



ANNUAL NETWORK CERTIFICATION

SPECIALTY MENTAL HEALTH SERVICES

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1. Executive Summary

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

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

Federal regulations require each MHP to submit to DHCS documentation on which the State bases its certification that the MHP 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 MHP's network

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

1.1. Assurance of Compliance Overview

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

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

[Section 2](#): California's Medicaid SMHS Program – Describes California's SMHS delivery system.

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

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

[Section 5](#): MHP Network Certification Results – Provides the Network Certification Results by MHP.

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

2. Specialty Mental Health Services Delivery System in California

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

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

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

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

3. Network Adequacy Requirements

3.1. Medicaid Managed Care Final Rule

On May 6, 2016, CMS published the Medicaid and Children's Health Insurance Program Managed Care Final Rule (Managed Care Rule),¹ which revised Title 42 of the Code of Federal Regulations. These changes aimed to align Medicaid managed care regulations with requirements of other major sources of coverage. MHPs are classified as PIHPs and must

¹ Managed Care Final Rule, Federal Register, Vol. 81, No. 88:

<https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicare-managed-care-chip-delivered>

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therefore comply with applicable federal managed care requirements. Effective July 1, 2018, MHPs must comply with the network adequacy requirements in the Managed Care Rule.

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

Network Adequacy Standards – Time and Distance

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

Network Adequacy Standards – Timely Access

Section 438.206, Availability of services, requires the 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.

Network Certification Requirements

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

- Offers an appropriate range of services that is adequate for the anticipated number of beneficiaries for the service area (i.e., county); and,
- Maintains a network of providers,² operating within the scope of practice under State law, that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the services area (i.e., county).³

After reviewing the documentation submitted by each MHP, and by July 1st of each fiscal year, DHCS must submit an assurance of compliance to CMS that each MHP meets the State’s requirements for the availability of services, as set forth in sections 438.68 and 438.206. In light of COVID 19, CMS approved extending the July 1st submission requirement to October 1, 2020 for state fiscal year 2020-2021 certification only. The submission to CMS must include documentation of an analysis that supports the assurance of the adequacy of the network for each MHP related to its provider network.

² The MHP’s network of providers includes county-owned and operated providers.

³ 42 C.F.R. sections 438.207(b), 438.604(a)(5)

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3.2. Network Adequacy Standards

DHCS established network adequacy standards for county MHPs pursuant to the federal Managed Care Rule as set forth in Title 42 of the Code of Federal Regulations, sections 438.68, 438.206, and 438.207 and Welfare and Institutions Code (WIC) Section 14197.

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

MHPs are permitted to use telehealth services to meet network adequacy standards, including the provider ratios for both outpatient SMHS and psychiatry services, and/or as a basis for alternative access requests in relation to time and distance standards. Telehealth services must comply with DHCS' [Medi-Cal Provider Manual telehealth Policy](#)⁴.

In order to utilize telehealth to fulfill network adequacy requirements for time and distance standards, the telehealth provider must be available to provide telehealth services to all beneficiaries in the defined service area. In addition, the physical location where beneficiaries receive telehealth services must meet the State's time and distance standards or an approved alternative access standard.

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

3.3. MHP Provider Network Documentation

DHCS issued [Behavioral Health Information Notice 20-012](#) to set forth federal network adequacy requirements for MHPs. 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 MHP to submit documentation to the State to demonstrate that it complies with the network adequacy requirements.

MHPs are required to submit to DHCS documentation on which the State bases its certification that the MHP 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 MHP is required to submit an annual Network Adequacy Certification Tool (NACT) detailing the MHPs' provider networks, including all

⁴ Medi-Cal Provider Manual. "Medicine: Telehealth."
<https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf>

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organizational, site, and rendering providers delivering SMHS within the MHPs' networks. Network providers include county-owned and operated providers and the MHP's contracted network providers.

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

Timely Access Report

For each state fiscal year, MHPs must submit a report that documents the timeliness of services provided to Medi-Cal beneficiaries. The report should include all service requests received by the MHP (and its network providers) during the applicable reporting period (i.e., for state fiscal year 2020-2021, the service requests address the reporting period of December 1, 2019 through February 29, 2020) and should include all of the following data elements:

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

Telephonic Language Line Encounters Analysis

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

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

Telephonic language line utilization should be reported for all network providers in relevant categories.

Geographic Access Maps

MHPs *are no longer* required to submit maps of all network providers in the MHP's service area. DHCS will prepare the maps based upon Medi-Cal beneficiary and Provider location data submitted in exhibit A3 of the NACT.

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Continuity of Care Report

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

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

System Infrastructure

Each MHP must also submit the following additional supporting documentation; complete beneficiary grievances and appeals, executed provider agreements and subcontractor agreements, MHP's provider directory, MHP's organizational chart, the MHP's provider contract boilerplate, and related policies and procedures.

4. Annual Network Certification

DHCS developed a comprehensive methodology to assess the adequacy of the MHPs' provider networks. In accordance with Title 42 Code of Federal Regulations part 438.68, the network certification analysis includes, but is not limited to, the following elements for each MHP:

- 1) The anticipated Medi-Cal enrollment;
- 2) The expected utilization of services;
- 3) The characteristics and health care needs of the Medi-Cal population;
- 4) The numbers and types (in terms of training, experience and specialization) of network providers required to furnish contracted Medi-Cal services;
- 5) The numbers of network providers who are not accepting new Medi-Cal beneficiaries;
- 6) The geographic location of network providers and Medi-Cal beneficiaries, considering distance, travel time, and the means of transportation ordinarily used by Medi-Cal beneficiaries;
- 7) The ability of network providers to communicate with limited English proficient beneficiaries in their preferred language(s);

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- 8) The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medi-Cal beneficiaries with physical or mental disabilities; and,
- 9) The availability of triage lines or screening systems, as well as the use of tele-medicine, e-visits, and/or other evolving and innovative technological solutions.

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

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

- I. Time and distance standards – geographic access mapping;
- II. Network composition and capacity;
- III. Timely access;
- IV. Mandatory provider types;
- V. Language assistance capabilities; and,
- VI. System infrastructure.

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

4.1. Time and Distance Standards

DHCS prepared geographic access maps for MHPs based upon Medi-Cal beneficiary and provider location data submitted in Exhibit A-3 of the NACT using ArcGIS software. DHCS plotted 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 separately. DHCS also included community-based settings, as reported in Exhibit B-1 of the NACT, where services are regularly delivered and any contracted network providers in neighboring service areas if needed to meet time and distance standards.

DHCS notified MHPs of deficient zip codes by provider type for both adults and children/youth.

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4.1.1. Community Based Service

Rehabilitative SMHS⁵ 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.⁶ 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.

4.1.2. Alternative Access Requests

The Managed Care Rule permits states to grant exceptions to the time and distance standards.⁷ DHCS notifies the MHP they cannot meet the time and distance standards; identified MHPs were required to submit a request for alternative access standards.⁸ Per the statutory requirements, DHCS is able to grant requests for alternative access standards if the MHP exhausted all other reasonable options to obtain providers to meet the applicable standard or if DHCS determined that the MHP demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.

MHPs were required to include a description of the reasons justifying the alternative access standards. Requests for alternative access standards are approved or denied on a zip code and service type basis.⁹

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 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).¹⁰

⁵ Mental Health Services, Crisis Intervention, Targeted Case Management and Medication Support

⁶ State Plan, Section 3, Supplement 3 to Attachment 3.1-A, page 2c

⁷ 42 C.F.R. section 438.68(d)(1)

⁸ Welf. & Inst. Code, section 14197, subd. (e)(2)

⁹ Welf. & Inst. Code, section 14197, subd. (e)(3)

¹⁰ 42 C.F.R sections 438.68(d)(2), 438.66(e)(2)(vi)

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DHCS will post all approved alternative access standards on its website.¹¹

4.2. Provider Composition and Network Capacity

4.2.1 Anticipated Need for SMHS

DHCS determined the anticipated need for SMHS using county-specific Medi-Cal enrollment data and estimates of prevalence of Serious Emotional Disturbance (SED) in children/youth and Serious Mental Illness (SMI) in adults.¹² 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.¹³ While these estimates were published in 2013, they are the only available prevalence estimates specific to the SED/SMI population within Medi-Cal. However, DHCS compared prevalence estimates over time and determined that prevalence rates within the population do not vary greatly over time.

Using its Medi-Cal Eligibility Data System (MEDS), DHCS calculated the average number of enrolled Medi-Cal beneficiaries in each county during fiscal year 2017/2018. DHCS then applied the SED and SMI prevalence estimates to average enrollment for each county. This adjusted Medi-Cal enrollment population represents the anticipated need for SMHS.

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

4.2.1. Provider Network Capacity and Composition

The MHPs reported detailed information about each MHP's provider network. For each rendering provider who delivers Mental Health Services, and Medication Support Services (for

¹¹ WIC Section 14197(e)(3)

¹² Prevalence estimates taken from the California Mental Health and Substance Use System Needs Assessment Report (September 2013).

¹³ Available at:

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

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psychiatrists only), the MHP is required to report, by age group (0-20 and 21+), each provider's full-time equivalency (FTE). Under the State Plan, providers in the following behavioral health classifications are eligible to provide SMHS:

- Licensed Psychiatrists;
- Licensed Physicians;
- Licensed Psychologists;
- Licensed Clinical Social Workers;
- Marriage and Family Therapists;
- Licensed Professional Clinical Counselors;
- Registered Nurses;
- Certified Nurse Specialists;
- Nurse Practitioners;
- Licensed Vocational Nurses;
- Psychiatric Technicians;
- Mental Health Rehabilitation Specialists;
- Physician Assistants;
- Pharmacists;
- Occupational Therapists; and,
- Other Qualified Providers.¹⁴

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

4.2.2. Network Composition and Capacity

DHCS established statewide provider to beneficiary ratios using Short-Doyle/Medi-Cal claims data as reported in its Performance Outcomes System (POS). The POS data includes, for adults and children/youth, the mean service quantity (i.e., number of minutes) per unique beneficiary by fiscal year. DHCS calculated the total mean number of minutes for outpatient SMHS (i.e., Mental Health Services) and psychiatry services (i.e., Medication Support Services – psychiatrists only) for adults and children/youth. DHCS assumed a 60% productivity rate

¹⁴ 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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(i.e., time spent on direct billable services) to determine the total productive minutes per state fiscal year (SFY) for each FTE SMHS provider.¹⁵ To calculate statewide ratios, DHCS divided the total productive minutes per year by the total average minutes for adults and/or children/youth. DHCS established statewide ratios, separately for adults and children/youth, for outpatient SMHS and psychiatry services (i.e., Medication Support Services).

For Medication Support Services provided by a psychiatrist, it was necessary to further analyze the data to isolate claims associated with a psychiatrist/neurologist¹⁶ taxonomy code. For each age group, the data were divided into quartiles representing all 56 county MHPs. Using this approach, DHCS was able to determine the median value for adults and children/youth. It was determined the billing patterns vary between adults and children/youth. The median percentage of minutes billed by psychiatrists/neurologists serving the adult population is 50.61%. The median percentage of minutes billed by psychiatrists/neurologists serving the children/youth population is 71.83%.

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

For MHP's utilizing telepsychiatry and/or Locums Tenens contracts to meet the need for outpatient SMHS or 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.

Provider-to-Beneficiary Ratio Standards

For the 2020 certification period, DHCS established the following provider-to-beneficiary ratio standards:

Certification Category	Ratio Standard
Children/youth outpatient SMHS	1:43
Adult outpatient SMHS	1:85

¹⁵ 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).

¹⁶ It is assumed that billings by neurologists for SMHS would be minimal, if not nil.

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Children/youth psychiatry	1:323
Adult psychiatry	1:524

Please note: DHCS is currently evaluating the ratio standards to determine if adjustments to the ratio standards should be made for subsequent certification periods.

4.3. Language Assistance Capacity

MHPs are required to maintain and monitor a network of providers that is supported by written agreements and is sufficient to provide adequate access to all covered services for all beneficiaries, including those with Limited English Proficiency (LEP).¹⁷ MHPs are also required to make oral interpretation and auxiliary aids, such as TTY/TDY and American Sign Language (ASL), available and free of charge for any language.¹⁸ To demonstrate compliance with these requirements, the MHPs must submit subcontracts for interpretation and language line services. In addition, MHPs are required to report, in the MHP's provider directory and in the NACT, the cultural and linguistic capabilities of network providers, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.¹⁹

4.4. Mandatory Provider Types - American Indian Health Facilities

In accordance with Title 42 Code of Federal Regulations, part 438.14(b)(1), MHPs are required to demonstrate that there are sufficient American Indian Health Facilities (AIHFs) participating in the MHP'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 contract.

¹⁷ 42 C.F.R. section 438.206(b)(1)

¹⁸ 42 C.F.R. section 438.10(h)(1)(vii)

¹⁹ 42 C.F.R. section 438.10(h)(1)(vii)

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

4.5. Network Adequacy System Infrastructure

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

DHCS reviewed the following supporting documentation for each county MHP:

- Complete beneficiary grievances (including the MHP's response to the grievance) related to access to SMHS. Grievances corresponding with the following Annual Beneficiary Grievance and Appeal Report (ABGAR) categories should be submitted for DHCS' review:
 - Services not available
 - Services not accessible
 - Timeliness of services
 - 24/7 Toll-free access line
 - Linguistic services
 - Other access issues
- Complete beneficiary appeals and expedited appeals (including the MHP's response to the appeal) related to access to SMHS. Grievances corresponding with the following ABGAR categories should be submitted for DHCS' review:
 - Authorization delay notices
 - Timely access notices
- Executed provider agreements with contracted network providers and the MHP's provider contract boilerplate;
- Executed agreements with subcontractors, including agreements pertaining to interpretation, language line, and telehealth services (please include budget detail for subcontracts);
- MHP's Provider directory. In addition to the paper directory, the MHP should include the website URL for online searchable directories, as applicable.
- Policies and procedures addressing the following topics:
 - Network adequacy monitoring - policies and procedures related to the MHP's procedures for monitoring compliance with the network adequacy standards;
 - Out of network access - policies and procedures related to beneficiary access to out-of-network providers;

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

4.6. Data Quality and Validation

For quality and validation purposes, DHCS made the following adjustments to the data submitted in the NACT:

1. Removed FTE for providers who were reported with an FTE greater than 100% across service settings and age groups
2. Removed FTE for non-psychiatry providers with medication support services (e.g., registered nurse, pharmacist) and
3. Removed FTE for duplicated SMHS/DMC-ODS providers who reported 100% FTE in the SMHS NACT

While DHCS is designing, developing, and implementing a data collection system for purposes of collecting and reporting MHP provider data at the level of detail requisite for conducting the network analysis, this system is not yet in place. The NACT reporting template is an Excel spreadsheet in which counties manually entered their provider data. The preparation and analysis of the MHP-submitted data was therefore also manual and laborious. A more automated, consolidated database is currently under construction to reduce the amount of manual data entry and data preparation and enable faster analysis of the MHP-submitted data. The database will require uniform submission of data from counties, and this data will replace the NACT submission. DHCS will need to undertake a significant technical assistance effort with counties to enable the understanding of format requirements. The database implementation for phase one testing target timeframe will occur in 2021.

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5. MHP Network Certification Results

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

- I. Time and distance standards– geographic access mapping;
- II. Network composition and capacity;
- III. Timely access;
- IV. Mandatory provider types;
- V. Language assistance capabilities; and,
- VI. System infrastructure.

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

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

For this certification period, DHCS determined that, overall, 13 county MHPs **pass** all network certification requirements, **and** 43 MHPs **conditionally pass** the network certification requirements and will be subject to ongoing monitoring and corrective actions, as appropriate.

MHP Name	Overall Results	Alternative Access Standard
Alameda	Conditional Pass	Did Not Submit as Required
Alpine	Pass	Not Required
Amador	Pass	Not Required
Butte	Pass	Not Required
Calaveras	Conditional Pass	Not Required
Colusa	Conditional Pass	Not Required

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MHP Name	Overall Results	Alternative Access Standard
Contra Costa	Conditional Pass	Not Required
Del Norte	Conditional Pass	Not Required
El Dorado	Conditional Pass	Not Required
Fresno	Conditional Pass	Not Required
Glenn	Conditional Pass	Not Required
Humboldt	Conditional Pass	In Review
Imperial	Pass	Not Required
Inyo	Conditional Pass	Not Required
Kern	Conditional Pass	In Review
Kings	Pass	Not Required
Lake	Conditional Pass	Not Required
Lassen	Conditional Pass	In Review
Los Angeles	Conditional Pass	Not Required
Madera	Conditional Pass	Not Required
Marin	Conditional Pass	Not Required
Mariposa	Conditional Pass	Not Required
Mendocino	Conditional Pass	Not Required
Merced	Pass	Not Required
Modoc	Pass	Not Required

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MHP Name	Overall Results	Alternative Access Standard
Mono	Pass	Approved
Monterey	Conditional Pass	In Review
Napa	Conditional Pass	Not Required
Nevada	Conditional Pass	Not Required
Orange	Pass	Not Required
Placer/Sierra	Conditional Pass	In Review
Plumas	Conditional Pass	Not Required
Riverside	Conditional Pass	Not Required
Sacramento	Conditional Pass	Not Required
San Benito	Pass	Not Required
San Bernardino	Conditional Pass	Not Required
San Diego	Pass	Not Required
San Francisco	Conditional Pass	Not Required
San Joaquin	Conditional Pass	Not Required
San Luis Obispo	Conditional Pass	In Review
San Mateo	Conditional Pass	In Review
Santa Barbara	Conditional Pass	Not Required
Santa Clara	Conditional Pass	Not Required
Santa Cruz	Conditional Pass	Not Required

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MHP Name	Overall Results	Alternative Access Standard
Shasta	Conditional Pass	In Review
Siskiyou	Conditional Pass	Did Not Submit as Required
Solano	Conditional Pass	Not Required
Sonoma	Conditional Pass	In Review
Stanislaus	Pass	Not Required
Sutter/Yuba	Pass	Not Required
Tehama	Conditional Pass	Not Required
Trinity	Conditional Pass	In Review
Tulare	Conditional Pass	Not Required
Tuolumne	Conditional Pass	Not Required
Ventura	Conditional Pass	Approved
Yolo	Conditional Pass	Not Required

6. Statewide Network Monitoring Efforts

6.1. Corrective Action Plans

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

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

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the MHP's corrective actions and require updated information from the MHP on a monthly basis until 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.²⁰ 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),²¹ including fines, penalties, the withholding of payments, special requirements, probationary or corrective actions, or any other actions deemed necessary to promptly ensure compliance.

6.2 Ongoing Monitoring

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

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

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

7. Appendices

7.1. Attachment A: Network Adequacy Standards

Time and Distance and Timely Access Standards

²⁰ 42, C.F.R., section 438.206(b)(4)

²¹ See also Cal. Code Regs., tit. 9, sections 1810.380 and 1810.385

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

Timely Access ²²	Within 15 business days from request to appointment
Time and Distance ²³	Up to 15 miles and 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.
	Up to 30 miles and 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.
	Up to 45 miles and 75 minutes from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.
	Up to 60 miles and 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

²² Welf. & Inst. Code, section 14197(d)(1); Cal. Code Regs., tit. 28, section 1300.67.2.2(c)(5)(D)

²³ Welf. & Inst. Code, section 14197(c)(1), (h)(2)(L)

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The time and distance and timely access standards for Outpatient SMHS are as follows:

Timely Access ²⁴	Within 10 business days from request to appointment
Time and Distance ²⁵	Up to 15 miles and 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.
	Up to 30 miles and 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.
	Up to 45 miles and 75 minutes from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.
	Up to 60 miles and 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

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

²⁴ Welf. & Inst. Code, section 14197(d)(1)(A); Cal. Code Regs., tit. 28, section 1300.67.2.2(c)(5)(E)

²⁵ Welf. & Inst. Code, section 14197(c)(3)