Network Certification Checklist

Purpose

The Department of Health Care Services (DHCS) will review, validate, and certify the provider network of each Mental Health Plan (MHP). DHCS must ensure adequate access to appropriate service providers in accordance with Title 42 of the Code of Federal Regulations (42 CFR) parts 438.207, 438.68 and 438.206(c)(1). The information will be used in the assurance of compliance with network adequacy requirements DHCS must send to the Centers for Medicare and Medicaid Services (CMS). In order to demonstrate network adequacy, MHPs must submit a completed Network Adequacy Certification Tool (NACT).

Submission Instructions

MHPs must upload electronic submissions* of the NACT and supporting documentation into their Behavioral Health Information Systems (BHIS) – Client and Service Information System (CSI) system account 'data exchange' folder, by the submission deadline established in the Information Notice and below. When submitting files, each MHP must use the following naming convention:

NACT (County Code)_MHP_County Name_Fiscal Year and Submission Period
• Example: NACT_05_MHP_Alameda_2020_April

*Please contact MHSDFinalRule@DHCS.ca.gov with any questions or to troubleshoot technical errors regarding the submission of the NACT or supporting documentation.

The applicable time and distance, and timely access, requirements are detailed in the Information Notice.

Timing of Submissions

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 4.[1] Submission of the NACT and supporting documentation and the accompanying certification is a condition for receiving payment.[2]

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:

[1] 42 CFR. § 438.604
[2] 42 CFR. § 438.600(b)

- 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. 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 DATA AND DOCUMENTATION REPORTING REQUIREMENTS

The Managed Care Rule[3] requires 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 42 CFR part 438.206. Part 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 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).[4]

MHPs must submit the required documentation as specified by DHCS. After reviewing the documentation submitted by each MHP, and by July 1 of each fiscal year, DHCS must submit an assurance of compliance to CMS that the MHP meets the State's requirements for the availability of services, as set forth in 42 CFR parts 438.68 and 438.206. The submission to CMS must include documentation of an analysis that supports the assurance of the adequacy of the network for each MHP related to its provider network.

Network Adequacy Certification Tool (NACT)

Each MHP shall submit the NACT (Enclosure 1) with the following exhibits:

- Exhibit A-1 Network Provider Data, Organizational/Legal Entity Level

  All MHPs must complete and submit Exhibit A-1. For the purposes of network adequacy, MHPs must complete Exhibit A-1 in reference to the county (Row #1) AND the MHP's subcontracted organizations. The term "Organization" refers to the parent organization and/or legal entity designation. Telehealth organizations must be included in this exhibit.

- Exhibit A-2 Network Provider Data, Provider Site Detail

  All MHPs must complete and submit Exhibit A-2. The term "site" refers to the physical location (i.e., clinic sites) where services are rendered to Medi-Cal beneficiaries. The "site"

[3] 42 CFR, §§ 438.207(a) and 438.604(a)(5)
[4] 42 CFR §§ 438.207(b), 438.604(a)(5)

information must include county-owned and operated facilities and contracted network provider sites.

- Exhibit A-3 Network Provider Data, Rendering Provider Detail

  All MHPs must complete and submit Exhibit A-3. The term “rendering service provider” refers to the individual practitioner, acting within his or her scope of practice, who is rendering services directly to the beneficiaries. This includes individuals employed by the MHP, individuals employed by a contracted organization, individual members of a provider group, and individual practitioners rendering services through “fee-for-service” contracts with the MHP. Telehealth practitioners must be included in this exhibit.

- Exhibit B-1 Community Based Services

  All MHPs must complete Exhibit B-1, if rendering provider routinely travels to a site different from the site listed in Exhibit A-2, and the MHP utilizes mobile and/or community-based services (e.g., mobile units, satellite sites, community centers) to deliver services to beneficiaries in community-based settings. Beneficiary’s homes should not be listed in this exhibit.

- Exhibit B-2 American Indian Health Facilities

  All MHPs must complete Exhibit B-2 to 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 maintain MHP affiliation; however, they retain the option to join a MHP at any time. In the exhibit, MHPs must to document any and all efforts to contract with AIHFs in the MHP’s service area.

  If the MHP does not have a contract with any AIHFs, 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. DHCS will review the MHP’s submission to determine compliance.

- Exhibit C-1 Provider Counts

  All MHPs must complete and submit Exhibit C-1. In the table provided on Exhibit C-1, enter the number of providers within the existing network, separated by provider type and the age group(s) served.

  For MHPs, enter the number of providers for the following provider types: Licensed Psychiatrists, Licensed Physicians, Licensed Psychologists, Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Marriage and Family Therapists, 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.

Geographic Access Maps

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

Alternative Access Standards
If time and distance standards are not met, DHCS will notify the county Plan of the findings. For each finding, the Plan shall submit an Alternative Access Standards Request. Plans that submitted an Alternative Access Standards Request previously must submit a new request, even if the previous request was approved. Instructions about how to request Alternative Access Standards are detailed in Enclosure 3, Alternative Access Standards Requests.

Timely Access Reporting
Each MHP 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 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);
- Date of the assessment (or first Medi-Cal service); and,
- 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.

Language Line Utilization for 24/7 Access Line	**Language Line Utilization for Face-to-Face Service Encounters**	**Language Line Utilization for Telehealth or Telephonic Service Encounters**
Exhibit Name: Language Line Utilization	Exhibit Name: Language Line Utilization	Exhibit Name: Language Line Utilization
MHP Name	MHP Name	MHP Name
Reporting Period	Reporting Period	Reporting Period
Total # encounters requiring language line services	Total # encounters requiring language line services	Total # encounters requiring language line services
# of encounters requiring language line services, stratified by language	# of encounters requiring language line services, stratified by language	# of encounters requiring language line services, stratified by language

Reason services could not be provided by bilingual provider/staff or contracted interpreter	Reason services could not be provided by bilingual provider/staff or via face-to-face interpretation	Reason services could not be provided by bilingual provider/staff or via face-to-face interpretation

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.

Additional Supporting Documentation
Each MHP must also submit the following additional supporting documentation on an annual basis unless noted otherwise:

- Complete beneficiary grievances (including the MHP's response to the grievance) related to access to SMHS. If none were received during the reporting period, the MHP must include attestation indicating so. 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. If none were received during the reporting period, the MHP must include attestation indicating so. Appeals corresponding with the following ABGAR categories should be submitted for DHCS' review:
    - Authorization delay notices
    - Timely access notices
- MHP's Provider directory. In addition to the paper directory, the MHP should include the website URL for online searchable directories, as applicable.
- An organizational chart detailing the MHP's clinical teams, including identification of deputy directors, clinical managers/supervisors, clinicians and staff.

- 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, telehealth services, and reserve/staffing contracts (please include budget detail for subcontracts).

- Policies and procedures addressing the following topics:

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