



# ANNUAL NETWORK CERTIFICATION

## SPECIALTY MENTAL HEALTH SERVICES

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## 1. Executive Summary

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

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

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

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

In spring 2018, DHCS conducted a comprehensive review of each MHP's provider network in accordance with the annual network certification requirements set forth in Title 42 Code of Federal Regulations part 438.207. As this was DHCS' inaugural effort to certify the MHPs' provider networks, this network certification review establishes the baseline for each MHP's provider network, as well as the initial targets for network capacity for use in ongoing network monitoring to ensure access to SMHS for Medi-Cal beneficiaries.

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

### 1.1. Assurance of Compliance Overview

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

[Section 1](#): Executive Summary – Provides an overview of DHCS' network certification analysis.

[Section 2](#): California's Medicaid Program – Describes California's specialty mental health services (SMHS) delivery system

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

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

[Section 5](#): Statewide Network Monitoring Efforts - Describes the network certification Corrective Action Plan (CAP) process and the ongoing monitoring efforts conducted by DHCS.

[Section 6](#): MHP Network Certification Results - Provides the Network Certification Results by MHP.

## 2. Specialty Mental Health Services Delivery System in California

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

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

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

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

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### 3. Network Adequacy Requirements

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#### 3.1. Medicaid Managed Care Final Rule

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On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children’s Health Insurance Program Managed Care Final Rule (Managed Care Rule),<sup>1</sup> which revised Title 42 of the Code of Federal Regulations. These changes aimed to align Medicaid managed care regulations with requirements of other major sources of coverage. MHPs are classified as Prepaid Inpatient Health Plans (PIHPs) and must therefore comply with applicable federal managed care requirements. Among the new requirements in the Managed Care Rule are requirements for network adequacy that become effective July 1, 2018.

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

##### **Network Adequacy Standards – Time and Distance**

Part 438.68, Network adequacy standards, requires states to develop time and distance standards for adult and pediatric behavioral health (mental health and SUD treatment) providers. Time means the number of minutes it takes a beneficiary to travel from the beneficiary’s residence to the nearest provider site. Distance means the number of miles a beneficiary must travel from the beneficiary’s residence to the nearest provider site.

##### **Network Adequacy Standards – Timely Access**

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

##### **Network Certification Requirements**

Part 438.207, Assurances of adequate capacity and services, requires each Plan to submit documentation to DHCS, in a format specified by DHCS, to demonstrate that it complies with the following requirements:

- Offers an appropriate range of services that is adequate for the anticipated number of beneficiaries for the service area (i.e., county); and,

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

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- Maintains a network of providers,<sup>2</sup> operating within the scope of practice under State law, that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the services area (i.e., county).<sup>3</sup>

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

### 3.2. Network Adequacy Standards

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

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

The use of clinically appropriate telecommunications technology<sup>4</sup> can be considered in determining compliance with the applicable standards and/or for the purpose of approving an alternative access standards request.

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<sup>2</sup> The Plan's network of providers includes county-owned and operated providers.

<sup>3</sup> 42 C.F.R. §§ 438.207(b), 438.604(a)(5)

<sup>4</sup> Telecommunications technology, consistent with the requirements of Section 2290.5 of the Business and Professions Code, includes telehealth, e-visits, or other evolving and innovative technological solutions that are used to provide care from a distance. (Welf. & Inst. Code, § 14197(e)(4))

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#### 4. Annual Network Certification

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##### 4.1. MHP Provider Network Documentation

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DHCS issued MHSUDS IN 18-011 to set forth federal network adequacy requirements for MHPs and DMC-ODS pilot counties. The IN identifies network adequacy standards and specifies network certification requirements, in accordance with Title 42 of the Code of Federal Regulations, part 438.207, including the requirement for each Plan to submit documentation to the State to demonstrate that it complies with the network adequacy requirements.

Part 438.207, Assurances of adequate capacity and services, requires each Plan to submit documentation to DHCS to demonstrate that it complies with the following requirements:

- Offers an appropriate range of services that is adequate for the anticipated number of beneficiaries for the service area (i.e., county); and,
- Maintains a network of providers,<sup>5</sup> operating within the scope of practice under State law, that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the services area (i.e., county).<sup>6</sup>

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

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

- Geographic access maps and accessibility analyses to confirm compliance with time or distance standards;
- An alternative access request, if applicable.
- An analysis of the availability of community based services (i.e., where the provider travels to the beneficiary to deliver services);

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<sup>5</sup> The Plan's network of providers includes county-owned and operated providers.

<sup>6</sup> 42 C.F.R. §§ 438.207(b), 438.604(a)(5)

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- An analysis and evidence of the Plan’s compliance with Title 42 Code of Federal Regulations, part 438.14(b)(1) demonstrating that there are sufficient American Indian Health Facilities participating in the Plan’s network to ensure timely access to services for Indian beneficiaries who are eligible to receive services;
- Provider counts;
- An analysis of the expected utilization of services; and,
- An analysis of language line utilization.

#### 4.1.1. Provider Network Capacity and Composition

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MHPs reported detailed data and information for each of its providers at the organizational, site, and rendering provider level. MHPs reported counts of full-time equivalent providers in the following behavioral health classifications:

- Licensed Psychiatrists;
- Licensed Physicians;
- Licensed Psychologists;
- Licensed Clinical Social Workers;
- Marriage and Family Therapists;
- Licensed Professional Clinical Counselors;
- Registered Nurses;
- Certified Nurse Specialists;
- Nurse Practitioners;
- Licensed Vocational Nurses;
- Psychiatric Technicians;
- Mental Health Rehabilitation Specialists;
- Physician Assistants;
- Pharmacists;
- Occupational Therapists; and,
- Other Qualified Providers.<sup>7</sup>

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<sup>7</sup> CA’s State Plan permits the provision of services by “Other Qualified Providers,” defined as, “an individual at least 18 years of age with a high school diploma or equivalent degree determined to be qualified to provide the service by the county mental health department.” (State Plan, Section 3, Supplement 3 to Attachment 3.1-A pages 2m-2p).

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MHPs were required to report aggregate provider counts taking into account full time equivalency (FTE), as well as to report full time equivalency dedicated to serving SMHS beneficiaries and current and maximum caseloads for each rendering provider.

DHCS calculated each MHP's current provider to beneficiary ratio for adults and children/youth populations in the specialty of psychiatry and for outpatient SMHS. Since outpatient SMHS can be provided by any mental health professional working within their scope of practice, DHCS included all relevant provider types in its calculation of the ratio for outpatient SMHS. California's State Plan describes SMHS and specifies the provider types for each service.

#### 4.1.2. American Indian Health Facilities

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

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

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

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

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

#### 4.2. Annual Network Certification Methodology

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DHCS developed a methodology to assess the adequacy of the MHPs' provider networks. As this is the first year DHCS is conducting an analysis and assessment of each MHP's network, this methodology is designed to establish a baseline of each MHP's network. In future years, this baseline will be a frame of reference for ongoing analysis and certification of each MHP network. DHCS' methodology includes the following elements:

- Anticipated Enrollment and Utilization of SMHS;
- Characteristics of the SMHS Population;
- Health Care Needs of the SMHS Population; and,
- Network Composition and Capacity.

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The methodology includes estimations of the MHPs' network compositions necessary to meet the anticipated need for SMHS. DHCS also took into account variations among the 56 county MHPs in terms of enrollment, utilization of SMHS, and network composition.

#### 4.2.1. Anticipated Enrollment and Utilization of SMHS

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For each county, DHCS determined anticipated enrollment and utilization based on the Medi-Cal enrollment data, county-submitted SMHS utilization data estimates,<sup>8</sup> and estimates of prevalence of Serious Emotional Disturbance (SED) in children/youth and Serious Mental Illness (SMI) in adults.<sup>9</sup> Using its Medi-Cal Eligibility Data System (MEDS), DHCS determined the counts of enrolled Medi-Cal beneficiaries, as of March 2018, in each county. DHCS applied to the enrollment counts the percent difference (i.e., estimated growth percentage or estimated reduction percentage) between each MHP's actual utilization data for SFY 2017/18 and its estimates of SMHS utilization for SFY 2018/19.

DHCS used SED and SMI prevalence rates to factor for potential need for SMHS. In order to estimate the subpopulations enrolled in Medi-Cal, who may meet SMHS medical necessity criteria to receive SMHS,<sup>10</sup> DHCS applied each MHP's SED and SMI prevalence rates to their March 2018 enrollment. The county prevalence rates were also applied to the MHP-submitted estimated beneficiary counts to determine the estimated need for SFY 2018/19. These SMHS need estimates were calculated separately for adults and children/youth.

DHCS estimated the expected utilization in each county for the following outpatient SMHS:

- Mental Health Services;
- Case Management;
- Crisis Intervention;
- Intensive Care Coordination;
- Intensive Home Based Services; and,
- Medication Support Services (including services provided by licensed psychiatrists).

DHCS estimated expected utilization by comparing SMHS claims data from its Performance Outcomes System (POS) with the enrolled beneficiary counts from MEDS, to determine the proportion of the Medi-Cal-enrolled population that had used SMHS. The difference between counts of beneficiaries served and the estimated count of beneficiaries needing SMHS services was used to assess network deficiencies as well as for ongoing monitoring of provider networks.

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<sup>8</sup> Each MHP was required to submit actual SMHS utilization for SFY 2017/18 and estimates of SMHS utilization for SFY 2018/19.

<sup>9</sup> Prevalence estimates taken from the California Mental Health and Substance Use System Needs Assessment Report (September 2013).

<sup>10</sup> Cal. Code Regs., tit. 9, §§ 1830.205 and 1830.210

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DHCS will continue to monitor each MHP's Medi-Cal enrollment, SMHS utilization, and SED/SMI prevalence estimates. This will help DHCS identify trends over time and will improve DHCS' ability to estimate SMHS caseload projections within each county, as well as to further strengthen the accuracy of DHCS' assessment of whether the MHPs' networks are sufficient to meet the need.

#### 4.2.2. Characteristics of the SMHS Population – Language Assistance

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DHCS used SFY 2016/17 MEDS data and SMHS claims data to obtain demographic and other descriptive data on the SMHS population. This information included unique client counts (unduplicated), primary spoken language, and primary written language.

DHCS used these state enrollment data to estimate language assistance needs. To determine the language assistance capacity of each MHP, DHCS required MHPs to report the linguistic capabilities of each rendering provider in prevalent non-English languages and language line utilization in telephonic and face-to-face encounters. MHPs were also required to submit subcontracts for interpretation and language line services.

For each prevalent non-English language, DHCS calculated each MHP's count of FTE providers classified as "certified" level of fluency. For provider sites (MHP county-owned and operated sites or contracted provider site) without the capacity to provide onsite bilingual or interpretation services, language line access is required to ensure providers can meet the needs of beneficiaries with Limited English Proficiency (LEP). DHCS analyzed the estimated language assistance needs data and the MHP FTE information and language line utilization to assess MHP capacity with regard to services to LEP beneficiaries.

#### 4.2.3. Network Composition and Capacity

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DHCS established statewide provider to beneficiary ratios using data from its POS and the numbers of FTE providers reported by the MHPs in the NACT. The POS data includes, for adults and children/youth, the mean service quantity (i.e., number of minutes) per unique beneficiary by fiscal year. DHCS calculated the total mean number of minutes for outpatient SMHS (i.e., Mental Health Services, Targeted Case Management, Medication Support Services, and Crisis Intervention) for adults and children/youth. DHCS assumed a 60% productivity rate (i.e., time spent on direct billable services) to determine the total productive minutes per SFY for each FTE SMHS provider.<sup>11</sup> To calculate statewide ratios, DHCS divided the total productive minutes per year by the total average minutes for adults and/or children/youth. DHCS established statewide ratios, separately for adults and children/youth, for outpatient SMHS and psychiatry services (i.e., Medication Support Services).

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<sup>11</sup> DHCS estimated that 40% of each provider's time is allocated for administrative and staff development activities (e.g., staff meetings, training, staff development, clinical supervision, paid time off, chart review, documentation).

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DHCS calculated each MHP's current provider to beneficiary ratio using the rendering provider detail and/or provider counts reported in the NACT and the estimated SMHS need. DHCS then compared each MHP's provider to beneficiary ratios to the statewide provider to beneficiary ratios to determine if the MHPs' current provider network is adequate.

DHCS also calculated each MHP's provider to beneficiary ratio based on the anticipated enrollment and utilization estimates for SFY 2018/19 to determine if the MHPs' networks will remain adequate based on the estimated growth in service utilization.

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

#### 4.2.4. Data Limitations

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As aforementioned, this is the first effort to collect MHP provider data from counties. In addition, this is the first time DHCS has established provider to beneficiary ratios for SMHS. There is limited research as to what constitutes a "sufficient" amount of providers for SED/SMI populations and/or what an "appropriate" provider to beneficiary ratio is for such populations. Moreover, conclusions or recommendations in this limited research is varied. Finally, while there are a number of different prevalence estimates for populations with mental health conditions, it varies widely and typically estimates mental health conditions or episodes within the general population. There is very limited availability of prevalence estimates for SED/SMI, particularly for the SED/SMI subpopulation eligible for Medicaid/Medi-Cal. Therefore, DHCS based SMHS need on the SED/SMI prevalence estimates calculated for the *Bridge to Reform Waiver*, developed by the Technical Assistance Collaborative and the Human Services Research Institute.<sup>12</sup> While these estimates were published in 2013, they are the only available prevalence estimates specific to the SED/SMI population within Medi-Cal.

Given that these analyses and data collection efforts were conducted for the first time as DHCS implements the new network adequacy requirements in 42 CFR 438, there are some data limitations and considerations to note. Some of the key limitations which affected this data analysis included the following circumstances:

1. County submissions for provider FTE and projections of need varied in their interpretations of definitions, which, at times, limited our ability to draw consistent

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<sup>12</sup> Available at:

<http://www.dhcs.ca.gov/provgovpart/Documents/CABridgetoReformWaiverServicesPlanFINAL9013.pdf>).

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conclusions. DHCS will continue to work with MHPs to have consistent definitions for ongoing monitoring and future annual certifications.

2. There were variations in quality of state-level data across counties. DHCS will continue to test different projection models to determine the most reliable method for projections used in ongoing monitoring and future annual certifications.
3. As this was the first time this type of network information was collected in this manner, DHCS relied on reporting template (the NACT) in which counties manually entered their provider data. The preparation and analysis of the MHP-submitted data was therefore manual and laborious. A more automated, consolidated database is currently under construction to reduce the amount of manual data entry and data preparation and enable faster analysis of the MHP-submitted data. The database will require uniform submission of data from counties. DHCS will undertake a significant technical assistance effort with counties to enable the understanding of format requirements.

#### **4.3. Time and Distance Standards**

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California's time and distance standards are based on the population density of each county. DHCS required MHPs to submit geographic access maps, accessibility charts, and access summaries to demonstrate compliance with the time and distance standards for the county. The MHPs were required to plot time and distance for all network providers, stratified by service type (i.e., psychiatry and outpatient SMHS), and geographic location, for both adult and children/youth<sup>13</sup> separately. MHPs were directed to include community based settings where services are regularly delivered and any contracted network providers in neighboring service areas if needed to meet time and distance standards.

MHPs were required to submit the following:

- An overview map of the entire service area which delineates boundaries and zip codes.
- An overview map of all beneficiaries receiving services in the county.
- Two geographic access maps for each service type (i.e., psychiatry, outpatient mental health, outpatient DMC-ODS, and opioid treatment programs) within the geographic area. The two maps include the following:
  1. Provider Map with radius
  2. Map combining Service Area, Provider and Enrollee with radius

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<sup>13</sup> For geographic access maps, Medi-Cal beneficiaries under the age of 21 are classified as children/youth.

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If the MHP did not meet the distance standards established by DHCS, each MHP was required to submit an accessibility chart and access summary to demonstrate that the time standards were met. The accessibility chart and access summary submission specified any zip codes and/or specific geographic locations within the county for which the Plan was not able meet the distance standards.

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

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

#### 4.3.1. Community Based Services

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Rehabilitative SMHS<sup>14</sup> are to be provided in the least restrictive setting, consistent with the goals of recovery and resiliency, and may be provided anywhere in the community.<sup>15</sup> DHCS considered the availability of services (i.e., when the provider travels to the beneficiary and/or a community-based setting to deliver services) when determining compliance with the time and distance standards.

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

#### 4.3.2. Alternative Access Requests

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The Managed Care Rule permits states to grant exceptions to the time and distance standards.<sup>16</sup> If the Plan cannot meet the time and distance standards, MHPs were required to submit a request for alternative access standards.<sup>17</sup> Per the statutory requirements, DHCS was able to grant requests for alternative access standards if the MHP exhausted all other reasonable options to obtain providers to meet the applicable standard or if DHCS determined that the MHP demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.

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<sup>14</sup> Mental Health Services, Crisis Intervention, Targeted Case Management and Medication Support

<sup>15</sup> State Plan, Section 3, Supplement 3 to Attachment 3.1-A, page 2c

<sup>16</sup> 42 C.F.R. § 438.68(d)(1)

<sup>17</sup> Welf. & Inst. Code, § 14197, subd. (e)(2)

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MHPs were required to include a description of the reasons justifying the alternative access standards. Requests for alternative access standards are approved or denied on a zip code and service type basis.<sup>18</sup>

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

Upon notification by DHCS, approved alternative access standards will be valid for one fiscal year; however, DHCS will monitor beneficiary access on an on-going basis and include the findings to CMS in the managed care program assessment report required under Title 42 Code of Federal Regulations part 438.66(e).<sup>19</sup>

DHCS will post all approved alternative access standards on its website.<sup>20</sup>

#### 4.4. Timely Access

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The Managed Care Rule requires the MHPs to meet State standards for timely access to care and services, taking into account the urgency of the need for services. Timely access standards refers to the number of business days in which a MHP must make an appointment available to a beneficiary from the date the beneficiary, or a provider acting on behalf of the beneficiary, requests a medically necessary service.

Effective July 1, 2018, MHPs must comply with the appointment time standards in accordance with section 1300.67.2.2(c)(1-4), (7) of Title 28 of the California Code of Regulations (CCR). As specified in Title 28, CCR, §1300.67.2.2, the applicable mental health services appointment time standards may be extended if the referring or treating provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the beneficiary's record that a longer waiting time will not have a detrimental impact on the health of the beneficiary.<sup>21</sup> In addition, periodic office visits to monitor and treat mental health conditions may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed mental health provider acting within the scope of his or her practice.<sup>22</sup>

Future network certification analyses will also include compliance with timely access standards. DHCS is modifying its Client and Services Information System (CSI) to include

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<sup>18</sup> Welf. & Inst. Code, § 14197, subd. (e)(3)

<sup>19</sup> 42 C.F.R §§ 438.68(d)(2), 438.66(e)(2)(vi)

<sup>20</sup> WIC Section 14197(e)(3)

<sup>21</sup> Cal. Code Regs., tit. 28, § 1300.67.2.2(c)(5)(G)

<sup>22</sup> Cal. Code Regs., tit. 28, § 1300.67.2.2(c)(5)(H)

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timely access reporting elements. It is expected this first phase of the CSI reporting will begin in FY18/19.

#### **4.5. Network Adequacy Infrastructure**

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

- Grievances and appeals related to availability of services and/or problems in obtaining services in a timely fashion, as well as the resolutions of such grievances and appeals;
- Provider agreement boilerplates for network providers and subcontractors, including agreements pertaining to interpretation, language line, and telehealth services;
- The Plan's provider directory/directories;
- The results of beneficiary satisfaction surveys related to network adequacy or timely access; and,
- Policies and procedures addressing the following topics:
  - Network adequacy monitoring;
  - Out of network access (MHPs only);
  - Timely access;
  - Service availability;
  - Physical accessibility;
  - Telehealth services;
  - 24/7 Access Line requirements; and,
  - 24/7 language assistance.

#### **4.6. Provider Network Evaluation Findings Summary**

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

- Network composition and capacity;
- Language assistance capabilities;
- Time and distance – geographic access mapping;
- Alternative Access Standards; and,
- System infrastructure.

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

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

As previously indicated, this was DHCS' inaugural effort to certify the MHPs' provider networks. DHCS utilized this network certification review to establish a baseline of each MHP's provider network, as well as to determine targets for improving access to SMHS for Medi-Cal beneficiaries. As such, for this certification period, DHCS determined that, overall, 2 county MHPs **pass** 54 MHPs **conditionally pass** the network certification requirements and will be subject to ongoing monitoring and corrective actions, as appropriate.

## 5. Statewide Network Monitoring Efforts

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### 5.1. Plans of Correction

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

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

Furthermore, if the MHP was determined not to meet network adequacy requirements and the provider network is unable to provide timely access to necessary services within the applicable time and distance standards, the MHP must adequately and timely cover these services out-of-network for the beneficiary.<sup>23</sup> The MHP must permit out-of-network access for as long as the MHP's provider network is unable to provide the services in accordance with the standards.

If the MHP does not effectively implement corrective actions, DHCS may impose additional corrective actions pursuant to Welfare and Institutions Code Section 14712(e),<sup>24</sup> including fines, penalties, the withholding of payments, special requirements, probationary or corrective actions, or any other actions deemed necessary to promptly ensure compliance.

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<sup>23</sup> 42, C.F.R., § 438.206(b)(4)

<sup>24</sup> See also Cal. Code Regs., tit. 9, §§ 1810.380 and 1810.385

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## 5.2 Ongoing Monitoring

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

- Quarterly NACT data submissions by MHPs;
- Triennial compliance reviews of each MHP;
- Annual program assessment reports submitted to CMS in accordance with Title 42 Code of Federal Regulations part 438.66;
- Annual External Quality Review Organization reviews;
- Plan performance dashboards;
- Corrective action monitoring and follow-up; and,
- Any other monitoring activities required by DHCS.

DHCS will post network adequacy documentation for each Plan on its website, including any approved alternative access standards.

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**6. MHP Network Certification Results**

<b>MHP Name</b>	<b>Overall Results</b>	<b>Alternative Access Standard</b>
Alameda	Conditional Pass	Not Submitted
Alpine	<b>Pass</b>	<b>Approve</b>
Amador	Conditional Pass	Not Submitted
Butte	Conditional Pass	<b>Approve</b>
Calaveras	Conditional Pass	Not Submitted
Colusa	Conditional Pass	Not Submitted
Contra Costa	Conditional Pass	TA Required
Del Norte	Conditional Pass	Not Submitted
El Dorado	Conditional Pass	Not Submitted
Fresno	Conditional Pass	Not Submitted
Glenn	Conditional Pass	Not Submitted
Humboldt	Conditional Pass	Not Submitted
Imperial	Conditional Pass	Not Submitted
Inyo	Conditional Pass	Not Submitted
Kern	Conditional Pass	TA Required
Kings	Conditional Pass	Not Submitted
Lake	Conditional Pass	Not Submitted
Lassen	Conditional Pass	Not Submitted

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<b>MHP Name</b>	<b>Overall Results</b>	<b>Alternative Access Standard</b>
Los Angeles	Conditional Pass	Not Submitted
Madera	Conditional Pass	Not Submitted
Marin	Conditional Pass	Not Submitted
Mariposa	<b>Pass</b>	TA Required
Mendocino	Conditional Pass	Not Submitted
Merced	Conditional Pass	Not Submitted
Modoc	Conditional Pass	Not Submitted
Mono	Conditional Pass	<b>Approve</b>
Monterey	Conditional Pass	TA Required
Napa	Conditional Pass	Not Submitted
Nevada	Conditional Pass	Not Submitted
Orange	Conditional Pass	TA Required
Placer/Sierra	Conditional Pass	Not Submitted
Plumas	Conditional Pass	Not Submitted
Riverside	Conditional Pass	Not Submitted
Sacramento	Conditional Pass	Not Submitted
San Benito	Conditional Pass	Not Submitted
San Bernardino	Conditional Pass	<b>Approve</b>
San Diego	Conditional Pass	TA Required
San Francisco	Conditional Pass	Not Submitted

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

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**7. Appendices**

**7.1. Attachment A: Network Adequacy Standards**

For psychiatry, the standards are as follows:

Timely Access <sup>25</sup>	Within <b>15 business days</b> from request to appointment
Time and Distance <sup>26</sup>	Up to <b>15 miles or 30 minutes</b> from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.
	Up to <b>30 miles or 60 minutes</b> from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.
	Up to <b>45 miles or 75 minutes</b> from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.
	Up to <b>60 miles or 90 minutes</b> from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

<sup>25</sup> Welf. & Inst. Code, § 14197(d)(1); Cal. Code Regs., tit. 28, § 1300.67.2.2(c)(5)(D)

<sup>26</sup> Welf. & Inst. Code, § 14197(c)(1), (h)(2)(L)

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

Timely Access <sup>27</sup>	Within <b>10 business days</b> from request to appointment
Time and Distance <sup>28</sup>	Up to <b>15 miles or 30 minutes</b> from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.
	Up to <b>30 miles or 60 minutes</b> from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.
	Up to <b>45 miles or 75 minutes</b> from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.
	Up to <b>60 miles or 90 minutes</b> from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

<sup>27</sup> Welf. & Inst. Code, § 14197(d)(1)(A); Cal. Code Regs., tit. 28, § 1300.67.2.2(c)(5)(E)

<sup>28</sup> Welf. & Inst. Code, § 14197(c)(3)