State of California—Health and Human Services Agency
Department of Health Care Services

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DIRECTOR

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DATE: November 20, 2020

Behavioral Health Information Notice No: 20-062
Supersedes MHSUDS IN No.: 19-020

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 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: Timely Access Submission Requirements for Mental Health Plans

PURPOSE: To update the mental health plans (MHPs) about requirements for data submissions for network adequacy compliance and the transition from Phase One to Phase Two of the Clinical Services Information (CSI) Assessment Record data submission.

REFERENCE: BHIN 20-012 and MHSUDS IN 19-020

BACKGROUND:
In June 2015, the Centers for Medicare & Medicaid (CMS) approved California's Medi-Cal Specialty Mental Health Services waiver authorized under section 1915(b) of the Social Security Act (the Act) for five years beginning July 1, 2015, through June 30, 2020. The approval of the waiver was subject to Special Terms and Conditions (STCs) from CMS. MHSUDS IN 19-020 addresses the STCs pertaining to timeliness.

In May, 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 Title 42 of the Code of Federal Regulations (CFR). These changes align Medicaid managed care regulations with requirements of other

major sources of coverage. MHPs are classified as Prepaid Inpatient Health Plans (PIHPs) 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:

(1) Network Adequacy Standards (42 CFR part 438.68),
(2) Availability of Services (part 438.206), and
(3) Assurances of Adequate Capacity and Services (part 438.207).

Welfare and Institutions (W&I) Code section 14197 includes time and distance and timely access standards. Subdivision (i) authorizes the Department of Health Care Services (DHCS) to interpret and implement section W&I Code Section 14197 via information notice.

Additionally, DHCS published its timely access standards on July 19, 2017, in the *Medicaid Managed Care Final Rule: Network Adequacy Standards*.

POLICY:

Section 1: Network Adequacy Standards

To ensure that MHPs ensure timely access to services, DHCS requires each MHP to have a system in place for tracking and measuring timeliness of care, including wait time to assessments and wait time to treatment.

DHCS published its timely access standards on July 19, 2017, in the Medicaid Managed Care Final Rule: Network Adequacy Standards. MHPs must provide Medi-Cal beneficiaries a non-urgent non-psychiatry mental health appointment within ten business days of the beneficiary's request. MHPs must provide Medi-Cal beneficiaries a non-urgent psychiatry appointment within 15 business days of the beneficiary's request.

Per IN 20-012, each MHP is required to submit a report documenting the timeliness of services provided to Medi-Cal beneficiaries to demonstrate the MHP's compliance with federal and state network adequacy requirements and standards. MHPs were advised to report all service requests received by the MHP (and its network providers) during the applicable reporting period and advised to include all of the following data elements:

- Name of the beneficiary;
- Date of the request for services;
- Referral source (e.g., beneficiary, authorized representative, social services agency, managed care plan);
- Date of the assessment (or first Medi-Cal service); and,
- Explanation if no service was provided;

- Information about offered appointments and/or “no-shows”

To streamline and standardize data collection, during the interim period until CSI is able to collect all data elements, DHCS developed a uniform collection tool, the Timely Access Data Tool (TADT, described below), in alignment with the CSI Assessment Record.

1. **CSI Assessment Record**
   In March 2019, DHCS issued BHIN 19-020, instructing MHPs to submit assessment records for new patients through new data elements added to the CSI. MHPs were instructed to provide the data in two phases. MHPs began reporting Phase One data in August 2019 and now are required to submit Phase Two data (see section 2 below for specifications).

2. **Timely Access Data Tool (TADT) Requirements**
   DHCS developed the Timely Access Data Tool (TADT) to standardize data submission during the interim period until the updates for the CSI system allow data submission directly through electronic health record extracts.

   In July 2020, DHCS offered MHPs the opportunity to resubmit their timely access data utilizing the TADT. DHCS determined the MHP’s compliance with timeliness standards using either resubmitted data through the TADT, or through the Fiscal Year (FY) 19-20 annual submission (for MHPs not using the TADT). MHPs were informed that resubmitting their information was optional in July. However, any MHPs found to be out-of-compliance with timeliness standards would be placed on corrective action plan (CAP) and required to submit their information using the TADT in January 2021 as part of their CAP response.

   January 2021 CAP submissions *(*reporting period September 1, 2020 through November 30, 2020)***:** MHPs on a CAP must use the TADT. Although the TADT contains data elements from both Phase One and Phase Two, only Phase One data is required for the January 2021 CAP responses, although the MHP is encouraged to provide Phase Two data, if available. TADTs lacking Phase Two data will not be rejected.

   April 2021 submissions (reporting period December 1, 2020 through February 28, 2021)***:*** MHPs must use the TADT. Only Phase One data elements are required, because the reporting period falls before the Phase Two data elements became mandatory on April 1, 2020.

January 2022 CAP submissions (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.

Please note, the TADT is separate from the CSI Assessment Record and counties must continue to submit data via the CSI Assessment Record, in addition to TADT. Once all MHPs have successfully and accurately implemented Phase Two data elements of the CSI Assessment Record, it is DHCS's intention to use that data solely for analyzing timeliness and the TADT will be phased out. Until that time the TADT will act as a bridge until full CSI Assessment Record adoption is complete.

Section 2: Data submission guidance:

To monitor and ensure MHPs meet the timely access standards, DHCS is requiring MHPs to add new data elements to the assessment records already being submitted into CSI. This section describes Phase One and Phase Two, the technical requirements for data submission, and the mechanism by which MHPs may claim reimbursement.

1. Phase One Implementation

In Phase One, DHCS required MHPs to begin submitting the minimum set of data elements needed to determine the number of days from a beneficiary's request for specialty mental health services to an initial assessment, and the number of days from the initial assessment to the first treatment appointment.

The following are the list of data elements collected and submitted in Phase One:

- Header fields (1.0-4.0)
- Assessment Record Number (ARN)
- DATE OF FIRST CONTACT TO REQUEST SERVICES
- ASSESSMENT APPOINTMENT FIRST OFFER DATE
- ASSESSMENT START DATE
- County Client Number (CCN) – the CCN is conditional, based upon county definition of a "new client", the CCN is required to be entered once an ASSESSMENT START DATE is established, but can also be entered any time before.
- ASSESSMENT END DATE
- TREATMENT APPOINTMENT FIRST OFFER DATE
- TREATMENT START DATE
- CLOSED OUT DATE

2. **Phase Two Implementation**
   In Phase Two, DHCS will require MHPs to begin submitting additional data elements that are needed to better understand why a beneficiary may not have received an appointment within the timely access standards. While MHPs may have begun submitting Phase Two data elements with the Phase One data elements, it has not been required. Counties can submit a request for an extension to submit data but may still be subject to fines and penalties. Requests can be submitted to DHCS Behavioral Health and Analytics Branch (BHARB) at BHData@dhcs.ca.gov and must provide a timeline for submission plus a detailed explanation for delayed submission.

   The following are the list of the Phase Two data elements that DHCS will require MHPs to submit to CSI 90 days from the implementation of this IN:
   - REFERRAL SOURCE
   - ASSESSMENT APPOINTMENT SECOND OFFER DATE
   - ASSESSMENT APPOINTMENT THIRD OFFER DATE
   - ASSESSMENT APPOINTMENT ACCEPTED DATE
   - TREATMENT APPOINTMENT SECOND OFFER DATE
   - TREATMENT APPOINTMENT THIRD OFFER DATE
   - TREATMENT APPOINTMENT ACCEPTED DATE
   - CLOSURE REASON
   - REFERRED TO

   The definitions for Phase One and Phase Two data elements are in the Assessment Record data dictionary and the technical requirements for data submission are posted to BHIS CSI, under system documentation, in the 'STCs CSI Assessment Record' Folder.

3. **Technical Requirements for Data Submission:**
   Assessment records will be within the monthly submission of all CSI records types (e.g., client, service, periodic, assessment). Submitting a batch means counties create a file for the upload of multiple records into CSI per monthly reporting period, once per month. Each assessment record submitted within the batch must adhere to specific technical requirements for the CSI application. The second option to submit assessment record data will be to enter individual records manually into CSI via the online interface. All of the necessary support documents are currently maintained and updated on CSI in the STCs CSI Assessment Record folder in System Documentation.

All data must be submitted in compliance with requirements delineated in the following documents posted to CSI, under system documentation, in the 'STCs CSI Assessment Record' Folder:

1. **CSI Assessment Record Process Flow Chart 202009** – The flow chart provides the sequence within which data should be entered.

2. **Data Dictionary-CSI-Assessment Record-V11** – A separate Assessment Record data dictionary has been developed to provide the formatting, valid codes, edits, and comments for this newly created and required CSI record.

3. **CSI Assessment Record Field Names and Business Rules_202009** – Contains each data element's Name, Type, and Description. Also contains the Business Rules (i.e., requirements) for submitting an assessment record.

4. **CSI Data Dictionary - New Error Codes - 2020** – Contains the list of error codes and descriptions so that the user can determine what specific errors were identified for a rejected assessment record.

5. **CSI Assessment Record** - **Technical Supplements**
    a. **Technical Supplement A - Record Layouts** – Contains the graphical representations of the CSI records including Client, Service, Periodic, Assessment, Key Change and Errors records. This supplement also visually depicts Bytes for each transactional record.
    b. **Technical Supplement B - Record Descriptions** – Contains detailed record and field-level information including Field Contents/Field Coding Name, Data Dictionary Number, Start and End byte locations, Format and Description for CSI Header, Control, Client, Service, Periodic, Assessment, Key Change, and Error File Records.
    c. **Technical Supplement C** - **Transaction Processing** – Contains the uniquely identified fields used to identify a record. This supplement also contains the transaction processing order in which the CSI date for each county will be processed
    d. **Technical Supplement D** - **Transaction Examples** – Contains specific CSI transaction examples (i.e., CSI record deletion, CSI record edit).

e. **Technical Supplement E** - **Edit Criteria** – Contains the edit criteria for Field, Relational, and System errors. The two levels of errors are Fatal (F) and Non-fatal (N).
f. **Technical Supplement F - Reporting Tips 4-5** – Contains further guidance for designation of the county code and a first request for service, the order within which to submit data, and what each data element means.

4. **Timeline**
   - User acceptance testing December 2020 through March 2021;
   - The CSI system will be not be available to users after 5 p.m. the day prior to the "go live" date;
   - CSI Assessment Record Phase 2 is scheduled to "go live" March 2021.

Section 3: MHP Reimbursement:

Pursuant to Proposition 30, DHCS will reimburse MHPs the federal share and one-half of the non-federal share for costs incurred to implement these new data collection and submission requirements. This section of the IN describes the type of costs eligible for reimbursement and the mechanism by which MHPs may claim reimbursement.

DHCS will reimburse MHPs for the following costs associated with collecting and submitting the assessment record data for Phase One and Phase Two data elements:

- Time spent training staff to enter timely access data into the TADT;
- Time staff spend entering timely access data into the TADT;
- Time spent preparing and submitting the TADT to DHCS;
- Time spent training staff to enter assessment records into CSI;
- Development costs incurred for IT upgrades (i.e., prior to implementation and afterwards) to capture the new data elements;
- Time staff spend entering assessment records data into CSI online interface;
- Time spent preparing and submitting assessment record data to an electronic health record (EHR) and DHCS (e.g., CSI).

MHPs may claim reimbursement for these costs on the MC 1982 B claim form. Please enter eligible costs on row three, Federal Medicaid Managed Care Final Rule and Parity Rule. MHPs may download these forms from the following webpage.

For questions on network adequacy requirements, contact the Medi-Cal Behavioral Health Division at (916) 322-7445 or MHSDFinalRule@dhcs.ca.gov. For questions on data submission, contact BHData@dhcs.ca.gov.

Sincerely,

Original signed by

Marlies Perez,
Acting Chief, Medi-Cal Behavioral Health Division
Chief, Community Services Division