CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
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DATE: April 25, 2025

Behavioral Health Information Notice No: 25-013
Supersedes BHIN 24-020

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 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: 2025 Network Certification Requirements for County Mental Health Plans (MHPs), Drug Medi-Cal Organized Delivery System (DMC-ODS) Plans, Drug Medi-Cal (DMC) State Plan Counties, Integrated Behavioral Health Plans (IBHPs) and Integrated DMC Behavioral Health Delivery Systems (DMC-IBHDS)

PURPOSE: To expand and clarify network adequacy certification submission requirements for the FY 2025-26 certification period.

REFERENCE: Title 42 Code of Federal Regulations (CFR) Parts 438.68, 438.206, and 438.207; Welfare and Institutions Code (WIC) section 14197; WIC 14197.1.

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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 (referred to as the "Managed Care Rule"), which aligns many of the Medicaid managed care regulations with requirements of other major sources of coverage. MHPs and DMC-ODS Plans, referred to in this document as Behavioral Health Plans (BHPs) when described collectively, are classified as Prepaid Inpatient Health Plans (PIHPs) under federal law and must therefore comply with the Managed Care Rule (with some exceptions). The Managed Care Rule directs states to develop and enforce network adequacy standards that meet federal requirements. Most network adequacy standards are set forth in 42 CFR Parts 438.68, 438.206, and 438.207. WIC section 14197 includes time or distance and timely access standards and authorizes the Department of Health Care Services (DHCS) to interpret and implement those standards by information notice. (WIC § 14197(j).) In addition, WIC section 14184.102(d) authorizes DHCS to implement the CalAIM statutes, including continuing to implement the Specialty Mental Health Services (SMHS) program (WIC section 14184.400(a)) and the DMC-ODS (WIC section 14184.401(a)), by information notice.

The MHP and DMC-ODS network certification requirements set forth in this information notice also apply to counties that have chosen to opt-in to administer Medi-Cal behavioral health benefits under a single contract with DHCS.[1] Counties that have integrated an MHP and DMC-ODS program, hereafter referred to as IBHPs, should follow the requirements for MHPs and DMC-ODS. Counties that have integrated an MHP and DMC benefits, hereafter referred to as DMC-IBHDS, should follow the requirements for MHPs and DMC fee-for-service. Please note that DMC State Plan Counties Timely Access requirements that were previously addressed in BHIN 22-070 are now included within this guidance.[2]

Integrated counties will use different reporting tools. These tools have been identified throughout this information notice and are listed as attachments on page 49.

Medi-Cal is the Medicaid health care program for California and DHCS administers this program and its requirements, which include all federal and state network adequacy standards.

[1] See CalAIM Section 1915(b) waiver
[2] Please note that the way DHCS uses the terms "BHP" "IBHP" and "DMC-IBHDS" in this network certification guidance, which distinguishes between submission requirements for each of these plan types, may be different than the way the terms are defined in other DHCS guidance.

POLICY:
DHCS is required by federal and state law to monitor and certify the adequacy of each BHP's, IBHP's and DMC-IBHDS' network annually. DHCS shall submit an assurance to CMS that each BHP, IBHP and DMC-IBHDS meets the State's requirements for the availability of services, on an annual basis and each time there has been a significant change in the BHP's, IBHP's and DMC-IBHDS' operations. Each BHP's, IBHP's and DMC-IBHDS' documentation serves as the basis for the State's assurance to CMS. DHCS' submission to CMS shall also include an analysis that supports the assurance of the adequacy of each BHP's provider network.[3] DHCS has the authority, in accordance with WIC section 14197.7, to sanction BHPs, IBHPs and DMC-IBHDS that are out-of-compliance with the submission requirements, including accuracy, and timeliness or lack of submission.

BHPs, IBHPs and DMC-IBHDS' shall submit documentation and data to DHCS, in a format specified by DHCS, annually, each time there has been a significant change in the BHP's, IBHP's and DMC-IBHDS' operations, and upon the request of DHCS.[4]

The documentation shall demonstrate compliance with the State's standards for access to services, including network adequacy and timely access standards; that the BHP, IBHP and DMC-IBHDS offers an appropriate range of services that is adequate for the anticipated number of members for the service area of the BHP, IBHP and DMC-IBHDS; and that the BHP, IBHP and DMC-IBHDS maintains a network of providers operating within their scopes of practice under State law that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area of the BHP, IBHP and DMC-IBHDS.[5]

The documentation and data shall demonstrate compliance for adult and children/youth services separately.

I. Network Certification Requirements

DHCS is required to monitor BHP's, IBHP's and DMC-IBHDS' compliance with the network adequacy requirements set forth in WIC section 14197 and 42 CFR Parts 438.68, 438.206, and 438.207 to ensure that all Medi-Cal managed care covered services are available and accessible to members of the BHPs, IBHPs and DMC-IBHDS.

[3] 42 CFR §438.207(d)
[4] 42 CFR § 438.207(c); WIC §14197(g)(1)
[5] WIC §14197(g)(1); 42 CFR § 438.207(a), (b)

Each MHP is required to provide, or arrange for the provision of, all SMHS covered in its MHP contract, and its network must include providers responsible for delivering all those SMHS. MHPs shall report information regarding which network providers deliver which SMHS in the monthly 274 file.

Each DMC-ODS Plan is required to provide, or arrange for the provision of, all DMC-ODS services covered in its Intergovernmental Agreement with DHCS, and its network must include providers responsible for delivering all those DMC-ODS services. DMC-ODS Plans shall report information regarding which network providers deliver which services in the monthly 274 file.

In accordance with 42 CFR 438.68(c)(1), the standards specified in this BHIN take into consideration the following elements:

i. The anticipated Medi-Cal enrollment;
ii. The expected utilization of services;
iii. The characteristics and health care needs of the Medi-Cal population;
iv. The numbers and types (in terms of training, experience, and specialization) of network providers required to furnish contracted Medi-Cal services;
v. The numbers of network providers who are not accepting Medi-Cal members;
vi. The geographic location of network providers and Medi-Cal members, considering distance, travel time, and the means of transportation ordinarily used by Medi-Cal members;
vii. The ability of network providers to communicate with limited English proficient members in their preferred language(s);
viii. The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medi-Cal members with physical or mental disabilities; and
ix. 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.

II. BHP, IBHP and DMC-IBHDS Submission Requirements

For the FY 2025-26 network adequacy certification period, BHPs, IBHPs and DMC-IBHDS' shall submit all requested and necessary supporting documentation no later than July 1, 2025.

Effective FY 2025-26, DMC-ODS Plans will no longer report provider data using the NACT. DMC-ODS Plans will submit provider data using the monthly 274 file submission. DHCS will utilize each BHP's, IBHP's and DMC-IBHDS' monthly 274 file submission to verify the BHP's, IBHP's and DMC-IBHDS' compliance with the

required provider capacity, mandatory provider types, provider service validation, contract validation, and time or distance standards. DHCS will inform BHPs, IBHPs and DMC-IBHDS which monthly 274 file will be used for Annual Network Certification (ANC) as part of the ANC documents package that will be emailed to the BHPs, IBHPs and DMC-IBHDS'. DHCS will also utilize the BHP's, IBHP's and DMC-IBHDS' 274 file submission if the BHP, IBHP or DMC-IBHDS is required to resubmit documentation due to errors identified during the ANC review process. If a BHP, IBHP or DMC-IBHDS submits the 274 file late, or the file is incomplete or inaccurate, the BHP, IBHP or DMC-IBHDS will be subject to the imposition of a Corrective Action Plan (CAP) and/or other enforcement actions. For detailed information on how to submit the 274 file, please see BHIN 23-042.

DMC-ODS Plans and IBHPs should submit supporting documents electronically by uploading them into the applicable Behavioral Health Information System (BHIS) folder. DMC-ODS Plans and IBHPs are to use the "DHCS-NAOS-DMC-ODS" root folder and navigate to the folder with the name of their county for documentation submission.

MHPs and DMC-IBHDS should submit supporting documents electronically by uploading them into the applicable BHIS folder. MHPs and DMC-IBHDS are to use the "DHCS-NAOS-MHP" root folder and navigate to the folder with the name of their county for documentation submission.

BHPs, IBHPs and DMC-IBHDS' unable to complete their submission via BHIS shall contact DHCS at the NAOS@dhcs.ca.gov. DHCS shall provide the BHP, IBHP and DMC-IBHDS with instructions for an alternative and secure documentation submission process.

When submitting files, BHPs, IBHPs and DMC-IBHDS' shall use the naming convention (County Name)_(FY XXXX-XX)_(Program)_(Document_Name)_(Submission Date YYYY-MM-DD). Examples are as follows:

- Alameda_FY 2025-26_DMC-ODS_Transition_of_Care_2025-XX-XX
- Napa_FY 2025-26_MHP_Language_Line_Attestation_2025-XX-XX
- Calaveras_FY 2025-26_DMC-IBHDS_TADT_2025-XX-XX
- Orange_FY 2025-26_IBHP_TADT_2025-XX-XX

BHPs, IBHPs and DMC-IBHDS' are required to submit supporting documentation, such as 1) Timely Access data, 2) Grievances and Appeals, 3) Language Line Encounters (LLEs), and 4) Continuity of Care Requests, by July

1, 2025. For state FY 2025-26 the reporting period is July 1, 2024, through March 31, 2025.

All supporting documents, including executed agreements with contracted network providers and subcontractors, agreements pertaining to interpretation, language line, telehealth services, and reserve/staffing contracts, shall apply to the certification year (e.g., valid July 1, 2025, through June 30, 2026). For auto-renewing contracts that would expire during the certification period but for the auto-renewing clause, the BHP, IBHP or DMC-IBHDS shall submit an attestation on county letterhead that there are no known factors that could preclude the auto-renewal. All auto-renewing contracts shall include a distinct, clear auto-renewal clause.

III. Certification of Network Adequacy Data and Documentation Submission

The Director, Chief Administrative Officer, or equivalent positions, of the Behavioral Health agency shall certify the information submitted by the BHP, IBHP or DMC-IBHDS in their county is accurate and complete. This certification shall be submitted with the supporting documentation.

Submission of the supporting documentation and the accompanying certification is a condition for receiving Medicaid payments.[6]

a. MHP Network Capacity and Composition: Provider to Member Ratios

Each MHP shall 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 members within their county, including those with limited English proficiency (LEP), or physical or mental disabilities.[7] MHPs shall 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 a 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 SMHS and Psychiatry Services, and 5) Evaluation of County Provider-Member Ratios.

[6] 42 CFR § 438.600(b)
[7] 42 CFR § 438.206(b)(1)

i. Productivity Calculation

For the productivity calculation baseline, DHCS determined 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 established a 60% productivity rate (i.e., time spent on direct billable services) to determine the total productive minutes (i.e., 124,800 minutes x 60% = 74,880 minutes) per state FY for each FTE 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., participation in meetings, professional events, and conferences, etc.).

ii. Average Minutes Calculation for Psychiatry Services

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 SMHS, parsed into adults and children/youth for the state FY 2020-21.

For psychiatry services, each MHP's medication support services were isolated into those only claimed under a psychiatrist, a neurologist, or a psychiatric mental health nurse practitioner (PMHNP) provider taxonomy code. Then the minutes were averaged for the state 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 percentage of medication support services billed by psychiatrists, neurologists, or PMHNPs for the adult member population was 51.6%. The median percentage of medication support services billed by psychiatrists, neurologists, or PMHNPs for the children/youth member population was 78.1%.

DHCS adjusted the statewide average of medication support services by these percentages to create a proportionate psychiatry provider ratio.

iii. 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.[8]

Table 1. Provider-To-Member Ratio Standards

Measurement Category	Ratio Standard
Psychiatry – Adults	1:457
Psychiatry – Children/Youth	1:267
Mental Health Services – Adults	1:85
Mental Health Services – Children/Youth	1:49

iv. Anticipated Need for SMHS and Psychiatry Services

DHCS determined the need for SMHS in each MHP's population based on the serious emotional disturbance (SED) in children/youth and serious mental illness (SMI) in adults' 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 CA Bridge to Reform Waiver Services. 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 has compared these estimates to other prevalence estimates for the population and determined that prevalence rates do not vary greatly over time.

Using the Medi-Cal Eligibility Data System (MEDS), DHCS calculates the average number of individuals eligible to enroll in Medi-Cal in each county during the most recent state FY. DHCS then applies the SED and SMI prevalence estimates by age group to establish the proportion of youth and adult members likely to

[8] FY 2020-21 Short-Doyle claims data.

need SMHS. These estimates represent the anticipated need for SMHS among youth and adult Medi-Cal eligibles in each county.

DHCS uses this same methodology to estimate the need for psychiatry services (i.e., services provided directly by a psychiatrist, neurologist, physician or PMHNP). However, to determine the estimated need for psychiatry services, DHCS further calculates the proportion of members within the existing SMHS population who received psychiatry services as a part of the member's individualized treatment plan. DHCS determined that 67% of adults and 27% of children/youth receiving SMHS receive psychiatry services as a part of their treatment. Thus, to estimate the proportion of members that may need psychiatry services, the estimated population needing SMHS was adjusted by these percentages, respectively.

v. Evaluation of County Provider-Member Ratios

DHCS calculates each MHP's current provider-to-member ratio using FTE provider counts (numerator) and the anticipated SMHS and psychiatry needs population (denominator). DHCS then evaluates the MHP's provider-to-member ratios to determine if the current provider network meets the statewide ratio requirement. For an example of this process, see the table below.

Table 2. County Provider Network Adequacy – Example Calculation

State FY 2020-21	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	1,536	74,880	74,880/1,536 = 1:49	6,000	70.2	Needs Population / FTE= 1:85	Deficient – Need to add 52.3 FTE
Mental Health Services – Adults	882	74,880	74,880/882 = 1:85	4,000	195.2	Needs Population / FTE = 1:20	Compliant

vi. Calculating Full-Time Equivalents

A provider may be counted as one (1) FTE position if the provider's full-time job assignment is direct service delivery to Medi-Cal members. In the case where a provider is assigned to direct service delivery on a part-time basis, the FTE should be calculated based on the percentage of time the provider dedicates to direct service delivery on an ongoing basis over the course of a year. An FTE position is 2,080 hours per year (i.e., 40 hours per week for 52 weeks). FTE calculations shall not exceed 40 hours per week, including between service type(s) and age group(s) served. (Please see the section titled "Additional Options to Meet Provider and Capacity Requirements" for instructions on how a Plan may report provider time in excess of 40 hours per week).

vii. Direct Providers of Outpatient Services

Only direct providers of mental health services and psychiatry services should be included in the 274 file. For each rendering provider (an employee or contracted provider), the MHP should report the total FTEs available to directly provide mental health services including psychiatry services as evidenced by the contract.

MHPs should only report FTE for outpatient settings and not report FTE for providers who are only available to work in residential or inpatient settings. Providers who are available to work in both inpatient and outpatient settings can be counted, but their FTEs should be allocated based on time available for the outpatient setting only. For providers that serve more than one age group, the percentage of FTEs allotted to each age group by service type should be listed on a separate line.

DHCS will evaluate compliance with psychiatry ratios using reported FTEs for psychiatrists/neurologists, PMHNPs, and physicians only. PMHNPs will fulfill requirements for counties in psychiatry ratios as long as the PMHNP ratios do not exceed 4:1 PMHNP/psychiatrist. MHPs shall submit an attestation on county letterhead affirming the rendering provider is a PMHNP and the facility does not exceed the 4:1 PMHNP/psychiatrist ratio requirement.

For outpatient SMHS ratios, DHCS will count reported FTEs for all

providers the MHP listed as available to provide outpatient SMHS, including Intensive Home Based Services (IHBS) and Intensive Care Coordination (ICC). This also includes providers who are available to provide other service types in addition to outpatient SMHS. However, DHCS will not count providers who are available only for services other than outpatient SMHS. For example, if a provider is only available to provide crisis stabilization services, the provider should be reported accordingly by the MHP and will not be included in the outpatient SMHS ratio calculation.

For MHPs to receive credit for SMHS outpatient ratios, they must select mental health services in the 274 file. This also includes providers who are available to provide other service types in addition to mental health services. However, if a rendering provider is contracted for additional service delivery, then the MHP should select all other appropriate service types in the 274 file.

For quality and validation purposes, DHCS makes the following adjustments to the data submitted in the 274 file:

1. Remove FTEs for providers who were reported with an FTE greater than 100% across service settings and age groups (For further guidance on how to submit an attestation for providers who work over 100%, please see the “Additional Options to meet Provider and Capacity Requirements” section below);
2. Remove FTEs for medication support services reported for providers that are not psychiatrists/neurologists, PMHNP, or physicians; and,
3. Remove FTEs for SMHS providers who reported 100% FTE in the SMHS 274 file (if no attestation is submitted) and are also reported in the 274 file for a DMC-ODS Plan.

The MHP may request further explanation of DHCS about which FTEs were excluded by reaching out to NAOS@dhcs.ca.gov.

viii. Administrative Staff

MHP administrative staff and/or members of leadership can only be included if they 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 regular capacity to serve clients. The FTE, if included, should accurately reflect the amount of time the individual is actually available to directly provide services to a member over the course of a year.

If counties report administrative staff, or other providers, as having ongoing caseloads of zero, they must include information with the submission that explains why the provider does not carry a regular caseload.

ix. Reserve/Staffing Contracts

MHPs are permitted to use reserve/staffing contracts to meet network adequacy standards and/or as a basis for an Alternative Access Standard (AAS) request. Reserve/staffing providers shall 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 member ratios, the provider shall be available to provide services to members in the defined service area.

In addition, the physical location where members receive services shall meet the State's time or distance standards or an approved AAS request.

If using reserve/staffing contracts to meet either network adequacy standards or an AAS, MHPs shall 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 number of the contracting agency, and a statement from the county describing the maximum number of FTEs that can be available under the contract (if this is not explicit in the contract itself).

x. MHPs: Additional Options to meet Capacity and Composition Requirements

DHCS may grant requests for AAS for Capacity and Composition requirements. MHPs may submit an AAS request for Capacity and Composition to DHCS at any time, including at the time the MHP submits its annual certification data. If DHCS denies the request for an AAS it shall provide a written explanation for the denial.

- DHCS will only consider FTE in excess of 40 hours per week through the AAS process. For Rendering Providers with FTEs in excess of 40 hours per week, MHPs shall not submit the provider's data in the 274 file. Rather, MHPs may submit a narrative request (on county letterhead) listing the provider details and FTEs to be considered—including a breakout of FTEs per delivery system, provider service modality, and age group(s) served.
    a. To be considered, the MHP shall also provide an executed provider contract for each provider listed in the narrative and supporting documentation, such as a signed attestation from the MHP explaining the validity of the FTEs if the contract does not state this clearly. If the provider is directly employed by the MHP a contract is not required, however, the MHP must submit an attestation indicating the provider is a county employee.

xi. Submission Requirements for Residential Treatment Services, Psychiatric Health Facility Services, and Inpatient Hospital Services (MHP Only)

All Medi-Cal certified and inpatient residential facilities must continue submitting data monthly through the 274 file. For each provider of residential treatment services, psychiatric health facility services, and inpatient hospital services in an MHP's network, the MHP must provide either an invoice from the provider for state FY 2024-25, or an executed contract, covering the certification period through June 30, 2026. The executed contract and or invoices is due on August 1, 2026, with the Network Adequacy Submission.

All facilities in the MHP's network that provide Medi-Cal covered services to any age group must be included. This may include inpatient psychiatric settings that are designated as Institutions for Mental Disease (IMD) but provide Medi-Cal reimbursable services for members under 21 or over 65 years of age to the reporting MHP. Providers of both crisis residential treatment services and adult residential treatment services must be included. Providers located outside of an MHP's service area (i.e., county) that are in the MHP's network must be included.

This data is being collected for DHCS review only and counties will not be subject to new standards for inpatient/residential beds in the 2026 certification cycle.

Psychiatric inpatient facilities and Psychiatric Health Facilities (PHF) designated as IMDs are not enrolled as SMHS-certified providers in the Provider Information Management System (PIMS). To ensure all required SMHS, including IMD-excluded inpatient psychiatric services and PHF services, are accurately validated, DHCS will require MHPs to enroll these sites in PIMs. MHPs must submit either a provider invoice for state FY 2024-25 or an executed contract covering the certification period from July 1, 2025 through June 30, 2026. DHCS will use this information to verify the provision of covered services and verify the provider is on the IMD list.

b. DMC-ODS – Availability of Services

Each DMC-ODS Plan shall maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to Substance Use Disorder (SUD) services for all members within their county, including those with LEP, or physical or mental disabilities.[9] DMC-ODS Plans shall meet or exceed network capacity requirements and proportionately adjust the number of network providers to support any anticipated changes in enrollment. Each DMC-ODS Plan is required to provide a list of all its network providers in the 274 file as part of its annual network adequacy certification submission. Each 274 file shall include the maximum number of members each provider can serve at any given time, separated by age group (i.e., 0-17, and 18+), and by service modality. For providers that serve more than one age group,

[9] 42 CFR § 438.206(b)(1)

the DMC-ODS Plan may adjust capacity by age group according to member needs. Thus, if there is not a specific maximum member count per age group established by contract, the DMC-ODS Plan should review utilization patterns and trends to determine the best way to allocate the maximum number of members per age group.

DMC-ODS Plans shall enter the provider separately in the 274 file indicating each age group and maximum number of members that the provider can serve. The proportion of maximum capacity allocated to each age group will be at the DMC-ODS Plan's discretion. Additionally, each DMC-ODS Plan is required to report whether each provider is accepting new members.

For provider contracts that do not include a limit on the number of members the provider can serve, the DMC-ODS Plan must determine and report the maximum number of members the DMC-ODS Plan anticipates referring to the provider at any point in time.

DMC-ODS Plans shall contract with a sufficient number of the appropriate types of providers to ensure the provision of all DMC-ODS services covered under its Intergovernmental Agreement with DHCS.

i. **Projected Utilization**
DHCS' projected utilization methodology is based on monthly enrollment totals derived from MEDS. Utilizing two state FYs of Medi-Cal enrollment data (e.g., for this certification, DHCS is using state FY 2022-23 and state FY 2023-24), two sets of projections are produced for each DMC-ODS Plan: one for children and youth (aged 0-17) and one for adults (aged 18 and over).

Monthly enrollment totals are forecasted through the certification period (e.g., for state FY 2025-26 certification the projection is through June 2026).

Utilizing the 2019 National Survey on Drug Use and Health (NSDUH)[10] and combined SUD estimates, DHCS applied the

[10] Substance Abuse and Mental Health Administration sponsored research evaluates the use of illegal drugs, prescription drugs, alcohol, and tobacco and misuse of prescription drugs; SUDs and

percentage of those aged 0-17 (4.55%) and 18+ (9.23%) estimated to be in need of treatment services to the number of individuals eligible to enroll in Medi-Cal through June 2026 for each age group. DHCS then applied a percentage of 10 to the estimated members in need of treatment services to estimate the number who will actually seek treatment. The 10% comes from America's Need for and Receipt of Substance Use Treatment in 2015 developed by NSDUH and found on the Substance Abuse and Mental Health Services Administration's website. These numbers are referred to as the "Seeking Treatment" estimates in this BHIN.

For further validation of expected utilization, DMC-ODS Plans are also required to provide projections of members who will seek treatment through the certification period (for state FY 2025-26, this projection is to June 2026) as well as the number of members per treatment modality.

ii. Network Capacity

To determine the network capacity and sufficiency to serve the Medi-Cal population of a DMC-ODS Plan, DHCS:

1. Compares the expected utilization (as calculated and reported by DMC-ODS Plans) to the Seeking Treatment Estimate. The Seeking Treatment Estimate is a baseline estimate calculated by DHCS using MEDS data that is specific to each DMC-ODS Plan (see above). It is expected that DMC-ODS Plans reported expected utilization must either meet or exceed this baseline estimate. This comparison results in either of the following two scenarios:
    a. If the DMC-ODS Plan projects a higher number of members expected to utilize services than the Seeking Treatment Estimate generated by DHCS, the DMC-ODS Plan's number is used to determine if the DMC-ODS Plan's network composition is sufficient.

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substance use treatment major depressive episode and depression care; serious psychological distress, mental illness, and mental health care using data from the NSDUH.

b. Sufficiency means that the maximum number of members that can be served per treatment modality (as reported by the DMC-ODS Plan within the 274 file) meets or exceeds the expected utilization.

2. If the DMC-ODS Plan's projections are lower than DHCS' Seeking Treatment Estimate, DHCS applies the percent difference to the DMC-ODS Plan's reported expected utilization (per treatment modality) to increase the estimate to meet or exceed DHCS' seeking treatment estimate. This new figure (new need estimate) is used to determine if the DMC-ODS Plan's network composition is sufficient.
    a. Sufficiency means that the maximum number of members that can be served per treatment modality (as reported within the 274 file) meets or exceeds the new need estimate.

iii. Additional Analysis of Residential Capacity:

Application of Length of Stay (LoS) Analysis

If the DMC-ODS Plan's reported point-in-time capacity to provide residential treatment services does not meet or exceed the DMC- ODS Plan's annual expected utilization, DHCS will consider average length of stay in the capacity analysis.

Utilizing the average LoS, DHCS will grow the bed capacity by the average LoS identified in the table below. After growing the bed capacity, DHCS will compare the reported expected utilization of the DMC-ODS Plan to the new bed capacity.

Table 3. Statewide Length of Stay

Age Group	Average # of Days Members Stayed in Residential Treatment	Rate of Bed Turnover (365 days per year / Average # of Days Members Stayed in Residential Treatment)
Adult	48	8
Youth	36	10

DHCS will not apply the above LoS analysis in scenarios where comparing capacity to projected utilization over time is inapplicable. For example, if the DMC-ODS Plan reports a significant change to the residential provider network and/or is currently failing to provide timely access to residential treatment services, accounting for bed turnover in order to estimate annual service capacity would be inappropriate.

iv. Additional Analysis of Monthly Utilization Data:
If DHCS finds that a DMC-ODS Plan is deficient in the initial network capacity analysis, DHCS also analyzes monthly utilization data as follows:

i. Utilizing the Attachment H – Supplemental Data Tool, the DMC-ODS Plan must report unique member counts per treatment category for the certification submission's state FY, organized by month and by age group. For validation purposes, DHCS compares this data to the claims data submitted by the DMC- ODS Plan. DHCS recognizes the DMC-ODS Plan may report greater monthly utilization counts than what is evident in the DHCS claims database due to lag in claims processing. However, the monthly utilization counts submitted in the Supplemental Data Tool should not be less than what is in DHCS' claims database. DHCS compares the expected utilization of the DMC-ODS Plan to the annual Seeking Treatment Estimate of DHCS, as discussed in the Network Capacity section above.

a. If the expected utilization of the DMC- ODS Plan is higher than the estimates of DHCS, DHCS uses

the monthly utilization of the DMC-ODS Plan to project monthly utilization through the certification year. DHCS then determines sufficient capacity.

i. "Sufficiency" means that the maximum number of members that can be served per treatment modality (as reported within the 274 file) meets or exceeds the projected monthly utilization for each treatment modality and age group.

b. If the expected utilization of the DMC-ODS Plan is lower than the estimates of DHCS, DHCS uses the monthly utilization of the DMC-ODS Plan to project the monthly utilization through the certification year. DHCS then applies the percent difference between DHCS Seeking Treatment Estimate and the DMC-ODS Plan's expected utilization to the projection of monthly utilization through the certification year to grow it to the appropriate number. DHCS then determines sufficient capacity.

Please note – DMC-ODS Plans are not required to submit monthly utilization data with the annual submission but can submit at their own discretion. DMC-ODS Plans opting to submit monthly utilization data must use the Supplemental Data Tool. The Supplemental Data Tool submission date, and reporting period shall be:

- For state FY 2025-26: annual submission – July 1, 2025 (reporting period: calendar year 2024).

If a DMC-ODS Plan is found deficient in capacity and composition standards, the DMC-ODS Plan shall submit the Supplemental Data Tool as part of the CAP and compliance reassessment data submission. (If a DMC-ODS Plan submitted a Supplemental Data Tool at annual submission, an additional tool is not required as part of the reassessment data submission).

DHCS may refine the methodology for capacity and composition determinations to include additional analyses as it determines necessary. DHCS will communicate any updates to the methodology to the DMC-ODS Plans.

Table 4. DMC-ODS, Estimated Need and the Seeking Treatment Estimate – Example Calculation

Projected Average Medi-Cal Enrollment Ages 0-17	Estimated Population in Need of SUD treatment Ages 0-17 (4.55%)	Estimated Population to Seek SUD treatment Ages 0-17 (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 5a. DMC-ODS, Expected Utilization per Service Modality – Example Calculation

Comparison of DHCS vs. DMC-ODS Plan Estimates			
DHCS Total Expected Utilization (N) Seeking Treatment for the DMC-ODS Plan	DMC-ODS Plan's Actual Total Expected Utilization (N)	Difference	% Difference
1000	750	250	33.3%

DHCS' Seeking Treatment Estimate is used as a baseline that the DMC-ODS Plan must either meet or exceed. In the example above, the DMC-ODS Plan total expected utilization (which is reported in Attachment A, is 750 members, which is less than DHCS' Seeking Treatment Estimate of 1,000 members in the children/youth age group (0-17) as shown in Table 5a.

Thus, DHCS calculates the numerical difference between the two estimates and then converts that difference into a percentage.

Table 5b(i). DMC-ODS, Expected Utilization per Service Modality for Outpatient Treatment – Example Calculation

Proportion Expected Utilization for Outpatient Treatment (n)	Applied % Difference	Adjusted Expected Utilization
350	117	467

Table 5b(ii). DMC-ODS, Expected Utilization per Service Modality for Intensive Outpatient Treatment (IOT) – Example Calculation

Proportion Expected Utilization for IOT (n)	Applied % Difference	Adjusted Expected Utilization
200	66	266

Table 5b(iii). DMC-ODS, Expected Utilization per Service Modality for Residential – Example Calculation

Proportion Expected Utilization for RES (n)	Applied % Difference	Adjusted Expected Utilization
150	50	200

Table 5b(iv). DMC-ODS, Expected Utilization per Service Modality for Opioid Treatment Programs (OTP) – Example Calculation

Proportion Expected Utilization for OTP (n)	Applied % Difference	Adjusted Expected Utilization
50	17	67

The percent difference is then applied to the DMC-ODS Plan's expected utilization broken out by service modality (also reported in the 274 file,) to grow those numbers proportionately (adjusted expected utilization) to meet DHCS' Seeking Treatment Estimate.

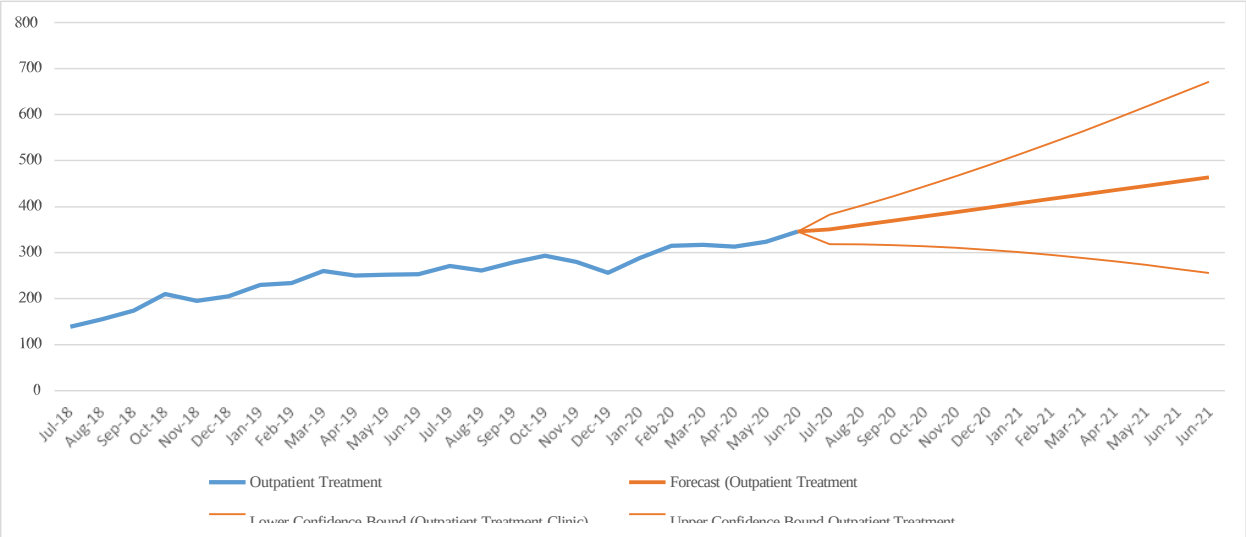
Table 6. DMC-ODS Plan Capacity and Composition Filter – Example

Row	Age Group(s) Served	Modality (DMC-ODS) - Outpatient Treatment Clinic	Modality (DMC-ODS) - Intensive Outpatient Clinic	Modality (DMC-ODS) - Residential	Modality (DMC-ODS) - OTP	Maximum Number of Medi-Cal Members
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 274 Capacity Report (Site Level Data) by age group, provider type, and maximum number of members served.

DHCS uses this filter to determine capacity to serve. For example, for youth (0-17) outpatient treatment services, DHCS can sum the maximum number of Medi-Cal members for rows 3, 6, 10, 11, and 13 for a total of 618 maximum capacity. If the expected utilization for youth (0-17) outpatient treatment services, using the examples in Table 6, is 467 members, the DMC-ODS Plan has sufficient capacity to meet expected utilization.

Figure 1. DMC-ODS Plan Monthly Utilization Data Projection – Example Projection



In the example above, DHCS uses two state FYs of monthly utilization data (reported by a DMC-ODS Plan, in Attachment H – DMC-ODS Supplemental Data Tool) to project utilization per month through the certification period.

DHCS may use this data to resolve the findings from the annual capacity analysis if DHCS finds a DMC-ODS Plan is noncompliant with capacity and composition standards.

DHCS calculates both annual and monthly estimates to determine the capacity of a DMC-ODS Plan, as there are many variables that affect the range between estimation and actual utilization. For instance, the annual estimation includes members currently receiving DMC-ODS services and those that will be new to the system. Utilization data is helpful in understanding the pattern in which services are actually accessed in a DMC-ODS Plan. However, utilization data 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 members 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 deficiencies. However, DMC-ODS Plans are expected to continually grow the networks to achieve sufficient capacity to serve the annual Seeking Treatment Estimate figure as an eventual benchmark goal.

c. Time or Distance

42 CFR Part 438.68(b)(1) requires DHCS to develop quantitative network adequacy standards, such as time or distance standards, for adult and pediatric behavioral health providers. WIC Section 14197(b) and (c) set forth time or distance standards for California. Time means the number of minutes it takes a member to travel from the member's residence to the nearest provider site. Distance means the number of miles a member must travel from the member's residence to the nearest provider site. Both standards are based on a county's population density, and Plans are required to meet either the time standard or distance standard. Time or distance standards for mental health services, psychiatry services, SUD outpatient treatment, and OTP services are specified in Attachment B – Time or Distance Standards.

i. Time or Distance Geographical Maps Methodology

DHCS assesses each BHP's, IBHP's and DMC-IBHDS' time or distance compliance based on the provider data from the 274 file for each of the BHP's, IBHP's and DMC-IBHDS' service areas, for all zip codes, accounting for all current and anticipated members. Please note, the 274 provider data is collected from the following areas by service delivery.

MHPs:

- 274 File: Provider detail

DMC-ODS Plans:

- 274 File: Site detail
- 274 File: Rendering Service Provider

DHCS prepares geographic access maps for BHPs, IBHP's and DMC-IBHDS' using ArcGIS software. DHCS applies an enhancement within ArcGIS created by the Environmental Systems Research Institute (ESRI) to run the driving times or driving

distances. ESRI utilizes the shortest driving time from each provider in a BHP's, IBHP's and DMC-IBHDS' network to the address of the furthest Medi-Cal eligibles in each zip code. The Department determines the members to include in the calculation using the most current data available from the MEDS system.

DHCS plots time and distance of the geographic locations of all network providers stratified by service type for MHPs (psychiatry and outpatient SMHS) and service modalities for DMC-ODS Plans (outpatient services and OTPs), for both adult and children/youth separately based on the BHP's, IBHP's and DMC-IBHDS' reported provider data. DHCS evaluates BHP, IBHP and DMC-IBHDS compliance with time or distance standards by age group (adults, and children/youth).

BHPs, IBHPs and DMC-IBHDS' may request a copy of the access maps by contacting the NAOS mailbox at NAOS@dhcs.ca.gov.

ii. Alternative Access Standard (AAS) – Time or Distance

The Managed Care Rule permits states to grant exceptions to the time or distance standards.[11] If a BHP, IBHP or DMC-IBHDS cannot meet the time or distance standards set forth in this BHIN for all coverage areas where Medi-Cal eligibles reside, DHCS will notify the BHP, IBHP or DMC-IBHDS to submit an Attachment C.1, C.2, and C.3 – AAS Request Template to DHCS within the appropriate timeframe (see AAS Validation section below for approval timelines).[12] For each coverage area for which the BHP, IBHP or DMC-IBHDS does not meet the time or distance standards for a service type, the BHP shall include a description of how the BHP, IBHP or DMC-IBHDS intends to arrange for Medi-Cal members who reside in that coverage area to access that service type.[13] All BHPs, IBHPs and DMC-IBHDS' are permitted to submit an AAS request with their annual certification package during the annual certification process.

[11] 42 CFR §438.68(d)
[12] WIC §14197(f)(3)
[13] WIC §14197(f)(4)

iii. Time or Distance AAS Request Template (Attachment C.1, C.2, and C.3)

DHCS will only consider requests for AAS if the BHP, IBHP and DMC-IBHDS has exhausted all other reasonable options to obtain providers to meet the applicable standard, or if DHCS determines that the BHP, IBHP and DMC-IBHDS has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.[14]

Requests for an AAS will be approved or denied on a zip code and service type basis. Requests for AAS must include a description of the reasons justifying the AAS based on the facts and circumstances applicable to each zip code/service type for which an AAS is requested.[15] Requests may also include seasonal considerations (e.g., winter road conditions) when appropriate. Furthermore, BHPs, IBHPs and DMC-IBHDS' 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 member to travel the time or distance that would result if DHCS granted the AAS.[16]

The Attachment C.1, C.2, and C.3 details the submission requirements for AAS requests. In the AAS request template, a BHP, IBHP and DMC-IBHDS must provide the name and address of the nearest in-network provider as well as the driving time or distance to that provider from the furthest members' location in each zip code.

To demonstrate that it has made good-faith efforts to exhaust other reasonable options to obtain providers to meet the applicable standard a BHP, IBHP and DMC-IBHDS must submit evidence of its Out-of- Network (OON) contracting efforts. For each OON provider that a Plan attempted to contract with, the BHP, IBHP and DMC-IBHDS must provide the name and address of the OON provider, and the driving time/distance from the OON provider to

[14] WIC §14197(f)(2)
[15] WIC §14197(f)(4)
[16] WIC §14197(f)(5)

the furthest eligible member(s) in that zip code; a description of its contracting efforts, including the frequency of the contracting efforts, and the reasons the Plan was unable to contract.

For each zip code/service-type for which a BHP, IBHP and DMC-IBHDS requests an AAS, the BHP, IBHP and DMC-IBHDS must attempt to contract with at least two OON providers.

iv. Alternative Access Standard Review Process

In Attachment C.1, C.2, and C.3, BHPs, IBHPs and DMC-IBHDS' must detail the name and address of the two nearest identified OON providers, the date the BHP, IBHP and DMC-IBHDS contacted the providers to discuss contracting with the BHP, IBHP and DMC-IBHDS, and the number of contracting attempts the BHP, IBHP and DMC-IBHDS made. Through the AAS review process, DHCS will request evidence of contracting efforts, which may include but will not be limited to: documentation demonstrating contracting efforts such as correspondence (via email or letter), scheduled phone calls, notes from negotiations, draft (unexecuted) contracts, marketing materials and advertisements, and correspondence or other evidence of follow-up attempts after initial contract efforts or outreach.

If a BHP, IBHP and DMC-IBHDS is unable to contract with a specific provider due to a quality-of-care issue, the BHP, IBHP and DMC-IBHDS must submit supporting documentation detailing the BHP's, IBHP's and DMC-IBHDS' 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.

The evidence of contracting efforts shall reflect contracting efforts conducted since the BHP's, IBHP's and DMC-IBHDS' last annual network adequacy certification submission. The supporting documentation submitted shall be dated prior to the AAS request in question taking effect.

DHCS approves or denies an AAS request on a zip code/ service

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 BHP's, IBHP's and DMC-IBHDS' efforts to identify the nearest in- network and OON providers.

Additionally, DHCS compares the identified providers submitted by the BHP, IBHP and DMC-IBHDS to the 274 file and to other resources.

DHCS reviews the AAS request and all supporting documentation to assess the facts and circumstances provided by the BHP, IBHP and DMC-IBHDS. BHPs, IBHPs and DMC-IBHDS' shall maintain documentation of their efforts to contract with the nearest 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 nearer OON providers during the review process.

On an annual basis and at DHCS' request, the BHP, IBHP and DMC-IBHDS shall demonstrate how it arranges for the delivery of services such as Medi-Cal covered transportation or telehealth, if members needed covered services from a provider or facility located outside of the time or distance standards specified in WIC section 14197(c).[18]

DHCS will approve or deny an AAS request within 90 days of submission by the BHP, IBHP and DMC-IBHDS. 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 BHP, IBHP and DMC-IBHDS requesting the AAS.[19] Upon submission of sufficient additional information to the department, the 90-day timeframe shall resume where 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.[20] Upon

[17] WIC §14197(f)(4)
[18] WIC §14197(g)(2)
[19] WIC §14197(f)(4)
[20] WIC §14197(f)(4)

notification by DHCS, an approved AAS will be valid for three years.[21] DHCS will annually reassess a BHP's, IBHP's and DMC-IBHDS' compliance with time or distance standards and provide the BHP, IBHP and DMC-IBHDS with updates for zip codes that are deficient, by age group and provider type, that are not part of the approved three-year AAS. If a zip code is identified as being deficient during the three-year period, the BHP, IBHP and DMC-IBHDS will be required to submit a revised AAS for the newly identified zip code(s) and services type. DHCS will monitor member access to the service type covered by the AAS on an on-going basis and report DHCS' findings to CMS.[22]

For all approved AAS requests, DHCS will monitor member access to the service type covered by the AAS request on an on- going basis and report DHCS' findings to CMS.[23] If DHCS denies a request for AAS, DHCS shall inform the BHP, IBHP and DMC-IBHDS of the reason for denying the request in writing. DHCS will post approved AAS requests on the DHCS website.[24]

v. Additional Options to Meet Time or Distance Standards Utilizing Field Based Services

SMHS and DMC-ODS services are to be provided in the least restrictive setting, consistent with the goals of recovery and resiliency. DHCS will consider providers traveling to the member or a field-based setting to deliver services in its time or distance methodology. For services where the provider travels to the member to deliver services, the BHP, IBHP and DMC-IBHDS must ensure services are provided in a timely manner.

MHP/DMC-IBHDS Only

MHPs requesting to use field-based or mobile providers to meet the time or distance standards must submit information to DHCS on the availability and provision of field-based or mobile services in the 274 file.

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[21] WIC §14197(f)(3)(C)
[22] 42 CFR §438.66(e) requires DHCS to submit a report to CMS annually on each managed care program the Department administers. 42 CFR Part 438.68(d)(2) and 438.66(e)(2)(vi) require the Department to include the results of the monitoring in that report.
[23] 42 CFR § 438.68(d)(2)
[24] WIC §14197(f)(4)

DMC-ODS/IBHP Only
DMC-ODS Plans requesting to use field-based or mobile providers to meet the time or distance standards must submit information to DHCS on the availability of providers who will travel to deliver services in the 274 file.

vi. Telehealth Services

BHPs, IBHPs and DMC-IBHDS' are permitted to use the synchronous mode of telehealth services to meet network adequacy standards, and/or as a basis for an AAS request.[25] However, 85% of members must reside within the required time or distance standards for provider types by zip code. For example, if 100 Medi-Cal eligibles reside in zip code 95814, 85 of those members must have an on-site provider available within time or distance standards.

Although DHCS permits the use of telehealth in order to meet time or distance standards, all members have the right to an in-person appointment.[26] Telehealth can only be provided when medically appropriate, as determined by the provider and as allowed by the applicable delivery systems' provider manual. For further information regarding telehealth requirements, please reference BHIN 23-018.

In accordance with the terms and conditions of the contract with DHCS, BHPs, IBHPs and DMC-IBHDS' must coordinate transportation with the local Managed Care Plan (MCP) for a member to a network provider and meet timely access standards for medically necessary services when a member is offered a telehealth visit but requests an in-person visit. If a BHP, IBHP and DMC-IBHDS is unable to arrange for an in-person visit with a network provider, the BHP, IBHP and DMC-IBHDS must authorize OON services and coordinate transportation with the local MCP for the member to travel to the appointment as needed per BHIN 21-008.

[25] WIC, §14197(e), (f)(1), (6).
[26] WIC, §14132.725(e)(1)(B).

Telehealth services must comply with BHIN 23-018 and DHCS' Medi-Cal Provider Manual Telehealth Policy.[27]

In order to utilize telehealth to fulfill network adequacy requirements for time or distance standards, telehealth services must be provided to members in the defined service area. In addition, the physical location where members receive telehealth services must meet the State's time or distance standards or approved AAS. If using telehealth to meet either network adequacy standards or AAS, BHPs, IBHPs and DMC-IBHDS' must submit information to DHCS on their telehealth providers.

Telehealth providers for BHPs, IBHPs, and DMC-IBHDS' must be reported in the 274 File.

d. Timely Access

MHP and DMC-ODS:
42 CFR Part 438.206(c)(1), Availability of Services, requires BHPs, IBHPs and DMC-IBHDS' to meet State standards for timely access to care and services, taking into account the urgency of the need for services. WIC section 14197 (d) sets forth timely access standards and requires MHP and DMC-ODS Plans to comply with the appointment time standards set forth in Health and Safety Code (HSC) section 1367.03 and Title 28, California Code of Regulations (CCR), section 1300.67.2.2. The specific appointment time standards for which the Department is currently collecting data are set forth in the Timely Access Data Tool (TADT) Attachments D.1 (MHP) and D.2 (DMC-ODS Plans).

i. Timely Access Data Tool (TADT): Attachment – D.1, D.2, and D.4
To ensure that BHPs, IBHPs and DMC-IBHDS' provide timely access to services, DHCS requires each BHP, IBHP and DMC-IBHDS to have a system in place for tracking and measuring timeliness of care, which includes the timeliness to receive the first SMHS appointment, or DMC-ODS appointment, and timeliness of their follow-up appointments. For this purpose, DHCS developed the TADT, a uniform data collection tool.

[27] WIC, §14197(e); Medi-Cal Provider Manual. "Medicine: Telehealth."

ii. Reporting Requirements

BHPs, IBHPs and DMC-IBHDS' are required to utilize the TADT to document service requests from new members who request a non-psychiatry SMHS; any new or established member requests for psychiatric services; new members requesting a SUD service; and the first follow-up appointment offered after the initial service appointment.

BHPs, IBHPs and DMC-IBHDS' must submit data via the TADT for the reporting period spanning July 1, 2024, to March 31, 2025. All timely access data reported through the TADT must encompass the entire provider network, including both county-operated facilities/providers and contracted facilities/providers. Additionally, BHPs, IBHPs and DMC-IBHDS' must disclose to DHCS on the TADT if the data is or is not inclusive of all providers within the BHP's, IBHP's and DMC-IBHDS' network.

The data reported in the TADT will be used to determine compliance with timely access standards. DHCS will determine compliance by appointment type and age group (i.e., will assess compliance separately for adults and youth). BHPs, IBHPs and DMC-IBHDS' must ensure that all services covered are available and accessible to members within timely access standards and without utilizing waitlists.

If DHCS determines the BHP, IBHP and DMC-IBHDS does not meet network adequacy requirements and the provider network is unable to provide timely access to necessary services, the BHP, IBHP and DMC-IBHDS shall adequately and timely cover these services with an OON provider for the member. The BHP, IBHP and DMC-IBHDS must permit OON access for as long as the BHP's, IBHP's and DMC-IBHDS' provider network is unable to provide the services in accordance with the standards.

BHPs, IBHPs and DMC-IBHDS' must report on the timeliness of care for OON providers if the BHP, IBHP and DMC-IBHDS is unable to arrange an appointment for a member with a network provider that meets the timely access standard. For additional information, please reference BHIN 21-008 for MHP/DMC-IBHDS and MHSUDS IN 19-024 for DMC-ODS Plans/IBHPs.

MHPs/DMC-IBHDS' are required to submit timely access data for:

- An urgent or non-urgent appointment with a non-physician mental health care provider of an outpatient SMHS;
- An urgent or a non-urgent appointment with a provider of psychiatry;
- Non-urgent follow-up appointments with a non-physician mental health care provider;[28] and,
- Appointments with OON providers (in cases where appointments with network providers are not available within timely access standards).
- Urgent and non-urgent appointments for Outpatient SUD services;
- Urgent and non-urgent Residential treatment, as applicable;
- Withdrawal Management (all WM is considered urgent), as applicable;
- Urgent and non-urgent appointments for OTP, and;
- Non-urgent follow-up appointments with a non-physician SUD provider.

DMC-ODS Plans/IBHPs are required to submit timely access data for:

- Urgent and non-urgent appointments for Outpatient SUD services;
- Urgent and non-urgent Residential treatment;
- Withdrawal Management (all WM is considered urgent);
- Urgent and non-urgent appointments for OTP;
- Non-urgent follow-up appointments with a non-physician SUD provider; and,
- Appointments with OON providers (in cases where appointments with network providers are not available within timely access standards).
- An urgent or non-urgent appointment with a non-physician mental health care provider of an outpatient SMHS;
- An urgent or a non-urgent appointment with a provider of psychiatry;
- Non-urgent follow-up appointments with a non-physician mental health care provider;[29] and,
- Appointments with OON providers (in cases where

[28] HSC § 1367.03(a)(5); BHIN 22-016
[29] HSC § 1367.03(a)(5); BHIN 22-016

appointments with network providers are not available within timely access standards).

Behavioral Health Delivery Systems are required to submit Timely Access Data for both SMHS and SUD services.

iii. Methodology for Determining BHP, IBHP and DMC-IBHDS Compliance with Timely Access Standards

DHCS calculates compliance of timely access standards using the "Date of First Contact to Request Services" and the number of business days between that date and the date of the first offered available appointment that qualifies as a billable service. For example, if a member requests an initial appointment for an outpatient SMHS or an outpatient DMC-ODS service on the first of the month and is offered an appointment on the 11th of the month, the BHP, IBHP and DMC-IBHDS would be considered to have met the 10-business day standard. For a BHP, IBHP and DMC-IBHDS to be compliant with timely access standards, 80% of members must have been offered an appointment within the applicable time frame.

Timely Access Standards for SMHS

Service Type	Standard*
Outpatient Non-Urgent Non-Psychiatric SMHS	Offered an appointment within 10 business days of request for services.
Psychiatric Services	Offered an appointment within 15 business days of request for services.
All Urgent SMHS Appointments	Urgent Appointments** 48 hours without prior authorization. 96 hours with prior authorization.
Non-urgent Follow-up Appointments	Offered a follow-up appointment with a non-physician within 10 business days of the prior appointment.[30]
*The above standards apply unless the waiting time for an appointment is extended pursuant to HCS 1367.03(a)(5)(H) or 28 CCR section1300.67.2.2(c)(5)(H). ** Urgent care means health care provided to a member when the member's condition is such that the member faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the member's life or health or could jeopardize their ability to regain maximum function.[31]	

[30] HSC §1367.03 (a)(5)(B), (D), (E) and (F)
[31] HSC §1367.03(e)(7); 28 CCR §1300.67.2.2 (b)(21))

Timely Access Standards for DMC-ODS Services

Modality Type	Standard
Outpatient Services – Outpatient SUD Services	Offered an appointment within 10 business days of request for services.
Residential	Offered an appointment within 10 business days of request for services.
Opioid Treatment Program*	Within three business days of request
All Urgent SUD Appointments***	Urgent Appointments** 48 hours without prior authorization. 96 hours with prior authorization.
Non-urgent Follow-up Appointments with a Non-Physician	Offered a follow-up appointment with a non-physician within 10 business days of the prior appointment.[32]

*For OTP patients, the OTP standards apply equally to both buprenorphine and methadone where applicable. Buprenorphine is not specified in several areas of the current regulations, so we default to the federal regulations. (For example, with take-home medication, time in treatment requirements are not applicable to buprenorphine patients.)

**Urgent care means health care provided to a member when the member's condition is such that the member faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the member's life or health or could jeopardize their ability to regain maximum function.[33]

***All appointments where Withdrawal Management (WM) is offered/utilized shall be considered urgent.

[32] HSC §1367.03 (a)(5)(B), (D), (E) and (F)
[33] HSC §1367.03(e)(7); 28 CCR §1300.67.2.2 (b)(21)

DMC State Plan Counties

To ensure DMC members have the same access to SUD services as members receiving care through a managed care or PIHP delivery system, DMC State Plan Counties shall comply with California's timely access standards. W&I Code section 14197, subdivision (d), sets forth timely access standards and requires compliance with the appointment time standards set forth in HSC section 1367.03 and Title 28, CCR, section 1300.67.2.2. The specific appointment wait time standards for which DHCS is currently collecting data are detailed in the TADT Attachment D.3 (DMC) and D.5 (DMC-IBHDS).

i. Timely Access Data Tool (TADT): Attachment – D.3 and D.5

To ensure DMC State Plan Counties provide timely access to services, DMC State Plan Counties shall have a system in place for tracking and measuring the timeliness of care, which includes timeliness to receive the first DMC appointment and timeliness of their follow-up appointments. For this purpose, DHCS developed the TADT, a uniform data collection tool designed to collect timely access data as part of the DMC State Plan Counties Annual Certification.

ii. Reporting Requirements

DMC State Plan Counties are required to utilize the TADT to document service requests from new members seeking DMC services. DMC State Plan Counties must submit data via the TADT for the reporting period spanning July 1, 2024, to March 31, 2025. All timely access data reported through the TADT must encompass all eligible service requests, including both county-operated facilities/providers and contracted facilities/providers. Additionally, DMC State Plan Counties must disclose to DHCS on the TADT if the data is or is not inclusive of all contracted providers.

The data reported in the TADT will be used to determine compliance with timely access standards. DHCS will determine compliance by appointment type and age group (i.e., will assess compliance separately for adults and youth). DMC State Plan Counties must ensure that all services covered are available and accessible to members within timely access standards and without utilizing waitlists.

DMC State Plan Counties are required to submit timely access data for:

- Urgent and non-urgent appointments for Outpatient SUD services;
- Urgent and non-urgent Residential treatment, as applicable;
- Withdrawal Management (all WM is considered urgent), as applicable;
- Urgent and non-urgent appointments for OTP, and;
- Non-urgent follow-up appointments with a non-physician SUD provider.

DMC State Plan Counties will not be placed on a CAP for timely access standards for the FY 2025-26 DMC State Plan Annual Certification. However, they will receive findings from DHCS regarding the percentage of requests meeting the standard. DMC State Plan Counties who do not meet the timely access standard will receive technical assistance accompanying their findings. Compliance monitoring for DMC Timely Access standards will commence in FY 2026-27.

iii. Methodology for Determining DMC State Plan County Compliance with Timely Access Standards

DHCS calculates compliance using the “Date of First Contact to Request” Services and the number of business days between that date and the date of the first offered available appointment that qualifies as a billable service. For example, if a member requests an initial appointment for an outpatient DMC service on the first of the month and is offered an appointment on the 11th of the month, the County would be considered to have met the 10-business day standard. For a County to be compliant with timely access standards, 80% of members must have been offered an appointment within the applicable time frame.

Timely Access Standards for DMC SUD Services

Modality Type	Standard
Outpatient Services – Outpatient SUD Services	Offered an appointment within 10 business days of request for services.
Residential	Offered an appointment within 10 business days of request for services.
Opioid Treatment Program*	Within three business days of request
All Urgent SUD Appointments***	Urgent Appointments** 48 hours without prior authorization. 96 hours with prior authorization.
Non-urgent Follow-up Appointments with a Non-Physician	Offered a follow-up appointment with a non-physician within 10 business days of the prior appointment.[34]

*For OTP patients, the OTP standards apply equally to both buprenorphine and methadone where applicable. Buprenorphine is not specified in several areas of the current regulations, so we default to the federal regulations. (For example, with take-home medication, time in treatment requirements are not applicable to buprenorphine patients.)

**Urgent care means health care provided to a member when the member's condition is such that the member faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the member's life or health or could jeopardize their ability to regain maximum function.[35]

***All appointments where Withdrawal Management (WM) is offered/utilized shall be considered urgent.

e. Language Assistance Capabilities

BHPs, IBHPs and DMC-IBHDS' shall submit to DHCS subcontracts with interpreters for interpretation and language line services. In addition, BHPs, IBHPs and DMC-IBHDS' are required to report, in the BHP's, IBHP's and DMC-IBHDS' provider directory[36] and in the 274 file, the

[34] HSC §1357.03 (a)(5)(B), (D), (E) and (F)
[35] HSC §1367.03(e)(7); 28 CCR §1300.67.2.2 (b)(21)
[36] 42 CFR §438.10(h)(1)(vii)

cultural and linguistic capabilities of network providers, including languages offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.

i. Language Capacity

BHPs, IBHPs and DMC-IBHDS' are required to maintain and monitor a network of providers that is supported by written agreements and is sufficient to provide adequate access to all covered services for all members, including those with LEP.[37] BHPs, IBHPs and DMC-IBHDS' are also required to make oral interpretation and auxiliary aids, such as TTY/TDY and American Sign Language (ASL), available to members, free of charge, for any language.[38]

- While DHCS does not require a fixed number of language subcontracts from BHPs, IBHPs and DMC-IBHDS' the BHP's, IBHP's and DMC-IBHDS' language assistance subcontracts shall cover—whether within a single contract or several—the following types of language assistance services at a minimum:
    a. Oral Interpretation – services offered for spoken language processed in real time, whether in-person, via video call, phone, or other medium.
    b. Written Translation – services offered for written language content, often processed separately from the time of the request for assistive language services.
    c. ASL – services offered for a spoken language processed in real time, whether in-person or via video call.

ii. Language Line Encounters (LLE) Report

BHPs, IBHPs and DMC-IBHDS' shall submit a report detailing language service encounters. The report shall detail the utilization of language line interpretation services to provide language access to members in non-English languages. For each of the following, BHPs, IBHPs and DMC-IBHDS' must report, by language, the total number of encounters for which the language

[37] 42 CFR § 438.206(b)(1); WIC §14713(a)
[38] 42 CFR §438.10(d)(4); MHP Contract, Att. 11, section 3, E.

line services were requested:

1. 24/7 access line encounters;
2. Face-to-face service encounters; and,
3. Other telehealth service encounters.

DHCS has developed a standardized tool for collecting such encounters: Attachment G.1 and G.2 – Language Line Encounter Template. To submit LLE, BHPs, IBHPs and DMC-IBHDS' shall complete the Attachment G.1 or G.2 and provide all required encounter information from July 1, 2024, through March 31, 2025, on an annual basis.

BHPs, IBHPs and DMC-IBHDS' may be subject to corrective action for failure to comply with LLE reporting.

BHPs, IBHPs and DMC-IBHDS' shall submit through the BHIS folder. MHPs are to use the "DHCS-NAOS-MHP" root folder and navigate to the folder with the name of their county for documentation submission. DMC-ODS Plans and IBHPs are to use the "DHCS-NAOS-DMC-ODS" root folder and navigate to the folder with the name of their county for documentation submission.

If the BHP, IBHP and DMC-IBHDS did not have any language line encounter requests for the reporting period, please enter "No service requests were received during this reporting period" in the report.

f. Mandatory Provider Types

BHPs, IBHPs and DMC-IBHDS' shall demonstrate compliance with federal regulations addressing protections for American Indians and American Indian Health Services provided within a managed care system (42 CFR Part 438.14).

i. Indian Health Care Providers (IHCP)

IHCPs are not required to contract with BHPs, IBHPs and DMC-IBHDS'; however, BHPs, IBHPs and DMC-IBHDS' shall document good-faith efforts to contract with all IHCPs in the BHP's County. If a BHP, IBHP, or DMC-IBHDS has a valid contract with an IHCP in the BHP's, IBHP's and DMC-IBHDS' County, the BHP, IBHP and DMC-IBHDS shall submit a copy of the contract with their

annual submission and complete the MHP and DMC-ODS 274 data fields corresponding with IHCP.

If a BHP, IBHP, or DMC-IBHDS does not have a contract with any of the IHCPs in the BHP's, IBHP's and DMC-IBHDS' County, the BHP, IBHP and DMC-IBHDS shall submit to DHCS an attestation on county letterhead including an explanation to DHCS to justify the absence of an IHCP in the BHP's, IBHP's, or DMC-IBHDS' provider network. The BHP, IBHP, or DMC-IBHDS must also submit supporting documentation. If a BHP, IBHP and DMC-IBHDS is unable to contract with an IHCP, BHP, IBHP, and DMC-IBHDS must allow eligible Members to obtain services from out-of-network IHCP in accordance with 42 CFR section 438.14.

DHCS will review the BHP's, IBHP's and DMC-IBHDS' submission to determine compliance.

g. Continuity of Care (CoC) and Transition of Care (ToC) Reports
Per MHSUDS IN 18-059 (MHP) and MHSUDS IN 18-051 (DMC-ODS Plan), BHPs, IBHPs and DMC-IBHDS' are required to report to DHCS all CoC and ToC requests. DHCS has developed a standardized tool for collecting CoC and ToC requests (see Attachment F.1 and F.2 – Continuity-Transition of Care Report Template). It is mandatory for Plans to submit their CoC/ToC data utilizing the Attachment F.1 or F.2 report template.

This data is considered Protected Health Information and must be submitted using the Secure Data Portal BHIS. Submission of the report

by email or through another method will constitute a breach of the federal privacy rules and DHCS will report it to the DHCS Privacy Office as a breach.

If the BHP, IBHP and DMC-IBHDS does not have any data to report for any of the data requirements during the reporting period, the BHP, IBHP and DMC-IBHDS can submit a statement on county letterhead, or on the report template, stating "No service request for the reporting period."

h. System Infrastructure
Each BHP, IBHP and DMC-IBHDS shall also submit the following

additional supporting documentation on an annual basis unless noted otherwise:

i. Grievance and Appeals

BHPs, IBHPs and DMC-IBHDS' are required to submit qualitative data regarding grievances and appeals, related to access to care (i.e. services not available, services not accessible, timeliness of services, 24/7 toll-free access line, linguistic services, authorization delay notices, geographic access, and/or timely access notices) that correspond with the following 1915(b) Waiver Appeals and Grievance report categories:

Appeals

- Denial or limited authorization of services;
- Reduction, suspension, or termination of a previously authorized service;
- Payment denial;
- Service timeliness;
- Untimely response to appeal or grievance;
- Denial of a members request to dispute financial liability; and/or
- Appeals filed for other reasons.

Grievances

- BHP, IBHP and DMC-IBHDS or provider customer service;
- BHP, IBHP and DMC-IBHDS or provider care management/case management;
- BHP, IBHP and DMC-IBHDS or provider access to care;
- Quality of care;
- BHP, IBHP and DMC-IBHDS communications;
- Payment or billing issues;
- Suspected fraud;
- Abuse/neglect/exploitation;
- Lack of timely response;
- BHP, IBHP and DMC-IBHDS denial of expedited appeal; and/or
- Grievances filed for other reasons.

The BHP's, IBHP's and DMC-IBHDS' submission shall include a copy of the following:

- Notice of Adverse Benefit Determination (appeals only)

- The member's filed appeal or grievance
- Acknowledgment letter of the filed appeal or grievance
- Supporting documentation used in determining the outcome of the filed appeal or grievance
- Notice of resolution of the filed appeal or grievance

The reporting period for the 2025 certification period is July 1, 2024, through March 31, 2025. If a BHP, IBHP and DMC-IBHDS did not receive any grievances or appeals during the reporting period, the BHP, IBHP and DMC-IBHDS shall include an attestation indicating that no grievances or appeals were received during the reporting period. BHPs, IBHPs and DMC-IBHDS' will be subject to corrective action for failure to comply with grievance and appeal submission requirements.

i. Provider Service Validation

Each BHP, IBHP and DMC-IBHDS is required to maintain a provider network that can provide a full array of SMHS services and DMC-ODS services. Each BHP's, IBHP's and DMC-IBHDS' network is responsible for delivering all services covered in their contract with DHCS by providers who are Medi-Cal enrolled, Medi-Cal certified, DMC certified, and authorized to bill.

For MHPs, DHCS validates 274 file provider data against PIMS SMHS enrollment data to ensure that all required services are being provided by the MHP. SMHS must be provided by SMHS-certified providers, and as such DHCS only counts in-network, contracted providers towards satisfactory validation of service availability for covered SMHS. MHPs that do not offer all required SMHS will be found to be out of compliance for Provider Service Validation.

For DMC-ODS, DHCS validates 274 provider data against the Master Provider File (MPF) to ensure that all required services are being provided by the Plan. In addition to validating DMC-certification status, DHCS further validates Residential facility licensures utilizing the California Health and Human Services Open Data Portal. DMC-ODS services must be provided by DMC-certified providers, and as such DHCS only counts in-network, DMC-certified, contracted providers towards satisfactory validation of service availability for covered DMC-ODS services. For further details on covered DMC-ODS services, please see BHIN 24-001.

DMC-ODS that do not offer all required DMC-ODS services will be found to be out of compliance for Provider Service Validation.

j. Organizational Provider Subcontract Submission Requirements

In order to streamline the validation process of network provider contracts, DHCS will send a pre-populated list of the provider contracts required for validation purposes to each BHP, IBHP and DMC-IBHDS within 60 days of BHP, IBHP and DMC-IBHDS submission and DHCS review of the 274 file. BHPs, IBHPs and DMC-IBHDS' will have a minimum of 10 business days to submit the required contracts. Each list compiled by DHCS will be reflective of each BHP's, IBHP's and DMC-IBHDS' designated sample size of provider contracts.

All BHPs, IBHPs and DMC-IBHDS' will be subject to corrective action for failure to comply with provider contract submission requirements.

Sample size requirements are detailed in Tables 7 and 8.

Table 7a. DMC-ODS Service Provider Contract Submission Requirements

County Size	Outpatient Treatment Adult and Youth, IOT Adult and Youth, and OTP Adult and Youth	Residential *Adult and Youth*
Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, Tuolumne ***Per WIC section 14197(c)(4)(A)(iii)*	DHCS will request between 3-5 contracts to cover an array of services for state FY 2025-26.	DHCS will request up to three contracts
Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, Yuba ***Per WIC section 14197(c)(4)(A)(iii)*	DHCS will request between 6-10 contracts to cover an array of services for state FY 2025-26.	DHCS will request up to three contracts

Table 7b. DMC-ODS Service Provider Contract Submission Requirements

County Size	Outpatient Treatment Adult and Youth, IOT Adult and Youth, and OTP Adult and Youth	Residential *Adult and Youth*
Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, Ventura ***Per WIC section 14197(c)(4)(A)(ii)*	DHCS will request between 11-15 contracts which cover an array of services for state FY 2025-26.	DHCS will request up to three contracts
Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, Santa Clara ***Per WIC section 14197(c)(4)(A)(i)*	DHCS will request between 16-20 contracts which cover an array of services for state FY 2025-26.	DHCS will request up to three contracts
**WIC section 14197(a) It is the intent of the Legislature that the department implement and monitor compliance with the time and distance requirements set forth in 42 CFR Parts 438.68, 438.206, and 438.207 and this section, to ensure that all Medi-Cal managed care covered services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as those standards were enacted in May 2016.		

Table 8a. MHP Service Provider Contract Submission Requirements

County Size	Psychiatry and SMHS**	ICC	IHBS
Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, Tuolumne ***Per WIC section 14197(c)(3)(D)*	DHCS will request between 3-5 contracts to cover an array of services (psychiatry and outpatient services) for state FY 2025-26.	DHCS will request at least one ICC contract.	DHCS will request at least one IHBS contract
Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, Yuba ***Per WIC section 14197(c)(3)(C)*	DHCS will request between 6-10 contracts which cover an array of services (psychiatry and outpatient services) for state FY 2025-26.	DHCS will request at least one ICC contract.	DHCS will request at least one IHBS contract

Table 8b. MHP Service Provider Contract Submission Requirements*

County Size	Psychiatry and SMHS**	ICC	IHBS
Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, Ventura ***Per WIC section 14197(c)(3)(B)*	DHCS will request between 11-15 contracts which cover an array of services (psychiatry and outpatient services) for state FY 2025-26.	DHCS will request at least one ICC contract.	DHCS will request at least one IHBS contract.
Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, Santa Clara ***Per WIC section 14197(c)(3)(A)*	DHCS will request between 16-20* contracts which cover an array of services (psychiatry and outpatient services) for state FY 2025-26. *If the MHP has fewer than 16 contracts the MHP shall submit all contracts.	DHCS will request at least one ICC contract.	DHCS will request at least one IHBS contract.

*A single contract *may be sufficient to* adequately satisfy the requirement if the contract covers more than one service type and/or age group.

**WIC section 14197(a) It is the intent of the Legislature that the department implement and monitor compliance with the time and distance requirements set forth in 42 CFR Parts 438.68, 438.206, and 438.207 and this section, to ensure that all Medi-Cal managed care covered services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as those standards were enacted in May 2016.

For auto-renewing contracts that would expire during the certification period but for the auto renewal provision, the BHP, IBHP and DMC-IBHDS must submit an attestation on county letterhead that there are no known factors that preclude the auto renewal. All auto-renewing contracts must include language pertaining to the auto-renewal.

Note: The contract terms and conditions must align with data reported in the 274 file for MHPs and DMC-ODS Plans. DHCS may request additional contracts during the annual network adequacy certification process.

k. Requirements for Submission of Policies and Procedures

BHPs and IBHPs must submit Policies and Procedures that address network adequacy requirements for both SMHS and DMC-ODS services covering the following areas:

i. Network adequacy monitoring - submit policies and procedures related to the BHP's procedures for monitoring compliance with the network adequacy standards;
ii. OON access - submit policies and procedures related to member access to OON providers;
iii. Timely access - submit policies and procedures addressing appointment time standards and timely access requirements;
    - Please note an integrated timely access policy and procedure applies to DMC-IBHDS'
iv. 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;
v. Physical accessibility - submit policies and procedures regarding access for members with disabilities pursuant to the Americans with Disabilities Act of 1990;
vi. Telehealth services - submit policies and procedures regarding use of telehealth services to deliver covered services;
vii. 24/7 Access Line requirements - submit policies and procedures regarding requirements for the BHP's 24/7 Access Line; and,
viii. 24/7 language assistance - submit policies and procedures for the provision of 24- hour interpreter services at all provider sites.

IBHPs are required to submit the above policies and procedures in an integrated format.

If any of the required policies and procedures have not been updated since the last time, they were submitted to DHCS, the BHP and IBHP may submit a statement listing those policies and procedures that remain the same as the version on file.

IV. Network Adequacy Monitoring

a. Significant Change to Network

Each BHP, IBHP and DMC-IBHDS shall submit data and documentation within 10 business days and as instructed by DHCS any time there has been a change in the BHP's, IBHP's and DMC-IBHDS' operations that would affect the adequacy of capacity and services.[39] DHCS defines a significant change in the BHP's, IBHP's and DMC-IBHDS' operations as:

i. Any change that would impact the BHP's, IBHP's and DMC-IBHDS' ability to make available the benefits required through its contract with DHCS; or,
ii. Any significant change to the BHP's, IBHP's and DMC-IBHDS' operations that would cause the BHP, IBHP and DMC-IBHDS either to become noncompliant or increase its degree of existing noncompliance with any of the requirements outlined in this BHIN.

A significant change may occur because of contract terminations, suspensions, or the decertification of a network provider or subcontractor. In addition to decreases in the number of network providers, a significant change may occur as a result of changes in a specific provider's capacity to deliver a service type/modality, and/or serve a specific demographic. Changes in services, benefits, geographic service area, composition of, payments to the plan's provider network[40], or enrollment of a new population[41] may also constitute a significant change as defined above.

If a plan is uncertain whether a change in its network meets criteria for a significant change, DHCS recommends the plan report the change.

Additionally, any decrease in administrative staffing of a BHP, IBHP and DMC-IBHDS that significantly impacts the BHP's, IBHP's and DMC-IBHDS' operations and would cause the BHP, IBHP and DMC-IBHDS to either be out of compliance or increase its degree of existing noncompliance with any of the requirements outlined in this BHIN, is

[39] 42 CFR § 438.207(c)(3)
[40] 42 CFR § 438.207(c)(3)(i)
[41] 42 CFR § 438.207(c)(3)(ii)

considered a significant change.

DHCS may initiate a significant change inquiry at any time based upon information or reports received from sources other than the BHP, IBHP and DMC-IBHDS.

When a significant change inquiry is initiated during the ANC process, DHCS will utilize new information and/or data from the BHP, IBHP and DMC-IBHDS to determine, or redetermine, compliance with ANC requirements.

b. Significant Change Disclosure Form

BHPs, IBHPs and DMC-IBHDS' must use the Attachment J – Significant Change Disclosure Form to notify DHCS of any significant changes, as defined in the section "Significant Change to Network" above within 10 business days of the change. The Significant Change Disclosure Form must be emailed to NAOS@dhcs.ca.gov.

Upon notification of a significant change, DHCS will communicate with the BHP, IBHP and DMC-IBHDS regarding next steps. BHPs, IBHPs and DMC-IBHDS' found out of compliance with these requirements are subject to administrative and/or monetary sanctions as specified in BHIN 22-045 or subsequent guidance issued by DHCS.

c. Semi-Annual Attestation Reporting Requirement

If a BHP, IBHP and DMC-IBHDS does not report a significant change to its operations during the attestation period listed below, the BHP, IBHP and DMC-IBHDS must attest to DHCS that there are no significant changes to their network semi-annually. The attestation due dates and reporting periods are in Table 9, below:

Table 9. Semi-Annual Attestation Due Dates

Submission Due Date	Attestation Period
July 1, 2025	January 1, 2025, to June 30, 2025
February 2, 2026	July 1, 2025, to December 31, 2025

BHPs, IBHPs and DMC-IBHDS' must utilize the Attachment I – Significant Change Attestation template to report that there have been no significant changes to their provider network during the attestation period. Failure to

submit the attestations may result in sanctions as specified in BHIN 22-045 or subsequent guidance issued by DHCS.

If there has been a significant decrease in a BHP's, IBHP's and DMC-IBHDS' provider network resulting in the BHP, IBHP and DMC-IBHDS falling out of compliance with one or more network adequacy standards, DHCS will require the BHP, IBHP and DMC-IBHDS to adhere to an Enhanced CAP Monitoring, which includes, but is not limited to, additional technical assistance and frequent contact between the BHP, IBHP and DMC-IBHDS and DHCS to evaluate progress to meet compliance.

d. Ongoing Monitoring

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

i. Provider data submissions for BHPs, IBHPs and DMC-IBHDS';
ii. Annual County Monitoring Activities for BHPs, IBHPs and DMC-IBHDS';
iii. Annual program assessment reports submitted to CMS in accordance with 42 CFR Part 438.66;
iv. Corrective action monitoring and follow-up; and,
v. Any other monitoring activities required by DHCS.

In addition, WIC Section 14197.05 requires DHCS' external quality review organization to annually gather data and assess whether each BHP's, IBHP's and DMC-IBHDS' network met the network adequacy requirements set forth in WIC section 14197 during the preceding 12 months.

DHCS will post network adequacy documentation for each BHP, IBHP and DMC-IBHDS on its website, including any approved AAS, in accordance with WIC section 14197.

V. Non-Compliance with Network Adequacy Standards

a. Corrective Action Plans

If a BHP, IBHP and DMC-IBHDS fails to submit any of the required data submissions for the ANC Reporting Period or is found to be deficient for one or more network standards after assessment, the BHP, IBHP and DMC-IBHDS shall develop a corrective action plan (CAP), to address the deficiencies, and submit the CAP for DHCS approval via standardized

CAP Tool developed by DHCS.

DHCS' review of each CAP will consider the steps the BHP, IBHP and DMC-IBHDS proposes to take to come into compliance with the standards. Upon CAP approval the BHP, IBHP and DMC-IBHDS is required to begin submitting supporting data and documentation needed to demonstrate compliance with the CAP. The submission deadlines for data and documentation are dependent on the actions and steps detailed in the approved CAP. Additionally, if a DMC-ODS Plan/IBHP is found to be deficient in capacity and composition standards, the DMC-ODS Plan/IBHP shall submit the Supplemental Data Tools as part of their CAP data submission.

Submission requirements for the CAP process are:

i. Submission due date – Will be communicated to the BHP's, IBHP's and DMC-IBHDS' 30 days prior to the submission due date.
   - Reporting period: Based on details of the approved CAP

Dependent on the approved CAP, DHCS may require subsequent submission(s) of additional documentation to demonstrate CAP compliance. If DHCS determines that a BHP, IBHP and DMC-IBHDS is not making satisfactory progress toward resolving their CAP or coming into compliance with applicable standards, the BHP, IBHP and DMC-IBHDS may be subject to temporary withholds and/or monetary sanctions. DHCS will monitor the BHP's, IBHP's and DMC-IBHDS' corrective actions and require updated information from the BHP, IBHP and DMC-IBHDS monthly at minimum until the BHP, IBHP and DMC-IBHDS meets the applicable standards.

VI. Monetary Sanctions and Temporary Withholds

DHCS may impose monetary sanctions on a BHP, IBHP and DMC-IBHDS pursuant to subdivisions (e) and (f) of WIC section 14197.7 and may temporarily withhold funds from a BHP, IBHP and DMC-IBHDS pursuant to subdivision (o). The basis for imposition of monetary sanctions and temporary withholds include, but are not limited to, the following:

i. Failure to comply with network adequacy standards, including, but not limited to, time or distance, timely access, and provider to member ratio requirements pursuant to standards and formulae that are set forth in federal or state law, regulation, state plan or

contract, and that are posted in advance to DHCS' internet website.[42]

ii. Failure to demonstrate that the BHP, IBHP and DMC-IBHDS has an adequate network to meet anticipated utilization in the county.[43]

iii. Failure to submit timely and accurate network provider data.[44]

For further information regarding sanctions, including notification and appeal rights for BHPs, IBHPs and DMC-IBHDS', please see BHIN 22-045 or subsequent guidance issued by DHCS.

Furthermore, if a BHP, IBHP and DMC-IBHDS is unable to meet network adequacy requirements because its provider network is deficient in capacity and composition, is unable to provide timely access to necessary services, or is unable to meet the applicable time and distance standards or secure approval of an AAS, the BHP, IBHP and DMC-IBHDS shall adequately and timely cover these services OON for the member. The BHP, IBHP and DMC-IBHDS shall permit OON access for as long as the BHP's, IBHP's and DMC-IBHDS' provider network is unable to provide the services in accordance with the standards. For additional guidance on OON providers, please see BHIN 21-008 for MHPs and MHSUDS IN 19-024 for DMC-ODS Plans.

For questions regarding this BHIN, please contact the Behavioral Health Oversight and Monitoring Division at NAOS@dhcs.ca.gov.

Sincerely,

Original signed by

Michele Wong, Chief
Behavioral Health Oversight and Monitoring Division

Attachments: Attachment A – DMC-ODS Expected Utilization (DMC-ODS_IBHP)
Attachment B – Time or Distance Standards
Attachment C.1– Alternative Access Standards Request Template (BHP)
Attachment C.2 – Alternative Access Standards Request Template (IBHP)
Continued on next page.

[42] WIC §14197.7(e)(6)
[43] WIC §14197.7(e)(5)
[44] WIC §14197.7(e)(8)

Attachments: Attachment C.3 – Alternative Access Standards Request Template (DMC-IBHDS)
Attachment D.1 – Timely Access Data Tool (MHP)
Attachment D.2 – Timely Access Data Tool (DMC-ODS Plan)
Attachment D.3 – Timely Access Data Tool (DMC State Plan County)
Attachment D.4 – Timely Access Data Tool (IBHP)
Attachment D.5 – Timely Access Data Tool (DMC-IBHDS)
Attachment E – Certification of Network Adequacy Data
Attachment F.1 – Continuity-Transition of Care Report Template (BHP)
Attachment F.2 – Continuity-Transition of Care Report Template (IBHP)
Attachment G.1 – Language Line Encounter Template (BHP)
Attachment G.2 – Language Line Encounter Template (IBHP)
Attachment H – Supplemental Data Tool
Attachment I – Significant Change Attestation Template
Attachment J – Significant Change Disclosure Template