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

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 (MHP). MHPs are considered Pre-paid Inpatient Health Plans (PIHP) 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 consistent with the beneficiary's mental health treatment needs and goals.

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 of the Code of Federal Regulations sections 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 part 438 for California's SMHS. It details DHCS' efforts to certify the networks in accordance with Title 42 Code of Federal Regulations section 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 section 438.207. Below is a summary of the contents:

2. Specialty Mental Health Services Delivery System in California

California's SMHS are provided under the authority of a Social Security Act section 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 in a manner consistent with the beneficiary's mental health treatment needs and goals.

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
- 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-medicaid-managed-care-chip-delivered

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 or Distance
Section 438.68, Network adequacy standards, requires states to develop time or 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 refer 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 on an annual basis, 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. 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. § 438.207 subd. (b), and § 438.604 subd. (a)(5)

3.2. Network Adequacy Standards

DHCS established network adequacy standards for county MHPs pursuant to the federal Managed Care Rule as set forth in Title 42 of the Code of Federal Regulations, sections 438.68, 438.206, and 438.207, and California Welfare and Institutions Code (W&I Code) 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 as an alternative access standard, including for the provider ratios for both outpatient SMHS and psychiatry services, and/or as a basis for alternative access standards in relation to time or distance requirements. 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 or 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 or 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 (BHIN) 21-023 to set forth federal network adequacy requirements for MHPs. The BHIN identifies network adequacy standards and specifies network certification requirements, in accordance with Title 42 of the Code of Federal Regulations section 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 section 438.206. Each MHP is required to submit an annual Network

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

Adequacy Certification Tool (NACT) detailing the MHPs' provider networks, including all organizational, site, and rendering providers delivering SMHS within the MHPs' networks. Network providers include county-owned and operated providers and the respective 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

DHCS requires each MHP to have a system in place for tracking and measuring timeliness of care, which includes the timeliness to receive a first appointment or first specialty mental health service. DHCS developed the Timely Access Data Tool (TADT) to standardize data submissions in alignment with the DHCS Behavioral Health Information System's Clinical Services Information (CSI) Assessment Record during an interim period until the CSI Assessment Record Data is sufficiently robust, reliable, and valid for DHCS' use as the sole source to determine timeliness.

MHPs must use the TADT to submit timely access data for beneficiaries who request services within the reporting period of December 1, 2020 to February 28, 2021.

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.

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: 1) complete beneficiary grievances and appeals, 2) executed provider agreements and subcontractor agreements, 3) MHP's provider directory, 4) MHP's organizational chart, 5) the MHP's provider contract boilerplate, and 5) 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 section 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);

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

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

4.1. Time or 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 or distance for all network providers, stratified by service type (e.g., outpatient or opioid treatment programs) and geographic location, for both adult and children/youth.

For the 2020 network adequacy certification year, the geographic access mapping process had several data limitations, including that estimates were formed based on beneficiary zip codes, not actual resident addresses, and the system was not automated. For the 2021 network adequacy certification, the mapping process was automated using Environmental Systems Research Institute (ESRI) technology, which determines the precise distance between beneficiary and provider addresses. This precision led to significant differences from the prior year in the calculations of how many beneficiaries lived outside of time or distance standards from the nearest provider. However, the majority of the deficient zip codes outside of time or distance standards are covered via telehealth providers as an Alternative Access Standard (AAS).

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

4.1.1. Community Based Service

Rehabilitative SMHS[5] 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

[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

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 or 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 or distance standards.[7] DHCS notifies the MHP in the event they cannot meet the time or 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 subsection 438.66(e).[10]

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

4.2. Provider Composition and Network Capacity

[7] 42 C.F.R. § 438.68, subd. (d)(1)
[8] W&I Code, § 14197, subd. (e)(2)
[9] W&I Code, § 14197, subd. (e)(3)
[10] 42 C.F.R § 438.68, subd. (d)(2), and § 438.66, subd. (e)(2)(vi)
[11] W&I Code § 14197, subd. (e)(3)

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 2019/2020. 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 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

[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).

- 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
- Other Qualified Providers[14]

DHCS calculated, separately for adults and children/youth, the counts of FTE providers that the MHPs' reported who provide SMHS 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 (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

[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).
[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, etc.).

children/youth. DHCS established statewide ratios, separately for adults and children/youth, for outpatient SMHS and psychiatry services (i.e., Medication Support Services).

For Medication Support Services provided by a psychiatrist, it was necessary to further analyze the data to isolate claims associated with a psychiatrist/neurologist[16] 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.

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

Provider-to-Beneficiary Ratio Standards

For the 2021 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**
Children/youth psychiatry	**1:323**
Adult psychiatry	**1:524**

Please note: DHCS is currently evaluating the ratio standards to determine if adjustments 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 Teletypewriter (TTY), Telecommunications Device for the Deaf (TDD), and American Sign Language (ASL) services 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 (ASL inclusive) 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, subsection 438.14(b)(1), MHPs are required to demonstrate that there are sufficient American Indian Health Facilities (AIHF) 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).

[17] 42 C.F.R. § 438.206, subd. (b)(1)
[18] 42 C.F.R. § 438.10, subd. (h)(1)(vii)
[19] 42 C.F.R. § 438.10, subd. (h)(1)(vii)

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

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

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

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

4.5. Network Adequacy 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 (including budget details 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;
  - 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.

5. MHP Network Certification Results

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

I. Time or distance standards– geographic access mapping

II. Network composition and capacity

III. Timely access

IV. Mandatory provider types

V. Language assistance capabilities

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.

  Note: A Conditional Pass designation can also result from any deficiency in the requisite supporting documentation that each DMC-ODS plan submits as part of the certification process.

The Time or Distance findings were further categorized as Passed, Passed with 10% Telehealth Allowance and Did not Pass with 10% Telehealth Allowance:

- A passed designation means that the DMC-ODS plan met all Time or Distance standards.

- Passed with 10% Telehealth Allowance as an AAS means that the DMC-ODS plan met 90% of beneficiaries with on-site providers and the remaining 10% are covered by telehealth providers as an AAS. However, the plan cannot require telehealth and will arrange transportation for beneficiaries if they request on-site providers.

- A Did Not Pass with 10% Telehealth Allowance means that the DMC-ODS plan must submit an AAS request because the county does not have at least 90% coverage of beneficiaries with on-site providers that are within Time or Distance standards.

For this certification period, DHCS determined that 17 county MHPs ***pass*** all network certification requirements, ***and*** 39 MHPs ***conditionally pass*** the network certification requirements and will be subject to ongoing monitoring and corrective actions, as appropriate.

Important note: Of the 39 MHPs that conditionally passed, 11 were due to administrative deficiencies (i.e., language capacity contracts not covering the entire certification period, deficient reporting of contracting efforts with AIHF(s) or continuity of care requests, etc.). The MHPs have confirmed with DHCS there is no disruption in services to beneficiaries. Please see the following table for the specific MHPs that were conditionally passed based on administrative deficiencies as indicated by an asterisk:

MHP Name	Overall Results- All Network Adequacy Certification Requirements	Time or Distance Standard		
		Passed	Passed with 10% Telehealth Allowance as an AAS	Did not Pass with 10% Telehealth Allowance – AAS Required
Alameda	Conditional Pass*	X		
Alpine	Conditional Pass			X
Amador	Pass	X		
Butte	Conditional Pass*		X	
Calaveras	Pass	X		
Colusa	Conditional Pass	X		
Contra Costa	Conditional Pass*	X		
Del Norte	Conditional Pass*		X	
El Dorado	Pass		X	
Fresno	Pass	X		

MHP Name	Overall Results- All Network Adequacy Certification Requirements	Time or Distance Standard		
		Passed	Passed with 10% Telehealth Allowance as an AAS	Did not Pass with 10% Telehealth Allowance – AAS Required
Glenn	Conditional Pass	X		
Humboldt	Pass		X	
Imperial	Pass		X	
Inyo	Conditional Pass		X	
Kern	Conditional Pass		X	
Kings	Conditional Pass	X		
Lake	Conditional Pass		X	
Lassen	Conditional Pass		X	
Los Angeles	Conditional Pass		X	
Madera	Conditional Pass		X	
Marin	Conditional Pass*		X	
Mariposa	Pass	X		
Mendocino	Conditional Pass		X	
Merced	Pass		X	
Modoc	Pass	X		
Mono	Conditional Pass			X
Monterey	Conditional Pass		X	

MHP Name	Overall Results- All Network Adequacy Certification Requirements	Time or Distance Standard		
		Passed	Passed with 10% Telehealth Allowance as an AAS	Did not Pass with 10% Telehealth Allowance – AAS Required
Napa	Conditional Pass		X	
Nevada	Pass	X		
Orange	Conditional Pass		X	
Placer/Sierra	Conditional Pass*	X		
Plumas	Conditional Pass			X
Riverside	Conditional Pass		X	
Sacramento	Conditional Pass	X		
San Benito	Conditional Pass*		X	
San Bernardino	Pass	X		
San Diego	Pass		X	
San Francisco	Conditional Pass*	X		
San Joaquin	Conditional Pass		X	
San Luis Obispo	Conditional Pass*		X	
San Mateo	Pass		X	
Santa Barbara	Conditional Pass	X		
Santa Clara	Conditional Pass		X	
Santa Cruz	Pass	X		

MHP Name	Overall Results- All Network Adequacy Certification Requirements	Time or Distance Standard		
		Passed	Passed with 10% Telehealth Allowance as an AAS	Did not Pass with 10% Telehealth Allowance – AAS Required
Shasta	Conditional Pass*	X		
Siskiyou	Pass		X	
Solano	Conditional Pass	X		
Sonoma	Conditional Pass*		X	
Stanislaus	Conditional Pass		X	
Sutter/Yuba	Conditional Pass		X	
Tehama	Conditional Pass			X
Trinity	Conditional Pass			X
Tulare	Conditional Pass		X	
Tuolumne	Conditional Pass		X	
Ventura	Pass		X	
Yolo	Conditional Pass		X	

* MHP conditionally passed due to administrative deficiencies (i.e., language capacity contracts not covering the entire certification period, deficient reporting of contracting efforts with AIHF(s) or continuity of care requests, etc.)

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 if, at the time of the initial submission, or at any time thereafter, the MHP does not meet the applicable time or distance standards or a DHCS approved alternate access standard and/or any of the network adequacy requirements, the MHP is required to submit a Corrective Action Plan (CAP). The MHP's CAP must demonstrate action steps the MHP will immediately implement to ensure it complies with the standards. DHCS will monitor the 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 or distance standards, the MHP must adequately and in a timely fashion 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;

[20] 42 C.F.R. § 438.206, subd. (b)(4)
[21] See also Cal. Code Regs., tit. 9, § 1810.380 and § 1810.385

- 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.

6.3 External Quality Review

In order to ensure an unbiased review of DMC-ODS waiver services, DHCS has contracted with an External Quality Review Organization (EQRO) pursuant to 42 CFR part 438. Related to Network Adequacy, the EQRO will review and validate the data collected by DHCS related to:

- Number of requests for AAS in the plan's service area for time or distance, categorized by all provider types, including specialists, by adult and children/youth;
- Number of allowable exceptions for the appointment time standard, if known, categorized by all provider types, including specialists, by adult and children/youth;
- Distance and driving time between the nearest network provider and zip code of the beneficiary furthest from that provider for requests for AAS;
- Approximate number of beneficiaries impacted by AAS or allowable exceptions;
- Number of requests for AAS approved or denied by zip code and provider and specialty type, and the reasons for the approval or denial of the request for AAS;
- The process of ensuring out-of-network access;
- Descriptions of contracting efforts and explanation for why a contract was not executed;
- Timeframe for approval or denial of a request for AAS by the department;
- Consumer complaints, if any; and,
- Rendering Provider Taxonomy for:
    - Invalid providers; and,
    - Non-SMHS providers.

The EQRO will complete an annual report and submit the results to DHCS. The annual report will cover the following:

1) Identify areas of systematic strengths and weaknesses within each county MHP's service delivery system and strategies to improve performance;
2) Identify and recommend strategies that are strength-based, solution-focused, culturally sensitive, action oriented and common sense driven;
3) Provide recommendations to increase accurate data collection, verification, analysis and integration/connectivity between state, county and provider-level health information systems;
4) Be posted to county MHP websites to ensure transparency; and,
5) Be used to support counties with programmatic and fiscal decision-making.

7. Appendices

7.1. Attachment A: Network Adequacy Standards

Time or Distance and Timely Access Standards

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

Timely Access[22]	Within **15 business days** from request to appointment
Time or 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 Joaquin, 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, 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] W&I Code, § 14197, subd. (d)(1); Cal. Code Regs., tit. 28, § 1300.67.2.2(c)(5)(D)
[23] W&I Code, § 14197, subd. (c)(1), subd. (h)(2)(L)

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

Timely Access[24]	Within **10 business days** from request to appointment
Time or 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 Joaquin, 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, 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] W&I Code, § 14197, subd. (d)(1)(A); Cal. Code Regs., tit. 28, § 1300.67.2.2(c)(5)(E)
[25] W&I Code, § 14197, subd. (c)(3)