must certify that the information submitted by the Plan in their county is accurate, complete, and truthful. The certification must be submitted with the NACT and supporting documentation. Submission of the NACT and supporting documentation and the accompanying certification is a condition for receiving payment.[33]

NETWORK ADEQUACY NON-COMPLIANCE

Non-Compliance with Submission Requirements

DHCS must certify the adequacy of every Plan's provider network to CMS on an annual basis. DHCS has the authority, in accordance with W&I Section 14197.7, to sanction Plans that are out-of-compliance with the submission requirements, including completeness, accuracy, and timeliness or lack of submission.

[33] 42 C.F.R. § 438.600(b) (2020).

Non-Compliance with Network Adequacy Standards

If DHCS determines that a Plan does not meet the network adequacy standards, or a DHCS approved alternate access standard, the Plan will be required to submit a CAP to DHCS demonstrating steps the Plan will take to come into compliance with the standards. DHCS will monitor the Plan's corrective actions and require updated information from the Plan on a monthly basis until the Plan meets the applicable standards.

If the Plan is not making satisfactory progress toward compliance with applicable standards, DHCS may impose sanctions pursuant to W&I Section 14197.7, including monetary sanctions, and the temporary withholding of payments.

Furthermore, if the Plan is determined not to meet Network Adequacy requirements and the provider network is unable to provide timely access to necessary services within the applicable time and distance standards or an approved AAS request, the Plan must adequately and timely cover these services out-of-network for the beneficiary. The Plan must permit out-of-network access for as long as the Plan's provider network is unable to provide the services in accordance with the standards.

ONGOING NETWORK ADEQUACY MONITORING

DHCS will regularly monitor compliance with Network Adequacy standards on an ongoing basis. Network Adequacy monitoring activities include, but are not limited to, the following:

- Annual NACT data submissions for Plans;
- Triennial reviews of each MHP;
- Annual reviews of each DMC-ODS plan;
- Annual program assessment reports submitted to CMS in accordance with 42 CFR part 438.66;
- Annual External Quality Review Organization (EQRO) reviews;
- MHP performance dashboards;
- Corrective action monitoring and follow-up; and,
- Any other monitoring activities required by DHCS.

DHCS will post Network Adequacy documentation for each Plan on its website, including any approved AAS in accordance with W&I Section 14197.

For questions regarding this BHIN, please contact the Medi-Cal Behavioral Health Division at (916) 322-7445 or MHSDFinalRule@dhcs.ca.gov or ODSSubmissions@dhcs.ca.gov.

Sincerely,

Original signed by

Shaina Zurlin, PsyD, LCSW, Chief

Medi-Cal Behavioral Health Division

Attachments A through E:

- Attachment A.1 – MHP NACT
- Attachment A.2 – DMC-ODS NACT
- Attachment B – Time and Distance Standards
- Attachment C – Alternative Access Standards Request Template
- Attachment D – Timely Access Data Tool
- Attachment E – Certification of Network Adequacy Data