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

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: April 3, 2020

Behavioral Health Information Notice No: 20-012 Superseded by BHIN 21-034

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: 2020 Federal Network Certification Requirements for County Mental Health Plans (MHPs)

REFERENCE: Information Notice 18-011

PURPOSE: This Behavioral Health (BH) Information Notice (IN) communicates federal network adequacy standards and requirements for the 2020 annual network certification of county Mental Health Plans (MHPs). The network adequacy standards were developed pursuant to Title 42 of the Code of Federal Regulations (42 CFR) sections 438.68, 438.206, and 438.207, and Welfare & Institutions (W&I) Code section 14197. The standards include time and distance, provider to beneficiary ratios, and timely access requirements. This IN also specifies network certification requirements, in accordance with 42 CFR, 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. This IN is an update to IN 18-011.

BACKGROUND

On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program Managed Care Final Rule

(Managed Care Rule),[1] which revised 42 CFR. 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 federal managed care requirements (with some exceptions). Three parts of the Managed Care Rule comprise the majority of network adequacy standards set forth in 42 CFR part 438.68 Network adequacy standards; part 438.206 Availability of services; and part 438.207 Assurances of adequate capacity and services. W&I Code section 14197 includes time and distance and timely access standards and subdivision (i) authorizes DHCS to interpret and implement section 14197 by information notice.

REQUIREMENTS

W&I Code section 14197 requires Department of Health Care Services (DHCS) to monitor MHPs compliance with the network adequacy requirements set forth in section 14197 and 42 CFR. sections 438.68, 438.206, and 438.207 to ensure that all Medi-Cal managed care covered services are available and accessible to beneficiaries of the MHPs in a timely manner. In accordance with 42 CFR. section 438.68, the standards specified in this IN take into consideration the following elements:

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.

[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

Network Adequacy Standards – Time and Distance
42 CFR, part 438.68, Network adequacy standards, requires states to develop time and distance standards for adult and pediatric behavioral health 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. Based on technical assistance received from CMS, the MHPs must meet time and distance standards. Time and distance standards are specified in the Welfare & Institutions Code, section 14197. However, the time and distance requirement is based on both standards and not time *or* distance.

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

Time and Distance[2]	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.

Alternative Access Standards
The Managed Care Rule permits states to grant exceptions to the time and distance standards.[3] If a MHP cannot meet the time and distance standards set forth in this IN for all coverage areas where beneficiaries reside, it shall submit a completed Alternative Access Standards Request (Enclosure 3) to DHCS.[4] Effective no sooner than contract periods commencing on or after July 1, 2020, the MHP shall include a description on how the MHP intends to arrange for beneficiaries to access covered services if the

[2] Welf. & Inst. Code, § 14197, subds. (c)(1), (3) & (h)(2)(L)
[3] 42 CFR. § 438.68(d)(1)
[4] Welf. & Inst. Code, § 14197, subd. (e)(2)

health care provider is located outside of the time and distance standards specified in Welfare & Institutions Code, section 14197 subdivision (c).

DHCS may grant requests for alternative access standards if the MHP has exhausted all other reasonable options to obtain providers to meet the applicable standard or if DHCS determines that the MHP has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.[5]

The MHP must include a description of the reasons justifying the alternative access standards. Requests for alternative access standards shall be approved or denied on a zip code and service type basis.[6]

Requests for alternative access standards may include seasonal considerations (e.g., winter road conditions), when appropriate. Furthermore, MHPs should, as appropriate, include an explanation about gaps in the county's geographic service area, including information about uninhabitable terrain within the county (e.g., desert, forest land). In determining whether to grant a request, DHCS shall consider whether it is reasonable for a beneficiary to travel the time and distance that would result if DHCS granted the alternative access standard.[7]

DHCS will make a decision to approve or deny a request within 90 days of submission by the MHP. DHCS may stop the 90-day timeframe on one or more occasions, as necessary, in the event of an incomplete submission or to obtain additional information from the MHP requesting alternative access standards.[8] Upon notification by DHCS, approved alternative access standards will be valid for one fiscal year. DHCS will monitor beneficiary access to the service type covered by the alternative access standard on an on-going basis and report DHCS's findings to CMS.[9]

If DHCS rejects the MHP's proposal, DHCS shall inform the MHP of the reason for rejecting the proposal. DHCS will post any approved alternative access standards on its website.[10]

---

[5] Welf. & Inst. Code, § 14197, subd. (e)(1)
[6] Welf. & Inst. Code, § 14197, subd. (e)(3)
[7] Welf. & Inst. Code, § 14197, subd. (e)(5)
[8] Welf. & Inst. Code, § 14197, subd. (e)(3)
[9] 42 C.F.R. section 438.66 (e) requires DHCS to submit a report to CMS annually on each managed care program the Department administers. 42 C.F.RN. sections 438.68(d)(2) and 438.66(e)(2)(vi) require the Department to include the results of the monitoring in that report.
[10] Welf. & Inst. Code, § 14197, subd. (e)(3)

Community Based and Mobile Services

Specialty mental health services (SMHS) are to be provided in the least restrictive setting, consistent with the goals of recovery and resiliency.[11] DHCS will consider a substitute standard, other than time and distance, when the provider travels to the beneficiary and/or a community-based setting to deliver services.

For services where the provider travels to the beneficiary to deliver services, the MHP must ensure services are provided in a timely manner in accordance with the timely access standards and consistent with the beneficiary's individualized client plan. MHPs must submit information to DHCS on the availability and provision of community-based or mobile services, see the Network Adequacy Certification Tool (NACT) Exhibit B-1, Community Based Services. This includes fixed-location community settings (e.g., school, community center) and/or field-based, mobile, and/or community-based services (e.g., mobile units, satellite sites, community centers) to deliver services to beneficiaries in community-based settings (not including a beneficiary's home).

Telehealth Services

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.[12] Telehealth services must comply with DHCS' Medi-Cal Provider Manual telehealth policy[13].

In order to utilize telehealth to fulfill network adequacy requirements for time and distance standards, telehealth services must be provided to 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.

If using telehealth to meet either network adequacy standards or alternative access standards, MHPs must submit information to DHCS on their telehealth providers. Telehealth providers must be included in NACT Exhibit A-3, Rendering Provider Detail.

Network Adequacy Standards – Timely Access

Part 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

[11] State Plan, Section 3, Supplement 3 to Attachment 3.1-A, page 2c; W&I Code section 14713, subd. (a)
[12] Welf. & Inst. Code, § 14197, subd. (e)(4)
[13] Medi-Cal Provider Manual. "Medicine: Telehealth."
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc

services.[14] Timely access or "appointment waiting time" means the time from the initial request for behavioral health care services, by a beneficiary or the beneficiary's treating provider, to the earliest date offered for the appointment for services.[15]

In accordance with the W&I Code, section 14197, subdivision (d)(1), MHPs must comply with the standards for timely access to care in section 1300.67.2.2 of Title 28 of the California Code of Regulations (CCR). MHPs shall provide or arrange for the provision of covered behavioral health services in a timely manner appropriate for the nature of the beneficiary's condition consistent with good professional practice.[16] MHPs shall establish and maintain provider networks, policies, procedures, and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.[17]

MHPs shall ensure that all MHP and provider processes necessary to obtain covered behavioral health services including, but not limited to, prior authorization processes, are completed in a manner that assures the provision of covered behavioral health care services to beneficiaries in a timely manner appropriate for the beneficiary's condition and in compliance with section 1300.67.2.2 of Title 28 of CCR.[18] When it is necessary for a provider or beneficiary to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the beneficiary's behavioral health care needs, and ensures continuity of care consistent with good professional practice.[19]

Interpreter services shall be coordinated with scheduled appointments in a manner that ensures timely access.[20]

In addition to complying with the clinical appropriateness standards described above, each MHP shall ensure that it's directly operated and/or contracted provider network has adequate capacity and maintains a network availability of licensed providers to offer beneficiaries appointments that meet the timeframes detailed in the table below.[21]

[14] 42 CFR., § 438.206(c)(1)
[15] Cal. Code Regs., tit. 28, § 1300.67.2.2(b)(2)
[16] Cal. Code Regs., tit. 28, § 1300.67.2.2(c)(1)
[17] Cal. Code Regs., tit. 28, § 1300.67.2.2(c)(1)
[18] Cal. Code Regs., tit. 28, § 1300.67.2.2(c)(2)
[19] Cal. Code Regs., tit. 28, § 1300.67.2.2(c)(3)
[20] Cal. Code Regs., tit. 28, § 1300.67.2.2(c)(4)
[21] Cal. Code Regs., tit. 28, § 1300.67.2.2(c)(5)

Appointment Type	Standard
Urgent care[22] appointment for services that do not require prior authorization	Within 48 hours of the request for appointment, except as provided in CCR §1300.67.2.2(c)(5)(G)
Urgent care appointments for services that require prior authorization	Within 96 hours of the request for appointment, except as provided in CCR §1300.67.2.2(c)(5)(G)
Non-urgent appointments with specialist physicians (i.e., psychiatrists)	Within 15 business days of the request for appointment, except as provided in CCR §1300.67.2.2(c)(5)(G) and (H)
Non-urgent appointments with a non-physician mental health care provider	Within 10 business days of the request for appointment, except as provided in CCR §1300.67.2.2(c)(5)(G) and (H)
Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition	Within 15 business days of the request for appointment, except as provided in CCR §1300.67.2.2(c)(5)(G) and (H)

Section 1300.67.2.2(c)(5)(G) of Title 28 of CCR provides that an appointment time "may be extended if the referring or treating [licensed health care] 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." In addition, CCR, title 28, section 1300.67.2.2(c)(5)(H) provides that 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.

[22] "Urgent care" means health care for a beneficiary whose "condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for [a non-urgent appointment] … would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function …." (28 CCR § 1300.67.2.2, subd. (b)(7); Health & Safety Code § 1367.01, subd. (h)(2))

The following are examples of an MHP meeting the timely access requirements.

- A beneficiary calls the MHP's 24/7 access line to request non-urgent outpatient SMHS, which are provided by a non-physician. The MHP must offer the beneficiary an appointment on a date that is within 10 business days of the day the MHP received the call.
- A beneficiary walks-in to a network provider site to request services and the MHP assesses the beneficiary's condition. The beneficiary requires non-urgent SMHS provided by a non-physician. The MHP must offer the beneficiary an appointment that is within 10 business days of the date the MHP completed its assessment.
- A beneficiary submits a written (e.g., email or fax) request for non-urgent outpatient services, which are provided by a non-physician. The MHP must offer the beneficiary an appointment on a date that is within 10 business days of the date the MHP received the request.
- A beneficiary submits a written (e.g., email or fax) request for psychiatrist services. The MHP must offer the beneficiary an appointment on a date that is within 15 business days of the date the MHP received the request.
- A beneficiary requests a follow up appointment with his or her provider for continuing services. The provider must schedule an appointment in accordance with the beneficiary's individualized treatment plan and applicable standards of practice as determined by the treating licensed provider.

This IN describes existing state standards for timely access. For further information about how MHPs must monitor and report timely access data, please refer to Information Notice 19-020 and interim timeliness reporting guidance issued by DHCS.

Network Adequacy Standards – Provider-to-Beneficiary Ratios

Each MHP must maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to SMHS, for all beneficiaries within their county, including those with limited English proficiency or physical or mental disabilities.[23] MHPs must meet or exceed network capacity requirements and proportionately adjust the number of network providers to support any anticipated changes in enrollment.

The process by which DHCS determines if an MHP meets or exceeds network capacity includes 1) Provider Productivity Calculation, 2) Mean Minutes Calculation, 3) Provider Ratio Calculation, and 4) Evaluation of County Provider-Beneficiary Ratios.

[23] 42 CFR § 438.206(b)(1)

Productivity Calculation

DHCS assumed that each full-time equivalent (FTE) provider can work a maximum of 2,080 hours (or 124,800 minutes) per year (assumptions: 52 weeks × 40 hours per week). DHCS assumes a 60% productivity rate (i.e., time spent on direct billable services) to determine the total productive minutes (i.e., 74,880) per State Fiscal Year (SFY) for each FTE SMHS provider.

Mean Minutes Calculation

Using claims data as reported in the Performance Outcomes System, DHCS calculated the total mean number of minutes for Mental Health Services for adults and children/youth.

For Psychiatry Services for adults and children/youth. DHCS determined the median percentage of minutes billed by psychiatrists/neurologists (50.6% for adults and 71.8% for children/youth). For each age group, DHCS then reduced total Psychiatrist Services minutes by the median percentage.

Provider Ratio Calculation

To calculate statewide ratios for Mental Health Services, DHCS divided the total productive minutes per year by the total average minutes billed for adults and/or children/youth.

To calculate statewide ratios for Psychiatry Services, DHCS divided the total productive minutes per year by the percentage of minutes calculated (as described above). The results of the provider ratio calculation are presented in Table 1.

Table 1. Provider-to-beneficiary ratio standards

Measurement Category	Ratio Standard
Psychiatry – Adults	1:524
Psychiatry – Children/Youth	1:323
Mental Health Services – Adults	1:85
Mental Health Services – Children/Youth	1:43

Evaluation of County Provider-Beneficiary Ratios

DHCS will calculate each MHP's current provider-to-beneficiary ratio using FTE provider counts (numerator) and the anticipated need population (denominator). DHCS will then evaluate the MHP's provider-to-beneficiary ratios to determine if the current provider network meets the statewide ratio requirement. For an example of this process, see Table 2.

Table 2. County Provider Network Adequacy – Example calculation

FY 17/18	Sum Average minutes	Provider productive minutes per year	Statewide ratio requirement	Example County Needs Population	Example County Provider FTE Reported	Example County Ratio	Example Findings
Mental Health Services – Children /Youth	1,733	74,880	74,880/1,733 = 1:43	6,000	70.20	Needs Population/ FTE= 1:85	Deficient – Need to add 69.33 FTE
Mental Health Services – Adults	882	74,880	74,880/882 = 1:85	4,000	195.15	Needs Population/ FTE= 1:20	Compliant

In the example above, for Children/Youth Mental Health Services, the county has 1 FTE per 85 Children. This is evidenced by dividing 70.2 FTE reported into the 6,000 beneficiaries in need of service. To determine how many FTE are needed to serve 6,000 beneficiaries, divide 43 (required ratio) into 6,000, which equals 139.53 FTE. By subtracting reported FTE (70.20) from required FTE (139.53), the deficiency in the example is 69.33FTE.

For MHPs utilizing tele-psychiatry and/or locums tenens contracts to meet the need for psychiatry services, DHCS will calculate the estimated FTE value of the contracts. DHCS estimates FTE by dividing the total FY budget amount by the mean hourly (i.e., business hours) rate to determine the total number of hours allotted via the contract. DHCS will consider alternate proposals from counties for estimating FTE on a case-by-case basis.

Calculating Full-Time Equivalents

A provider may be counted as one FTE position if the individual's full-time job assignment is direct service delivery to Medi-Cal beneficiaries. In the case where an individual is assigned to direct service delivery on a part-time basis, the FTE should be calculated based on the percentage of time the individual could be dedicated to direct service delivery on an ongoing basis over the course of a year. A FTE position is 2,080 hours per year (i.e., 40 hours per week). FTE calculations shall not exceed 100% of time; including between service type and age group served.

Only direct providers of Mental Health Services and Psychiatrist Services should be included. For each rendering provider (an employee or contracted provider), report the total FTE (capacity) available to directly provide Mental Health Services (including Intensive Home Based Services) and Psychiatrist Services as evidenced by the contract. Only report time available to provide services in outpatient settings; do not report FTE for providers who are only available to work in inpatient or residential settings. Providers who are available to work in both inpatient and outpatient settings can be counted, but their FTE should be allocated based on time available for the outpatient setting only.

DHCS will evaluate compliance with psychiatry ratios using reported FTE for psychiatrists only. For outpatient specialty mental health ratios, DHCS will count reported FTE for all providers the MHP has listed as being available to provide outpatient mental health services (including intensive home-based services). This includes providers who are available to provide other service types in addition to outpatient mental health services. However, DHCS will not count providers who are available only for services other than outpatient mental health services. For example, if a provider is only available to provide targeted case management or crisis stabilization services, the provider should be reported accordingly by the MHP and will not be included in the outpatient ratio calculation.

Administrative Staff

These staff and/or members of leadership can only be included if they genuinely have capacity to serve clients on a regular and on-going basis. If an administrative staff employee is needed to function 100% in their administrative role (e.g., director, medical director, quality improvement manager) but could pick up a client on an emergency basis, the employee should not be included as they do not have actual capacity to serve clients. The FTE, if included, should accurately reflect the amount of time the individual can actually be available to directly provide services to a beneficiary over the course of a year.

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

Reserve/Staffing Contracts

MHPs are permitted to use reserve/staffing contracts to meet network adequacy standards and/or as a basis for alternative access requests. Reserve/staffing providers must meet the provider requirements for the applicable SMHS, be enrolled as providers in the Medi-Cal program, and able to comply with state and federal requirements for the Medi-Cal program.

In order to utilize reserve/staffing contracts to meet provider to beneficiary ratios, the provider must be available to provide services to beneficiaries in the defined service area. In addition, the physical location where beneficiaries receive services must meet the State's time and distance standards or an approved alternative access standard.

If using reserve/staffing contracts to meet either network adequacy standards or alternative access standards, MHPs must submit information to DHCS on their reserve/staffing providers during scheduled submission periods. This information should include a copy of the reserve contract, the name and National Provider Identifier (NPI) number of the contracting agency, and a statement from the county describing the number of FTE that can be available under the contract maximum (if this is not explicit in the contract itself).

Language 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).[24] MHPs are also required to make oral interpretation and auxiliary aids, such as TTY/TDY and American Sign Language (ASL), available to beneficiaries, free of charge, for any language.[25] To demonstrate compliance with these requirements, 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.[26]

Mandatory Provider Type – American Indian Health Facilities
MHPs must demonstrate compliance with federal regulations addressing protections for American Indians and American Indian Health Services provided within a managed care system (42 CFR 438.14). American Indians and American Indian Health Facilities (AIHF) are not required to contract with MHPs; however, MHPs must document good-faith efforts to contract with all AIHFs in the MHP's service area (i.e., county).

If a MHP does not have a contract with all of the AIHFs in the MHP's county, the MHP must submit an explanation to DHCS that includes supporting documentation, to justify the absence of the mandatory provider type in the MHP's network. Please see

[24] 42 CFR § 438.206(b)(1)
[25] MHP Contract, Att. 11, section 3, E.
[26] 42 CFR § 438.10(h)(1)(vii)

Enclosure 2, NACT Exhibit B-2 for details. DHCS will review the MHP's submission to determine compliance.

Mandatory Provider Type – Intensive Care Coordination and Intensive Home Based Services Providers

Per the MHP Contract,[27] MHPs are required to provide, or arrange for the provision of, all covered SMHS, including Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS). Each MHP's network must include providers responsible for delivering ICC and IHBS. ICC and IHBS providers should be included in NACT Exhibit A-3.

NETWORK CERTIFICATION/DATA AND DOCUMENTATION REPORTING REQUIREMENTS

DHCS is required to certify to CMS that each MHP's provider network meets the network adequacy standards for availability and accessibility of services.[28] The Managed Care Rule requires each MHP to submit to DHCS documentation on which the State bases its certification.[29] The documentation is to demonstrate that the MHP 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 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).[30]

DHCS will review 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. Continuity of care as described in IN 18-059;
V. Mandatory provider types;

[27] Exhibit E, Attachment 2.
[28] 42 CFR § 438.207(d)
[29] 42 CFR, §§ 438.207(a) and 438.604(a)(5); W&I Code section 14197 (f) requires MHPs, annually and when requested by DHCS, to demonstrate compliance with the time and distance and appointment time standards and for DHCS to evaluate their compliance.
[30] 42 CFR §§ 438.207(b), 438.604(a)(5)

VI. Language assistance capabilities; and,
VII. System infrastructure.

DHCS will review data and information from multiple sources, including network data, claims data, enrollment data, eligibility data, external quality reviews, and provider files submitted by the MHPs to analyze the adequacy of each MHP's network. Details regarding the required documentation can be found in Enclosure 2.

After reviewing and analyzing the documentation, and by July 1 of each fiscal year, DHCS must certify to CMS that each MHP meets the requirements for the availability of services set forth in this IN. The submission to CMS must include an analysis that supports the certification.

In addition, California Welfare & Institutions Code section 14197.05 requires DHCS' external quality review organization to annually gather data and assess whether each MHP's network met the network adequacy requirements set forth in §14197 during the preceding 12 months.

SUBMISSION REQUIREMENTS

MHPs shall submit the NACT and supporting documentation no later than April 1. The Annual Submissions will be due on April 1, or the next business day if the 1st day of the month falls on a weekend or holiday. The submissions must comply with the reporting periods below:

- Fiscal Year 2019/2020: Annual Certification - April 1 (reporting period: December 1, 2019 – February 29, 2020)
- Fiscal Year 2020/2021: Annual Certification – April 1 (reporting period: December 1, 2020 to February 28, 2021)

The MHP Director and Chief Administrative Officer, or equivalents, must certify that the information submitted by the MHP in their county is accurate, complete and truthful. The certification must be submitted with the NACT and supporting documentation as described in Enclosure 2.[31] Submission of the NACT and supporting documentation and the accompanying certification is a condition for receiving payment.[32]

[31] 42 CFR. § 438.604
[32] 42 CFR. § 438.600(b)

Any County that is found deficient and placed on a CAP must submit the NACT and supporting documentation by January to demonstrate compliance. The submissions must comply with the reporting periods below:

- State Fiscal Year 2019/2020: CAP County submission - January 2 (reporting period: September 1, 2020 – November 30, 2020)
- State Fiscal Year 2020/2021: CAP County submission - January 2 (reporting period: September 1, 2021 – November 30, 2021)

In addition, MHPs are required to notify DHCS by email to MHSDFinalRule@dhcs.ca.gov within 10 business days, any time there has been a significant change in the MHP's operations that would render the MHP non-compliant with standards for network adequacy and capacity including, but not limited to, the composition of the MHP's provider network.[33] For example, MHPs must notify DHCS if the loss of a network provider, e.g., a psychiatrist(s) serving children/youth, results in the MHP being out of compliance with provider-to-beneficiary ratios.

NETWORK ADEQUACY NON-COMPLIANCE

Non-Compliance with Submission Requirements

DHCS must certify the adequacy of every MHPs' provider network to CMS by July 1 of each year. As such, there is no flexibility with the submission deadlines. DHCS has the authority, in accordance with, W&I Code Section 14197.7, to sanction MHPs that are out-of-compliance with the submission requirements, including completeness, accuracy, and timeliness or lack of submission.

Non-Compliance with Network Adequacy Standards

If DHCS determines that a MHP does not meet the network adequacy standards, or a DHCS approved alternate access standard, the MHP will be required to submit a corrective action plan (CAP) to DHCS demonstrating steps the MHP will take to come into compliance 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 meets the applicable standards.

If the MHP is not making satisfactory progress toward compliance with applicable standards, DHCS may impose sanctions pursuant to W&I Code Section 14197.7, including monetary sanctions, and the temporary withholding of payments.

[33] 42 CFR § 438.207(c)(3)

Furthermore, if the MHP is 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 or an approved alternate access request, the MHP must adequately and timely cover these services out-of-network for the beneficiary.[34] 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.

ONGOING NETWORK ADEQUACY MONITORING

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

- Annual NACT data submissions for MHP;
- Triennial reviews of each MHP;
- Annual program assessment reports submitted to CMS in accordance with 42 CFR part 438.66;
- Annual External Quality Review Organization (EQRO) reviews;
- MHP performance dashboards;
- Corrective action monitoring and follow-up; and,
- Any other monitoring activities required by DHCS.

[34] 42, CFR, § 438.206(b)(4)

DHCS will post network adequacy documentation for each MHP on its website, including any approved alternative access standards in accordance with Welfare and Institutions Code Section 14197.

For questions regarding this IN, please contact the Medi-Cal Behavioral Health Division at (916) 322-7445 or MHSDFinalRule@dhcs.ca.gov.

Sincerely,

Brenda Grealish, Chief
Medi-Cal Behavioral Health Division

Enclosures:

- Enclosure 1 – Network Adequacy Certification Tool
- Enclosure 2 – Network Adequacy Checklist
- Enclosure 3 – Alternative Access Standard Request
- Enclosure 4 – County Certification of Network Adequacy Data and Documentation Submission