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

2019 ANNUAL NETWORK CERTIFICATION SPECIALTY MENTAL HEALTH SERVICES

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1. Executive Summary

The Department of Health Care Services (DHCS) contracts with 56 county Mental Health Plans (MHPs). MHPs are considered Pre-paid Inpatient Health Plans (PIHPs) under Title 42, Code of Federal Regulations (42 CFR), part 438. The MHPs are responsible for providing, or arranging for the provision of, specialty mental health services (SMHS) to Medi-Cal beneficiaries who meet medical necessity criteria in a manner consistent with the beneficiary's mental health treatment needs and goals, and as documented in the beneficiary's treatment plan.

Each MHP must maintain and monitor a provider network adequate to serve, within scope of practice under State law, the population of adults and children/youth Medi-Cal beneficiaries eligible for SMHS. Plans must meet or exceed network capacity requirements and proportionately adjust the number of network providers to support any anticipated changes in enrollment and the expected utilization of SMHS.

Federal regulations require each MHP to submit to DHCS documentation on which the State bases its certification that the Plan has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in Title 42 Code of Federal Regulations parts 438.68 and 438.206.

DHCS is required to certify the network of each MHP and submit assurances of adequacy to the Centers for Medicare and Medicaid Services (CMS). DHCS reviewed data and information from multiple sources, including network data submissions by the MHPs, to conduct an analysis of the adequacy of each Plan's network

This report serves as DHCS' assurance of compliance with the network adequacy requirements in 42 CFR 438, for California's SMHS. It details DHCS' efforts to certify the networks in accordance with Title 42 Code of Federal Regulations part 438.207. DHCS will make available to CMS, upon request, all documentation collected by the State from the MHPs.

1.1. Assurance of Compliance Overview

This report details DHCS' efforts to certify the networks in accordance with Title 42 Code of Federal Regulations part 438.207. Below is a summary of the contents:

Section 1: Executive Summary – Provides an overview of DHCS' network certification analysis.

Section 2: California's Medicaid SMHS Program – Describes California's SMHS delivery system

Section 3: Network Adequacy Requirements – Provides background on the federal Medicaid Managed Care network adequacy requirements and standards established by the State of California.

Section 4: Annual Network Certification - Describes DHCS' network certification methodology and analysis of the MHPs' networks.

Section 5: MHP Network Certification Results - Provides the Network Certification Results by MHP.

Section 6: Statewide Network Monitoring Efforts - Describes the network certification Corrective Action Plan (CAP) process and the ongoing monitoring efforts conducted by DHCS.

2. Specialty Mental Health Services Delivery System in California

California's SMHS are provided under the authority of a 1915(b) Waiver. The 1915(b) SMHS Waiver provides California with the opportunity to deliver Rehabilitative Mental Health Services to children and adults through a managed care delivery system. DHCS contracts with 56 county MHPs who are responsible for providing, or arranging for the provision of, SMHS to Medi-Cal beneficiaries who meet medical necessity criteria in a manner consistent with the beneficiary's mental health treatment needs and goals, and as documented in the beneficiary's treatment plan.

The county MHPs provide outpatient SMHS in the least restrictive community-based settings. The SMHS provided through the 1915(b) SMHS Waiver service delivery system are also covered in California's Medicaid State Plan, with the exception of the specific services which fall into the broader category of Early and Period Screening, Diagnostic and Treatment (EPSDT) services (i.e., Intensive Care Coordination, Intensive Home Based Services, Therapeutic Foster Care Services, and Therapeutic Behavioral Services). SMHS are as follows:

- Mental Health Services;
- Medication Support Services;
- Day Treatment Intensive;
- Day Rehabilitation;
- Crisis Intervention;
- Crisis Stabilization;
- Adult Residential Treatment;
- Crisis Residential Treatment Services;
- Psychiatric Health Facility Services;
- Intensive Care Coordination;
- Intensive Home Based Services;
- Therapeutic Foster Care Services;
- Therapeutic Behavioral Services;
- Targeted Case Management; and
- Psychiatric Inpatient Hospital Services.

MHPs are reimbursed through a claims-based fee-for-service (FFS) payment structure based on their actual expenditures for services rather than on a capitated basis. MHPs negotiate reimbursement rates and contract with providers to ensure services are rendered in accordance with state and federal laws, policies, and regulations. SMHS are funded through multiple dedicated funding sources, including Medicaid, 1991 Realignment, 2011 Realignment, Mental Health Services Act, Block Grants from the Substance Abuse and Mental Health Services Administration (SAMHSA), and locally-generated matching funds for 1991 Realignment, or other local revenues.

3. Network Adequacy Requirements

3.1. Medicaid Managed Care Final Rule

On May 6, 2016, CMS published the Medicaid and Children's Health Insurance Program Managed Care Final Rule (Managed Care Rule),[1] which revised Title 42 of the Code of Federal Regulations. These changes aimed to align Medicaid managed care regulations with

[1] Managed Care Final Rule, Federal Register, Vol. 81, No. 88: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered

requirements of other major sources of coverage. MHPs are classified as PIHPs and must therefore comply with applicable federal managed care requirements. Effective July 1, 2018, MHPs must comply with the network adequacy requirements in the Managed Care Rule.

Three sections of the Managed Care Rule comprise the majority of network adequacy standards set forth in Title 42 of the Code of Federal Regulations: § 438.68 Network adequacy standards; § 438.206 Availability of services; and § 438.207 Assurances of adequate capacity and services.

Network Adequacy Standards – Time and Distance
Section 438.68, Network adequacy standards, requires states to develop time and distance standards for adult and pediatric behavioral health, mental health and substance use disorder services (SUDS) 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.

Network Adequacy Standards – Timely Access
Section 438.206, Availability of services, requires the Plans to meet State standards for timely access to care and services, taking into account the urgency of the need for services. Timely access standards refers to the number of business days in which a Plan must make an appointment available to a beneficiary from the date the beneficiary, or a provider acting on behalf of the beneficiary, requests a medically necessary service.

Network Certification Requirements
Section 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:

- 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,[2] 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 services area (i.e., county).[3]

Plans must submit the required documentation as specified by DHCS. After reviewing the documentation submitted by each Plan, and by July 1st of each fiscal year, DHCS must submit an assurance of compliance to CMS that each Plan meets the State's requirements for the availability of services, as set forth in §§ 438.68 and 438.206. The submission to CMS must include documentation of an analysis that supports the assurance of the adequacy of the network for each Plan related to its provider network.

[2] The Plan's network of providers includes county-owned and operated providers.
[3] 42 C.F.R. §§ 438.207(b), 438.604(a)(5)

3.2. Network Adequacy Standards

DHCS established network adequacy standards for county MHPs pursuant to the federal Managed Care Rule as set forth in Title 42 of the Code of Federal Regulations, §§ 438.68, 438.206, and 438.207.

In July 2017, DHCS published Network Adequacy Standards in compliance with the network adequacy provisions of the Managed Care Rule. The document has subsequently been amended as a result of Assembly Bill (AB) 205 (Chapter 738, Statutes of 2018), which codified California's network adequacy standards, including time and distance and timely access standards.

In order to comply with federal requirements to ensure the MHPs networks are adequate, DHCS also established provider-to-beneficiary ratios. Pursuant to federal Managed Care Rule, each MHP must maintain and monitor a provider network adequate to serve, within scope of practice under State law, the population of adults and children/youth Medi-Cal beneficiaries eligible for SMHS. MHPs must meet or exceed network capacity requirements and proportionately adjust the number of network providers to support any anticipated changes in enrollment and the expected utilization of SMHS.

Plans are permitted to use telehealth to meet network adequacy standards and/or as a basis for alternative access requests.[4] Telehealth services must comply with DHCS' Medi-Cal Provider Manual telehealth policy[5] and telehealth providers must meet the following criteria:

- Licensed to practice medicine in the State of California;
- Screened and enrolled as providers in the Medi-Cal program; and,
- Able to comply with state and federal requirements for the Medi-Cal program.

In order to utilize telehealth to fulfill network adequacy requirements for time and distance standards, the telehealth provider must be available to provide telehealth services to all 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 an approved alternative access standard.

DHCS' network adequacy standards for county MHPs are outlined in Attachment A.

3.3. MHP Provider Network Documentation

[4] Welf. & Inst. Code, § 14197, subd. (e)(4)
[5] Medi-Cal Provider Manual. "Medicine: Telehealth."
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc

DHCS issued Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice (IN) 18-011 to set forth federal network adequacy requirements for MHPs and Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot counties. The IN identifies network adequacy standards and specifies network certification requirements, in accordance with Title 42 of the Code of Federal Regulations, part 438.207, including the requirement for each Plan to submit documentation to the State to demonstrate that it complies with the network adequacy requirements.

Plans are required to submit to DHCS documentation on which the State bases its certification that the Plan has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in Title 42 Code of Federal Regulations part 438.206. Each Plan is required to submit a quarterly Network Adequacy Certification Tool (NACT) detailing the MHPs' provider networks, including all organizational, site, and rendering providers delivering SMHS within the MHPs' networks. Network providers include county-owned and operated providers and the MHP's contracted network providers.

In addition to the NACT, each Plan is required to submit supporting documentation of its own analysis of the Plan's network adequacy. This supporting documentation included the following:

Geographic Access Maps
Plans must submit geographic access maps, separately for children/youth (ages 0-20) and adults (ages 21+), for psychiatry services and outpatient SMHS to confirm compliance with time or distance standards. Each map must plot the location of each of the Plan's network providers in relation to the MHP's beneficiaries. The Plan must also include locations of community based settings where services are regularly delivered. If applicable, the maps should include contracted network providers in neighboring service areas. The MHP must submit the following maps:

- An overview map of the entire service area which delineates boundaries and zip codes;
- An overview map of all beneficiaries receiving services in the county;

- A map of psychiatric services providers serving children/youth (0-20). This map should show the location of the providers in relation to current Plan beneficiaries.
- A map of psychiatric services providers serving adults (21+). This map should show the location of the providers in relation to current Plan beneficiaries.
- A map of outpatient SMHS providers serving children/youth (0-20). This map should show the location of the providers in relation to current Plan beneficiaries.
- A map of outpatient SMHS providers serving adults (21+). This map should show the location of the providers in relation to current Plan beneficiaries.

Timely Access Report

Each Plan must submit a report that documents the timeliness of services provided to Medi-Cal beneficiaries. The report should include all service requests received by the MHP (and its network providers) during the applicable reporting period (December 1, 2018 – February 28, 2019) and should 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); and,
- Date of the assessment (or first Medi-Cal service).

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:

- 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.

Additional Supporting Documentation
Each Plan must also submit the following additional supporting documentation:

- Complete beneficiary grievances (including the MHP's response to the grievance) related to access to SMHS. Grievances corresponding with the following Annual Beneficiary Grievance and Appeal Report (ABGAR) categories should be submitted for DHCS' review:
    - Services not available
    - Services not accessible
    - Timeliness of services
    - 24/7 Toll-free access line
    - Linguistic services
    - Other access issues

- Complete beneficiary appeals and expedited appeals (including the MHP's response to the appeal) related to access to SMHS. Grievances corresponding with the following ABGAR categories should be submitted for DHCS' review:
    - Authorization delay notices
    - Timely access notices

- Executed provider agreements with contracted network providers and the MHP's provider contract boilerplate;

- Executed agreements with subcontractors, including agreements pertaining to interpretation, language line, and telehealth services (please include budget detail for subcontracts);

- Plan's Provider directory. In addition to the paper directory, the Plan should include the website URL for online searchable directories, as applicable.

- Results of beneficiary satisfaction surveys related to network adequacy or timely access; and,

- 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;
    - Out of network access - submit policies and procedures related to beneficiary access to out-of-network 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 (i.e., 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 Plan'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.

4. Annual Network Certification

DHCS developed a comprehensive methodology to assess the adequacy of the MHPs' provider networks. In accordance with Title 42 Code of Federal Regulations part 438. 68, the network certification analysis includes, but is not limited to, the following elements for each Plan:

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.

DHCS reviewed and analyzed the MHPs' data and documentation to determine if the Plan has an adequate network of providers, sufficient in mix, number, and geographic location, to meet the needs of the Medi-Cal beneficiaries in each county. DHCS utilized various data sources (e.g., claims data, enrollment data, eligibility data, external quality reviews, provider files) to validate county data submissions.

DHCS reviewed each MHP's compliance in the following areas:

I. Time and distance standards– geographic access mapping;

II. Network composition and capacity;

III. Timely access;

IV. Mandatory provider types;

V. Language assistance capabilities; and,

VI. System infrastructure.

DHCS' network certification methodology in each of these areas is described in greater detail below.

4.1. Time and Distance Standards

California's time and distance standards are based on the population density of each county. DHCS required MHPs to submit geographic access maps to demonstrate compliance with the time and distance standards for the county. The MHPs were required to plot time and distance for all network providers, stratified by service type (i.e., psychiatry and outpatient SMHS) and geographic location, for both adult and children/youth[6] separately. MHPs were directed to include community-based settings where services are regularly delivered and any contracted network providers in neighboring service areas if needed to meet time and distance standards.

DHCS validated each MHP's geographic access maps using ArcGIS software. DHCS reviewed and validated the children/adult psychiatry and children/adult outpatient SMHS geographic access maps submitted by the plans by:

1. Examining each map for provider locations, beneficiary density, and driving-time/distance standards; and,
2. Re-creating each map using provider counts/locations (from NACT), beneficiary counts/locations (internal databases), drive-time/distance standards (county standards).

4.1.1. Community Based Services

Rehabilitative SMHS[7] are to be provided in the least restrictive setting, consistent with the goals of recovery and resiliency, and may be provided anywhere in the community.[8] DHCS considered the availability of services (i.e., when the provider travels to the beneficiary and/or a community-based setting to deliver services) when determining compliance with the time and distance standards.

For services where the provider travels to the beneficiary to deliver services, MHPs are required to ensure services are provided in a timely manner in accordance with the timely access standards and consistent with the beneficiary's individualized client plan.

[6] For geographic access maps, Medi-Cal beneficiaries under the age of 21 are classified as children/youth.
[7] Mental Health Services, Crisis Intervention, Targeted Case Management and Medication Support
[8] State Plan, Section 3, Supplement 3 to Attachment 3.1-A, page 2c

4.1.2. Alternative Access Requests

The Managed Care Rule permits states to grant exceptions to the time and distance standards.[9] If the Plan cannot meet the time and distance standards, MHPs were required to submit a request for alternative access standards.[10] Per the statutory requirements, DHCS was able to grant requests for alternative access standards if the MHP exhausted all other reasonable options to obtain providers to meet the applicable standard or if DHCS determined that the MHP demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.

MHPs were required to include a description of the reasons justifying the alternative access standards. Requests for alternative access standards are approved or denied on a zip code and service type basis.[11]

Requests for alternative access standards may include seasonal considerations (e.g. winter road conditions), when appropriate. As appropriate, MHPs included an explanation about gaps in the county's geographic service area, including information about uninhabitable terrain within the county (e.g., desert, forest land).

Upon notification by DHCS, approved alternative access standards will be valid for one fiscal year; however, DHCS will monitor beneficiary access on an on-going basis and include the findings to CMS in the managed care program assessment report required under Title 42 Code of Federal Regulations part 438.66(e).[12]

DHCS will post all approved alternative access standards on its website.[13]

4.2. Provider Composition and Network Capacity

4.1.1 Anticipated Need for SMHS

DHCS determined the anticipated need for SMHS using county-specific Medi-Cal enrollment data and estimates of prevalence of Serious Emotional Disturbance (SED) in children/youth and Serious Mental Illness (SMI) in adults.[14] While there are a number of different prevalence estimates for populations with mental health conditions, it varies widely and typically estimates mental health conditions or episodes within the general population. There is very limited availability of prevalence estimates for SED/SMI, particularly for the SED/SMI subpopulation

[9] 42 C.F.R. § 438.68(d)(1)
[10] Welf. & Inst. Code, § 14197, subd. (e)(2)
[11] Welf. & Inst. Code, § 14197, subd. (e)(3)
[12] 42 C.F.R §§ 438.68(d)(2), 438.66(e)(2)(vi)
[13] WIC Section 14197(e)(3)
[14] Prevalence estimates taken from the California Mental Health and Substance Use System Needs Assessment Report (September 2013).

eligible for Medicaid/Medi-Cal. Therefore, DHCS based SMHS need on the SED/SMI prevalence estimates calculated for the *Bridge to Reform Waiver*, developed by the Technical Assistance Collaborative and the Human Services Research Institute.[15] 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 its Medi-Cal Eligibility Data System (MEDS), DHCS calculated the average number of enrolled Medi-Cal beneficiaries in each county during fiscal year 2017/2018. DHCS then applied the SED and SMI prevalence estimates to average enrollment for each county. This adjusted Medi-Cal enrollment population represents the anticipated need for SMHS.

DHCS used this same methodology to estimate the need for psychiatry services (i.e., Medication Support Services provided by a psychiatrist). However, to determine estimated need for psychiatry services, DHCS further calculated the proportion of beneficiaries within the existing SMHS population who received Medication Support Services as a part of the beneficiary's individualized treatment plan. DHCS determined that 67% of adults and 29% of children/youth receiving SMHS receive Medication Support Services as a part of their treatment plan.

4.2.1. Provider Network Capacity and Composition

The MHPs reported detailed information about each Plan's provider network. For each rendering provider who delivers Mental Health Services, Targeted Case Management, Crisis Intervention, and Medication Support Services (for psychiatrists only), the MHP is required to report, by age group (0-20 and 21+), each provider's full-time equivalency (FTE). Under the State Plan, providers in the following behavioral health classifications are eligible to provide SMHS:

- Licensed Psychiatrists;
- Licensed Physicians;
- Licensed Psychologists;
- Licensed Clinical Social Workers;
- Marriage and Family Therapists;
- Licensed Professional Clinical Counselors;
- Registered Nurses;
- Certified Nurse Specialists;
- Nurse Practitioners;
- Licensed Vocational Nurses;

[15] Available at: http://www.dhcs.ca.gov/provgovpart/Documents/CABridgetoReformWaiverServicesPlanFINAL9013.pdf).

- Psychiatric Technicians;
- Mental Health Rehabilitation Specialists;
- Physician Assistants;
- Pharmacists;
- Occupational Therapists; and,
- Other Qualified Providers.[16]

DHCS calculated, separately for adults and children/youth, the counts of FTE providers that the MHPs' reported who provide outpatient SMHS (Mental Health Services, Targeted Case Management, and Crisis Intervention) and psychiatry (Medication Support Services – psychiatrists only). California's State Plan describes SMHS and specifies the provider types for each service. Since outpatient SMHS can be provided by any mental health professional working within their scope of practice, DHCS included all relevant provider types in its calculation of the ratio for outpatient SMHS.

4.2.2. Network Composition and Capacity

DHCS established statewide provider to beneficiary ratios using Short-Doyle/Medi-Cal claims data as reported in its Performance Outcomes System (POS). The POS data includes, for adults and children/youth, the mean service quantity (i.e., number of minutes) per unique beneficiary by fiscal year. DHCS calculated the total mean number of minutes for outpatient SMHS (i.e., Mental Health Services, Targeted Case Management, and Crisis Intervention) and psychiatry services (i.e., Medication Support Services – psychiatrists only) for adults and children/youth. DHCS assumed a 60% productivity rate (i.e., time spent on direct billable services) to determine the total productive minutes per state fiscal year (SFY) for each FTE SMHS provider.[17] To calculate statewide ratios, DHCS divided the total productive minutes per year by the total average minutes for adults and/or children/youth. DHCS established statewide ratios, separately for adults and children/youth, for outpatient SMHS and psychiatry services (i.e., Medication Support Services).

For Medication Support Services provided by a psychiatrist, it was necessary to further analyze the data to isolate claims associated with a psychiatrist/neurologist[18] taxonomy code. For each age group, the data were divided into quartiles representing all 56 county MHPs. Using this approach, DHCS was able to determine the median value for adults and

[16] CA's State Plan permits the provision of services by "Other Qualified Providers," defined as, "an individual at least 18 years of age with a high school diploma or equivalent degree determined to be qualified to provide the service by the county mental health department." (State Plan, Section 3, Supplement 3 to Attachment 3.1-A pages 2m-2p).
[17] DHCS estimated that 40% of each provider's time is allocated for administrative and staff development activities (e.g., staff meetings, training, staff development, clinical supervision, paid time off, chart review, documentation).
[18] It is assumed that billings by neurologists for SMHS would be minimal, if not nil.

children/youth. It was determined the billing patterns vary between adults and children/youth. The median percentage of minutes billed by psychiatrists/neurologists serving the adult population is 50.61%. The median percentage of minutes billed by psychiatrists/neurologists serving the children/youth population is 71.83%.

For each of the measurement categories (adult psychiatry, children/youth psychiatry, adult outpatient SMHS, and children/youth outpatient SMHS), DHCS then calculated each MHP's current provider to beneficiary ratio using FTE provider counts (numerator) and the anticipated need population (denominator). DHCS then compared each MHP's provider to beneficiary ratios to the statewide provider to beneficiary ratios to determine if each MHP's current provider network is adequate.

For MHP's utilizing telepsychiatry and/or Locums Tenens contracts to meet the need for psychiatry services, DHCS calculated the estimated FTE value of the contracts. DHCS divided the total Fiscal Year budget amount by the highest hourly (i.e., business hours) rate to determine the total number of hours allotted via the contract. DHCS used the number of allotted hours to calculate the estimated FTE value of the contract.

4.3. Language Assistance Capacity

MHPs are required to maintain and monitor a network of providers that is supported by written agreements and is sufficient to provide adequate access to all covered services for all beneficiaries, including those with Limited English Proficiency (LEP).[19] MHPs are also required to make oral interpretation and auxiliary aids, such as TTY/TDY and American Sign Language (ASL), available and free of charge for any language.[20] To demonstrate compliance with these requirements, the MHPs must submit subcontracts for interpretation and language line services. In addition, MHPs are required to report, in the plan's provider directory and in the NACT, the cultural and linguistic capabilities of network providers, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.[21]

4.4. Mandatory Provider Types - American Indian Health Facilities

In accordance with Title 42 Code of Federal Regulations, part 438.14(b)(1), MHPs are required to demonstrate that there are sufficient American Indian Health Facilities (AIHFs) participating in the Plan's network to ensure timely access to services for American Indian beneficiaries who are eligible to receive services. As such, MHPs are required to offer to contract with each AIHF in their contracted service area (i.e., county).

[19] 42 C.F.R. § 438.206(b)(1)
[20] 42 C.F.R. § 438.10(h)(1)(vii)
[21] 42 C.F.R. § 438.10(h)(1)(vii)

The NACT reporting template included the following required elements for each MHP:

- Name of the provider or facility,
- Location of the provider or facility and their identifying information;
- Whether the MHP provides beneficiaries with access to the AIHF; and,
- Status of the MHP's efforts to contract with the provider or facility.

If an MHP did not have an executed contract with an AIHF, the MHPs were required to submit to DHCS an explanation and supporting documentation to justify the absence of a required contract.

DHCS reviewed the MHPs' submissions and verified the information with approved data sources to ensure compliance. DHCS verified the MHPs' reported efforts to contract with AIHF in the county by comparing reported providers with the Department's list of facilities.

4.5. Network Adequacy Infrastructure

DHCS reviewed supporting documentation submitted by each MHP to determine if the MHP's system infrastructure is effective and capable of meeting the needs of SMHS beneficiaries. DHCS reviewed the following supporting documentation for each county MHP:

- Complete beneficiary grievances (including the MHP's response to the grievance) related to access to SMHS. Grievances corresponding with the following Annual Beneficiary Grievance and Appeal Report (ABGAR) categories should be submitted for DHCS' review:
    - Services not available
    - Services not accessible
    - Timeliness of services
    - 24/7 Toll-free access line
    - Linguistic services
    - Other access issues

- Complete beneficiary appeals and expedited appeals (including the MHP's response to the appeal) related to access to SMHS. Grievances corresponding with the following ABGAR categories should be submitted for DHCS' review:
    - Authorization delay notices
    - Timely access notices

- Executed provider agreements with contracted network providers and the MHP's provider contract boilerplate;

- Executed agreements with subcontractors, including agreements pertaining to interpretation, language line, and telehealth services (please include budget detail for subcontracts);

- Plan's Provider directory. In addition to the paper directory, the Plan should include the website URL for online searchable directories, as applicable.
- Results of beneficiary satisfaction surveys related to network adequacy or timely access; and,
- Policies and procedures addressing the following topics:
    - Network adequacy monitoring - policies and procedures related to the Plan's procedures for monitoring compliance with the network adequacy standards;
    - Out of network access - policies and procedures related to beneficiary access to out-of-network providers;
    - Timely access - policies and procedures addressing appointment time standards and timely access requirements;
    - Service availability - policies and procedures addressing requirements for appointment scheduling, routine specialty (i.e., psychiatry) referrals, and access to medically necessary services 24/7;
    - Physical accessibility - policies and procedures regarding access for beneficiaries with disabilities pursuant to the Americans with Disabilities Act of 1990;
    - Telehealth services - policies and procedures regarding use of telehealth services to deliver covered services;
    - 24/7 Access Line requirements - policies and procedures regarding requirements for the Plan's 24/7 Access Line; and,
    - 24/7 language assistance - policies and procedures for the provision of 24-hour interpreter services at all provider sites.

4.6. Data Limitations – Data Quality and Validation

Some of the key limitations which affected this data analysis included the following circumstances:

1. MHPs lack the appropriate infrastructure to ensure the quality and accuracy of the data reported in the NACT.
2. Data quality issues resulted in inflated reporting of provider FTEs. DHCS adjusted data sets to remove FTE for providers who were reported with an FTE greater than 100% across service settings and age groups.
3. While DHCS is designing, developing, and implementing a data collection system for purposes of collecting and reporting MHP provider data at the level of detail requisite for conducting the network analysis, this system is not yet in place. The NACT reporting

template is an Excel spreadsheet in which counties manually entered their provider data. The preparation and analysis of the MHP-submitted data was therefore also manual and laborious. A more automated, consolidated database is currently under construction to reduce the amount of manual data entry and data preparation and enable faster analysis of the MHP-submitted data. The database will require uniform submission of data from counties. DHCS will need to undertake a significant technical assistance effort with counties to enable the understanding of format requirements.

4. DHCS implemented data validation measures to audit the MHPs' submissions; however, due to the extent of the data quality issues, the auditing processes is lengthy and labor intensive.

5. MHP Network Certification Results

DHCS reviewed each MHP's compliance in the following areas:

I. Time and distance standards– geographic access mapping;

II. Network composition and capacity;

III. Timely access;

IV. Mandatory provider types;

V. Language assistance capabilities; and,

VI. System infrastructure.

DHCS evaluated the MHP's performance in each of these areas to determine compliance with the requirements. The following designations were assigned for each component:

- A Pass designation means the standard has been met and no further action is required.
- A Conditional Pass designation means the MHP did not meet all of the network adequacy requirements and/or that ongoing monitoring and corrective actions are required to improve access to SMHS for beneficiaries.
- A Not Applicable (N/A) designation means that this certification element does apply to the MHP.

For this certification period, DHCS determined that, overall, 27 county MHPs ***pass*** 29 MHPs ***conditionally pass*** the network certification requirements and will be subject to ongoing monitoring and corrective actions, as appropriate.

MHP Name	Overall Results	Alternative Access Standard
Alameda	Pass	Not Submitted

MHP Name	Overall Results	Alternative Access Standard
Alpine	Pass	Not Submitted
Amador	Pass	Not Submitted
Butte	Pass	**Approve**
Calaveras	Pass	Not Submitted
Colusa	Conditional Pass	Not Submitted
Contra Costa	Pass	Not Submitted
Del Norte	Pass	Not Submitted
El Dorado	Conditional Pass	Not Submitted
Fresno	Conditional Pass	Not Submitted
Glenn	Pass	Not Submitted
Humboldt	Pass	Not Submitted
Imperial	Conditional Pass	Not Submitted
Inyo	Conditional Pass	Not Submitted
Kern	Conditional Pass	Not Submitted
Kings	Conditional Pass	Not Submitted
Lake	Conditional Pass	Not Submitted
Lassen	Pass	Not Submitted
Los Angeles	Conditional Pass	Not Submitted
Madera	Conditional Pass	Not Submitted

MHP Name	Overall Results	Alternative Access Standard
Marin	Pass	Not Submitted
Mariposa	Pass	Not Submitted
Mendocino	Conditional Pass	Not Submitted
Merced	Conditional Pass	Not Submitted
Modoc	Conditional Pass	Not Submitted
Mono	Pass	**Approve**
Monterey	Pass	Not Submitted
Napa	Pass	Not Submitted
Nevada	Pass	Not Submitted
Orange	Conditional Pass	Not Submitted
Placer/Sierra	Pass	Not Submitted
Plumas	Pass	Not Submitted
Riverside	Conditional Pass	Not Submitted
Sacramento	Conditional Pass	Not Submitted
San Benito	Conditional Pass	Not Submitted
San Bernardino	Conditional Pass	**Approve**
San Diego	Pass	Not Submitted
San Francisco	Pass	Not Submitted
San Joaquin	Conditional Pass	Not Submitted

MHP Name	Overall Results	Alternative Access Standard
San Luis Obispo	Pass	Not Submitted
San Mateo	Pass	Not Submitted
Santa Barbara	Conditional Pass	Not Submitted
Santa Clara	Pass	Not Submitted
Santa Cruz	Pass	Not Submitted
Shasta	Conditional Pass	Not Submitted
Siskiyou	Conditional Pass	Not Submitted
Solano	Pass	Not Submitted
Sonoma	Pass	Not Submitted
Stanislaus	Conditional Pass	Not Submitted
Sutter/Yuba	Conditional Pass	Not Submitted
Tehama	Conditional Pass	Not Submitted
Trinity	Conditional Pass	Not Submitted
Tulare	Conditional Pass	Not Submitted
Tuolumne	Conditional Pass	Not Submitted
Ventura	Pass	Not Submitted
Yolo	Conditional Pass	Not Submitted

6. Statewide Network Monitoring Efforts

6.1. Corrective Action Plans

DHCS will grant the MHP a conditional pass on its Annual Network Certification if the MHP is unable to meet the network adequacy requirements.

If DHCS determined that, at the time of the initial submission, or at any time thereafter, the MHP does not meet the applicable time and distance standards or a DHCS approved alternate access standard and/or any of the network adequacy requirements, the MHP is required to submit a corrective action plan (CAP). The MHP's CAP must demonstrate action steps the MHP will immediately implement to ensure it complies with the standards. DHCS will monitor the Plan's corrective actions and require updated information from the MHP on a bi-weekly basis until such time the MHP is able to meet the applicable standards.

Furthermore, if the MHP was 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, the MHP must adequately and timely cover these services out-of-network for the beneficiary.[22] The MHP must permit out-of-network access for as long as the MHP's provider network is unable to provide the services in accordance with the standards.

If the MHP does not effectively implement corrective actions, DHCS may impose additional corrective actions pursuant to Welfare and Institutions Code Section 14712(e),[23] including fines, penalties, the withholding of payments, special requirements, probationary or corrective actions, or any other actions deemed necessary to promptly ensure compliance.

6.2 Ongoing Monitoring

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

- Quarterly NACT data submissions by MHPs;
- Triennial compliance reviews of each MHP;
- Annual program assessment reports submitted to CMS in accordance with Title 42 Code of Federal Regulations § 438.66;
- Annual External Quality Review Organization reviews;
- Plan performance dashboards;

[22] 42, C.F.R., § 438.206(b)(4)
[23] See also Cal. Code Regs., tit. 9, §§ 1810.380 and 1810.385

- 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 alternative access standards.

7. Appendices

7.1. Attachment A: Network Adequacy Standards

Time and Distance and Timely Access Standards

For psychiatry, the time and distance and timely access standards are as follows:

Timely Access[24]	Within **15 business days** from request to appointment
Time and Distance[25]	Up to **15 miles or 30 minutes** from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.
	Up to **30 miles or 60 minutes** from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.
	Up to **45 miles or 75 minutes** from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.
	Up to **60 miles or 90 minutes** from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

[24] Welf. & Inst. Code, § 14197(d)(1); Cal. Code Regs., tit. 28, § 1300.67.2.2(c)(5)(D)
[25] Welf. & Inst. Code, § 14197(c)(1), (h)(2)(L)

The time and distance and timely access standards for Mental Health Services, Targeted Case Management, Crisis Intervention, and Medication Support Services are as follows:

Timely Access[26]	Within **10 business days** from request to appointment
Time and Distance[27]	Up to **15 miles or 30 minutes** from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.
	Up to **30 miles or 60 minutes** from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.
	Up to **45 miles or 75 minutes** from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.
	Up to **60 miles or 90 minutes** from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

Effective July 1, 2018, MHPs must comply with the appointment time standards in accordance with section 1300.67.2.2(c)(1-4), (7) of Title 28 of the California Code of Regulations (CCR).

Provider-to-Beneficiary Ratio Standards

For the 2019 certification period, DHCS established the following provider-to-beneficiary ratio standards:

Certification Category	Ratio Standard
Children/youth outpatient	**1:30**
Adult outpatient	**1:50**
Children/youth psychiatry	**1:323**
Adult psychiatry	**1:524**

Please note: DHCS will re-evaluate the ratio standards in three years to determine if appropriate adjustments to the ratio standards should be made.

[26] Welf. & Inst. Code, § 14197(d)(1)(A); Cal. Code Regs., tit. 28, § 1300.67.2.2(c)(5)(E)
[27] Welf. & Inst. Code, § 14197(c)(3)