



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



EDMUND G. BROWN JR.
GOVERNOR

DATE: February 13, 2018

MHSUDS INFORMATION NOTICE NO.: 18-011

TO: COUNTY BEHAVIORAL HEALTH DIRECTORS
COUNTY DRUG & ALCOHOL ADMINISTRATORS
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION OF CALIFORNIA
CALIFORNIA COUNCIL OF COMMUNITY BEHAVIORAL HEALTH AGENCIES
COALITION OF ALCOHOL AND DRUG ASSOCIATIONS
CALIFORNIA ASSOCIATION OF ALCOHOL & DRUG PROGRAM EXECUTIVES, INC.
CALIFORNIA ALLIANCE OF CHILD AND FAMILY SERVICES
CALIFORNIA OPIOID MAINTENANCE PROVIDERS

SUBJECT: FEDERAL NETWORK ADEQUACY STANDARDS FOR MENTAL HEALTH PLANS (MHPS) AND DRUG MEDICAL ORGANIZED DELIVERY SYSTEM (DMC-ODS) PILOT COUNTIES

PURPOSE

The Department of Health Care Services (DHCS) is issuing this Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice (IN) to set forth federal network adequacy requirements for county Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot counties. This IN identifies network adequacy standards developed pursuant to Title 42 of the Code of Federal Regulations (CFR) Part 438.68, as specified in Chapter 738, Statutes of 2017 (Assembly Bill (AB) 205). The standards include time, distance, and timely access requirements with which MHPs and DMC-ODS pilot counties', herein referred to as Plans unless otherwise specified, must comply. This IN also specifies network certification requirements, in accordance with Title 42 of the CFR, Part 438.207, including the requirement for each Plan to submit documentation to the State to demonstrate that it complies with the network adequacy requirements.

This IN also addresses compliance with the Parity in Mental Health and Substance Use Disorder Services Final Rule (Parity Rule) as it relates to network adequacy. On March 30, 2016, CMS issued the Parity Rule in the Federal Register¹ (81.Fed.Reg. 18390) to strengthen access to mental health and substance use disorder (SUD) services for Medicaid beneficiaries. The Parity Rule aligned certain protections required of commercial health plans under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to the Medicaid program.

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),² which revised Title 42 of the CFR. These changes aimed to align Medicaid managed care regulations with requirements of other major sources of coverage. MHPs and DMC-ODS pilot counties are classified as Prepaid Inpatient Health Plans and must therefore comply with federal managed care requirements (with some exceptions). Among the new requirements in the Managed Care Rule are requirements for network adequacy that become effective July 1, 2018.

Three parts of the Managed Care Rule comprise the majority of network adequacy standards set forth in Title 42 of the CFR Part 438.68 Network adequacy standards; Part 438.206 Availability of services, and Part 438.207 Assurances of adequate capacity and services.

Network Adequacy Standards – Time and Distance

Part 438.68, Network adequacy standards, requires states to develop time and distance standards for adult and pediatric behavioral health (mental health and SUD treatment) providers. Time means the number of minutes it takes a beneficiary to travel from the beneficiary's residence to the nearest provider site. Distance means the number of miles a beneficiary must travel from the beneficiary's residence to the nearest provider site. While states are required to establish time and distance standards, Plans are required to meet the standards for time or distance. For example, in large counties, the mental health and/or substance use disorder services must either be within 15 miles from the beneficiary's residence or be within a 30-minute drive from the beneficiary's residence in order to meet the standards.

¹ Medicaid Mental Health Parity Final Rule Federal Register:
<https://www.gpo.gov/fdsys/pkg/FR-2016-03-30/pdf/2016-06876.pdf>

² 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>

DHCS issued network adequacy standards in July 2017.³ On October 13, 2017, Governor Brown signed AB 205 into law, which codified several Managed Care Rule requirements in the State statute, specifically the Welfare and Institutions Code (W&I).⁴ AB 205 clarified network adequacy standards for outpatient mental health services and SUD services, including the time and distance and timely access standards. The network adequacy standards established in State law are based on the population density of each county.

The Parity Rule applies to both adult and pediatric providers of outpatient specialty and non-specialty mental health services. Plans will be required to demonstrate compliance with network adequacy standards for outpatient specialty mental health services and, where applicable, DMC-ODS services provided to both adults and children/youth.

Network Adequacy Standards – Timely Access

Part 438.206, Availability of services, requires the Plans to meet State standards for timely access to care and services, taking into account the urgency of the need for services. Timely access standards refers to the number of business days in which a Plan must make an appointment available to a beneficiary from the date the beneficiary, or a provider acting on behalf of the beneficiary, requests a medically necessary service. Examples of timely access include, but are not limited to, the following:

- A beneficiary calls the Plan's 24/7 Access line to request outpatient services and the Plan must offer an appointment within 10 business days;
- A beneficiary walks-in to a network provider site to request services, the Plan conducts an assessment of the beneficiary's condition and then Plan must schedule a follow-up appointment within 10 business days;
- A beneficiary submits a written (e.g., email or fax) request for outpatient services and the Plan must contact the beneficiary to offer an appointment within 10 business days;
- A beneficiary submits a written (e.g., email or fax) request for psychiatric services and the Plan must contact the beneficiary to offer an appointment within 15 business days; and/or,
- A beneficiary requests services from his or her provider for continuing services and the provider must schedule an appointment in accordance with timely access standards and the beneficiary's individualized treatment plan.

In accordance with AB 205, effective July 1, 2018, Plans must also comply with the appointment time standards pursuant to Section 1300.67.2.2 of Title 28 of the California

³ DHCS Network Adequacy Standards, July 2017:

<http://www.dhcs.ca.gov/formsandpubs/Documents/FinalRuleNAFinalProposal.pdf>

⁴ AB 205 amended Sections 10950, 10951, 10952, and 10959, and adding Section 10951.5 and adds Article 6.3 (commencing with Section 14197) to Chapter 7 of Part 3 of Division 9 of W&I.

Code of Regulations (CCR), as well as the standards set forth in contracts between DHCS and the Plan.⁵

Network Certification Requirements

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

- Offers an appropriate range of services that is adequate for the anticipated number of beneficiaries for the service area (i.e., county); and,
- Maintains a network of providers,⁶ 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).⁷

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

⁵ W&I § 14197, subd. (d)(1)

⁶ The Plan's network of providers includes county-owned and operated providers.

⁷ 42 CFR §§ 438.207(b), 438.604(a)(5)

STANDARDS

Commencing July 1, 2018, Plans must comply with the network adequacy standards, as specified in the tables below. In addition, effective July 1, 2018, Plans must comply with the requirements in Section 1300.67.2.2(c)(1-4), (7) of Title 28 of CCR.

For psychiatry, the standards are as follows:

Timely Access ⁸	Within 15 business days from request to appointment
Time and Distance ⁹	Up to 15 miles or 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 or 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 or 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 or 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.

⁸ W&I § 14197(d)(1); CCR Title 28, § 1300.67.2.2(c)(5)(D)

⁹ W&I § 14197(c)(1), (h)(2)(L)

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

Timely Access ¹⁰	Within 10 business days from request to appointment
Time and Distance ¹¹	Up to 15 miles or 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 or 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 or 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 or 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.

As specified in Title 28, CCR, §1300.67.2.2, the applicable mental health services appointment time standards may be extended if the referring or treating provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the beneficiary's record that a longer waiting time will not have a detrimental impact on the health of the beneficiary.¹² In addition, periodic office visits to monitor and treat mental health conditions may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed mental health provider acting within the scope of his or her practice.¹³

¹⁰ W&I § 14197(d)(1)(A); CCR Title 28, § 1300.67.2.2(c)(5)(E)

¹¹ W&I § 14197(c)(3)

¹² CCR Title 28, § 1300.67.2.2(c)(5)(G)

¹³ CCR Title 28, § 1300.67.2.2(c)(5)(H)

For outpatient SUD services, other than opioid treatment programs (OTPs), the standards are as follows:

Timely Access ¹⁴	Within 10 business days from request to appointment
Time and Distance ¹⁵	Up to 15 miles or 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 or 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 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Monterey, Mono, Napa, Nevada, Plumas, San Benito, San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba.

For DMC-ODS services, time, distance and timely access standards differ between outpatient SUD services and OTPs due to the need for beneficiaries in an OTP to receive their medication daily since imminent withdrawal will occur without medication.

¹⁴ The Department established this standard to comply with the Parity Rule pursuant to W&I, Section 14197.1 (a) & (b).

¹⁵ W&I § 14197, subd. (c)(4)(A)

For OTPs, the standards are as follows:

Timely Access ¹⁶	Within 3 business days from request to appointment
Time and Distance ¹⁷	Up to 15 miles or 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 or 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 or 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 or 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.¹⁸ If a Plan cannot meet the time and distance standards, it shall submit a request for alternative access standards.¹⁹ DHCS may grant requests for alternative access standards if the Plan has exhausted all other reasonable options to obtain providers to meet the applicable standard or if DHCS determines that the Plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.

The Plan 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.²⁰

Requests for alternative access standards may include seasonal considerations (e.g. winter road conditions), when appropriate. Furthermore, Plans should, as appropriate,

¹⁶ W&I § 14197, subd. (d)(3)

¹⁷ W&I § 14197, subd. (c)(4)(B)

¹⁸ 42 CFR § 438.68(d)(1)

¹⁹ W&I § 14197, subd. (e)(2)

²⁰ W&I § 14197, subd. (e)(3)

include an explanation about gaps in the county's geographic service area, including information about uninhabitable terrain within the county (e.g., desert, forestland). The use of clinically appropriate telecommunications technology²¹ may be considered in determining compliance with the applicable standards established in this IN and/or for the purpose of approving an alternative access request.

If a Plan cannot meet the time and distance standards set forth in this IN, it shall submit a request for alternative access standards to DHCS by March 30, 2018, (April 1st, or the next business day, in subsequent years). To request an alternative access standard for time and distance, the Plans must complete Enclosure 3, Alternative Access Standards Request.

DHCS will make a decision to approve or deny the request within 90 days of submission by the Plan. 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 Plan requesting alternative access standards.²² Upon notification by DHCS, approved alternative access standards will be valid for one fiscal year; however, DHCS will monitor beneficiary access on an on-going basis and include the findings to CMS in the managed care program assessment report required under Title 42 CCR Part 438.66(e).²³

If DHCS rejects the Plan's proposal, DHCS shall inform the Plan of the reason for rejecting the proposal. DHCS will post any approved alternative access standards on its website.²⁴

Community-Based and Mobile Services

Rehabilitative SMHS²⁵ 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.²⁶ 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 Plan 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. Plans

²¹ Telecommunications technology, consistent with the requirements of Section 2290.5 of the Business and Professions Code, includes telehealth, e-visits, or other evolving and innovative technological solutions that are used to provide care from a distance. (W&I § 14197(e)(4))

²² W&I § 14197, subd. (e)(3)

²³ 42 CFR §§ 438.68(d)(2), 438.66(e)(2)(vi)

²⁴ W&I § 14197, subd. (e)(3)

²⁵ Mental Health Services, Crisis Intervention, Targeted Case Management and Medication Support

²⁶ State Plan, Section 3, Supplement 3 to Attachment 3.1-A, page 2c

must submit information to DHCS on the availability and provision of community-based or mobile services, see Exhibit B-1, Community Based Services.

Telehealth Services

Plans are permitted to use telehealth to meet network adequacy standards and/or as a basis for alternative access requests.²⁷ Telehealth services must comply with DHCS' Medi-Cal Provider Manual telehealth policy²⁸ and telehealth providers must meet the following criteria:

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

If using telehealth to meet either network adequacy standards or alternative access standards, Plans must submit information to DHCS on their telehealth providers. Telehealth providers must be included in Exhibit A-3, Rendering Provider Detail, as well as Exhibit C-1, Provider Counts.

NETWORK DATA REPORTING REQUIREMENTS

The Managed Care Rule²⁹ requires each plan to submit to DHCS documentation on which the State bases its certification that the Plan has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in Title 42 C.F.R. Part 438.206. Each Plan shall complete the enclosed Network Adequacy Certification Tool (NACT) for all network providers at the organizational (Exhibit A-1), site (Exhibit A-2) and rendering provider (Exhibit A-3) level of detail. The Managed Care Rule defines network providers as any provider, group of providers, or entity that has a network provider agreement with a Plan and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the State's contract with the Plan.³⁰ For the purposes of this IN, network providers include county-owned and operated providers, as well as the MHP's contracted network providers. The organizational level refers to the provider's legal

²⁷ W&I § 14197, subd. (e)(4)

²⁸ Medi-Cal Provider Manual. "Medicine: Telehealth."

http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc

²⁹ 42 CFR, §§ 438.207(a) and 438.604(a)(5)

³⁰ 42, CFR, § 438.2

entity. The site level refers to the physical location of the provider. The rendering provider refers to the individual practitioner, acting within his or her scope of practice, who is rendering services directly to the beneficiaries. See Enclosure 1, Network Adequacy Certification Tool, for detailed reporting requirements and instructions. In addition to the NACT, each Plan shall submit supporting documentation of its own analysis of the Plan's network adequacy; see Enclosure 2, Network Certification Checklist for specific instructions. This supporting documentation shall include, at a minimum, all of the following, separately for both children/youth and adults:

- Geographic access maps and accessibility analyses to confirm compliance with time or distance standards. The map must plot time and distance for all network providers, stratified by service type, and geographic location. The Plan must also include a map of community-based settings where services are regularly delivered. The Plan's analysis must illustrate that it complies with applicable time or distance standards or it must demonstrate that it has requested DHCS approval for an alternative access standard. See Enclosure 2, Network Certification Checklist for additional instructions;
- An alternative access request, if applicable. See Enclosure 3, Alternative Access Standards;
- An analysis of the availability of community based services (i.e., where the provider travels to the beneficiary to delivery services). See Exhibit B-1, Community Based Service Providers;
- An analysis and evidence of the Plan's compliance with Title 42 CFR Part 438.14(b)(1) demonstrating that there are sufficient American Indian Health Facilities participating in the Plan's network to ensure timely access to services for Indian beneficiaries who are eligible to receive services. See Exhibit B-2;
- Provider counts. See Exhibit C-1;
- An analysis of the expected utilization of services. See Exhibit C-2; and,
- An analysis of language line utilization. See Enclosure 2, Network Certification Checklist for additional instructions;

Each Plan must also submit the following additional supporting documentation:

- Grievances and appeals related to availability of services and/or problems in obtaining services in a timely fashion, as well as the resolutions of such grievances and appeals;
- Provider agreement boilerplates for network providers and subcontractors, including agreements pertaining to interpretation, language line, and telehealth services;
- For MHPs only, the Plan's provider directory/directories;

- For MHPs only, the results of beneficiary satisfaction surveys related to network adequacy or timely access; and,
- Policies and procedures addressing the following topics:
 - Network adequacy monitoring;
 - Out of network access (MHPs only);
 - Timely access;
 - Service availability;
 - Physical accessibility;
 - Telehealth services;
 - 24/7 Access Line requirements; and,
 - 24/7 language assistance.

SUBMISSION REQUIREMENTS

Plans shall submit the initial NACT and supporting documentation no later than March 30, 2018. MHPs are required to submit subsequent NACTs on a quarterly basis beginning July 1, 2018. Subsequent submissions will be due on July 1, October 1, January 1, and April 1, or the next business day if the 1st day of the month falls on a weekend or holiday.

Operating DMC-ODS counties are required to submit NACTs annually on April 1st. Counties may be subject to enhanced reporting frequency, based upon DHCS' review of network certification documentation.

Plans shall electronically submit the tool and supporting documentation in accordance the submission instructions detailed in Enclosure 2, Network Certification Checklist. The submission shall comply with the requirements set forth in Title 42 CFR Part 438. 606.

In addition, Plans are required to notify DHCS, within 10 business days, any time there has been a significant change in the Plan's operations that would affect the adequacy and capacity of services, including but not limited to the composition of the Plan's

provider network.³¹ For example, Plans must notify DHCS if there is any loss of a network provider (e.g., psychiatrist(s) serving children/youth).

NETWORK CERTIFICATION AND VALIDATION

Each Plan must maintain and monitor a provider network adequate to serve, within scope of practice under State law, the beneficiary capacity, for both adults and children/youth, within their county. Plans must meet or exceed network capacity requirements and proportionately adjust the number of network providers to support any anticipated changes in enrollment.

DHCS is required to certify the network of each Plan and submit assurances to CMS. DHCS will review data and information from multiple sources, including network data submissions by the Plans, to conduct an analysis of the adequacy of each Plan's network. In accordance with Title 42 CFR Part 438.68, the network certification analysis includes, but is not limited to, the following elements for each Plan:

- 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 will review and analyze the data and documentation to determine if the Plan 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 will utilize various data sources (e.g., claims data, enrollment data, eligibility data, external quality reviews, provider files) to validate county data submissions. In addition, W&I Section 14197.05 requires DHCS' external quality review organization to annually gather data and assess

³¹ 42 CFR § 438.207(c)(3)

whether each Plan's network met the adequacy requirements set forth in §14197 during the preceding 12 months.

NETWORK ADEQUACY NON-COMPLIANCE

Non-Compliance with Submission Requirements

The Managed Care Rule³² requires Plans to comply with the network data submission requirements as a condition for receiving payment under a Medi-Cal managed care program. Specifically, Plans must submit documentation on which the State bases its certification that the Plan has complied with the State's requirements for availability and access to services, including the adequacy of the provider network.³³ DHCS must certify the networks by July 1st of each year. As such, there is no flexibility with the submission deadline of March 30, 2018 (or ongoing quarterly submission deadlines as specified in this IN). Any Plan out-of-compliance with the submission requirements, including completeness, accuracy, and timeliness or lack of the submission, will be subject to fines, sanctions and penalties in accordance with the W&I, Section 14712(e).³⁴

Non-Compliance with Network Adequacy Standards

If DHCS determines that, at the time of the initial submission, or at any time thereafter, the Plan does not meet the applicable time and distance standards, or a DHCS approved alternate access standard, DHCS will notify the Plan that it must submit, within the Department established timeframe, a Plan of Correction to DHCS demonstrating action steps the Plan will immediately implement to ensure it complies with the standards by July 1st. DHCS will monitor the Plan's corrective actions and require updated information from the Plan on a bi-weekly basis until such time the Plan is able to meet the applicable standards.

If the Plan is not in compliance with the applicable standards by July 1, 2018, DHCS may impose additional corrective actions pursuant to W&I Section 14712(e),³⁵ including fines, penalties, the withholding of payments, special requirements, probationary or corrective actions, or any other actions deemed necessary to promptly ensure compliance.

Furthermore, if the Plan 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, the Plan must adequately and timely cover these services out-of-network for the beneficiary.³⁶ The Plan must permit out-of-network

³² 42, CFR, § 438.600(b)

³³ 42, CFR, § 438.604(a)(5)

³⁴ See also CCR Title 9, §§ 1810.380 and 1810.385

³⁵ See also CCR Title 9, §§ 1810.380 and 1810.385

³⁶ 42, CFR, § 438.206(b)(4)

access for as long as the Plan'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 on-going basis. Network adequacy monitoring activities include, but are not limited to, the following:

- Quarterly NACT data submissions for MHPs and Annual NACT data submissions for DMC-ODS counties;
- Triennial reviews of each MHP and annual reviews of each DMC-ODS county;
- Annual program assessment reports submitted to CMS in accordance with Title 42 CFR Part 438.66;
- Annual EQRO reviews;
- Plan performance dashboards;
- Corrective action monitoring and follow-up; and,
- Any other monitoring activities required by DHCS.

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

For questions regarding this IN, please contact the Mental Health Services Division at (916) 322-7445 or MHSDFinalRule@dhcs.ca.gov or the Substance Use Disorder Program, Policy and Fiscal Division at (916) 327-8608 or DMCODSWaiver@dhcs.ca.gov.

Sincerely,

Original signed by

Brenda Grealish, Acting Deputy Director
Mental Health & Substance Use Disorder Services

Enclosures:

- Enclosure 1 – Network Adequacy Certification Tool
- Enclosure 2 – Network Certification Checklist
- Enclosure 3 – Alternative Access Standard Request