7.1.5. Provider Network Adequacy Policy

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References: Sonoma County's Mental Health Plan Contract with Department of Health Care Services, Attachment 7 and 8; Sonoma County's Drug Medi-Cal Organized Delivery System Contract with Department of Health Care Services, Exhibit A, Attachment I; Title 42, Code of Federal Regulations (CFR), Section 438.10; 438.68; 438.206; 438.207; 438.214; Title 9 CCR, Division 4, Chapter 5; Section 1810.385; W&I Code 14197; Title 28 CCR, Section 1300.67.2.2; Behavioral Health Information Notice 24-001; 24-020 23-042; DHCS Medicaid Managed Care Final Rule: Network Adequacy Standards, Updated March 26, 2018; 28 CCR Section 1300.67.2.2(c)(5)(G) and (H).

Policy Owner: Behavioral Health Division, Quality Assessment and Performance Improvement (QAPI), Section Manager

Director Signature: Signature on File

I. Policy Statement

It is the policy of the Department of Health Services (DHS), Behavioral Health Division (BHD) to add individual, group and/or organizational network providers that enhance the capability of the DHS-BHD to adequately provide Mental Health (MH) and Substance Use Disorder (SUD) treatment. In accordance with state and federal regulations, Medi-Cal clients will be able to access providers and services within the timeframe and distance standards.

If DHS-BHD is unable 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, DHS-BHD will adequately and timely cover these services by working to secure an out-of-network provider for the client. DHS-BHD will permit out-of-network access for as long as the DHS-BHD provider network is unable to provide the services in accordance with the standards.

II. Scope

This policy addresses DHS-BHD network adequacy responsibilities to develop and maintain a service system as required by the contract between Sonoma County and the California Department of Health Care Services (DHCS) to serve as the Medi-Cal Mental Health Plan (MHP) and Drug Medi-Cal (DMC) Organized Delivery System (ODS).

III. Definitions

A. Network Provider: An individual, group, or organization that is contracted to provide mental health &/or substance use treatment services to Sonoma County Medi-Cal beneficiaries under contract with Sonoma County Department of Health Services – Behavioral Health Division, as part of the County's MHP or DMC-ODS plan.

B. Mental Health Plan (MHP): The managed Mental Health Care plan for Medi-Cal eligible residents of Sonoma County, defined by a State-County contract partnership between California Department of Health Care Services and Sonoma County, authorized under Welfare & Inst Code §14680 – 1472.

C. Drug Medi-Cal Organized Delivery System Plan (DMC-ODS Plan): The Prepaid Inpatient Health Plan (PIHP) operating in Sonoma County serving eligible residents providing automatic and mandatory enrollment of Medi-Cal beneficiaries. Defined by a State-County contract partnership between California Department of Health Care Services and Sonoma County.

D. Notice of Adverse Benefit Determination (NOABD): A formal communication of any action and consistent with 42 CFR 438.404 and 438.10:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service;
4. The failure to provide services in a timely manner;
5. The failure to act within the required timeframes for standard resolution of grievances and appeals, or;
6. The denial of a beneficiary's request to dispute financial liability.

F. Quality Assessment & Performance Improvement (QAPI): DHS-BHD quality management section providing quality assurance and quality improvement oversight and guidance for both the MHP and the DMC-ODS plan.

IV. Policy

A. DHS-BHD shall ensure that all Medi-Cal provider sites are certified and direct service providers meet all required credentialing criteria.

B. DHS-BHD will maintain an adequate network to serve Medi-Cal beneficiaries for covered services. DHS-BHD will monitor network needs and recruit providers when needed to meet network requirements.

C. DHS-BHD will monitor network providers to conduct formal periodic performance evaluations, identify corrective actions, and confirm network adequacy requirements are met.

D. DHS-BHD will submit Provider Network Data in the format specified by DHCS.

E. DHS-BHD will complete required submissions for Timely Access Data.

F. DHS-BHD will utilize Out of Network (OON) providers to meet timely access requirements and other network deficiencies when needed.

G. DHS-BHD will give notice to impacted plan members when a network provider is terminated.

V. Procedures

A. Provider Certification:

1. Providers shall meet all credentialing criteria, as set forth in DHS-BHD policy BH 7.1.1. Provider Credentialing and Continuous Monitoring;

2. All MHP Medi-Cal provider sites must be certified consistent with the DHS-BHD policy MHP-15 Short-Doyle Medi-Cal Site Certification for County Owned and Operated MHP Contract Providers;

3. All DMC-ODS Medi-Cal provider sites must be DMC certified by DHCS and maintain current certification;

4. All MHP and DMC-ODS providers shall ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS, if the provider serves only Medicaid enrollees (438.206 (c)(1)(ii));

5. All MHP and DMC-ODS providers shall make services available 24 hours a day, 7 days a week, when medically necessary. Providers shall refer beneficiaries to Sonoma County's toll-free 24-hour access line at 1-800-870-8786 when unable to meet requirement themselves or with an alternative in network referral (438.206 (c)(1)(iii));
6. All MHP and DMC-ODS providers shall ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities (§438.206 (c)(3)).

B. Network Provider Enrollment:

1. Provider network enrollment, retention, and referral criteria can be referenced in policy 7.1.3.

D. Provider Network Data Reporting:

1. DHS-BHD will submit a Network Adequacy Certification Tool (NACT), or other format specified, to DHCS for all network providers at the organizational, site, and rendering provider levels of detail on an annual basis in accordance with the schedule outlined in DHCS Behavioral Health Information Notice (BHIN) 24-020 and any superseding BHIN.
2. In addition to the NACT, DHS-BHD will submit supporting documentation of its own analysis of the Mental Health Plan (MHP) and DMC Organized Delivery System (DMC-ODS) network adequacy for both children/youth and adults consistent with the requirements of BHIN 24-020 and any superseding BHIN:
    a. Based on this documentation, the State certifies that the Plan has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network;
    b. DHS-BHD will submit monthly 274 provider network data submissions for all DMC-ODS network providers at the Group (Organization), Site, and Provider detail level (rendering service provider) as specified in BHIN 23-042 and any superseding BHIN.
    c. DHS-BHD will submit monthly 274 provider network data submissions that shall include:
        i. Outpatient and psychiatry Specialty Mental Health Services (SMHS) providers that are within the MHP's provider network at the Group (Organization), Site, and Provider detail level (rendering service provider) as specified in BHIN 22-032 and any superseding BHIN;

ii. Inpatient/hospital and residential facility reporting at the Group (Organization) and Site level.

E. Timeliness to Services and Availability Requirements:

1. Outpatient Mental Health Non-Urgent Non-Psychiatric Specialty Mental Health and Outpatient Substance Use Disorder Services: The provider must offer a first service appointment within **10 business days** from request to appointment;

2. Psychiatry appointments: The provider must offer a psychiatry appointment within **15 business days** from the date the client, or a person acting on behalf of the client, requests.

3. Urgent care appointments:

a. For services that do not require prior authorization, **within 48 hours** from the date the client, or a person acting on behalf of the requests;

b. For services that do require prior authorization, **within 96 hours** from the date the client, or a person acting on behalf of the requests;

d. Substance Use Services Opioid Treatment Program: The provider must offer an OTP appointment within **3 business days** from request to appointment;

e. Substance Use Services Residential: The provider must offer a Residential appointment within **10 business days** from request to appointment;

f. Non-Urgent Follow-up Appointments with a Non-Physician: Must be offered with a non-physician within **10 business days** of the prior first service appointment;

g. Out of Network (OON) provider referrals are utilized to provide adequate and timely services for as long as network is unable to meet services in accordance with standards specified in BHIN 24-020 and any superseding BHIN;

h. After-hours calls: Telephone screening services or triage must be available with language capability in all languages spoken by clients of the county, 24 hours per day, 7 days per week, **with waiting time not to exceed 30 minutes**;

i. Failure to meet timeliness and availability standards may result in sanctions and penalties;

j. Timeliness requirements may be extended if the referring or treating provider has determined and noted in the client's record that a longer

waiting time will not have a detrimental impact on the health of the beneficiary;

k. Timely Access Data DHS BHD will utilize TADT, or any other data collection tool specified by DHCS, for MHP and DMC-ODS plan submissions for new beneficiaries as specified in BHIN 24-020 and superseding BHIN.

F. Time and Distance Standards: The MHP and DMC-ODS managed care plans shall maintain a network of providers that are located within the following time or distance standards for the following services listed below:

1. Outpatient Mental Health Services and Psychiatry Services – **Up to 30 miles and 60 minutes** from the beneficiary's place of residence;
2. Outpatient Substance Use Disorder Services – **Up to 30 miles or 60 minutes** from the beneficiary's place of residence;
3. Opioid Treatment Programs - **Up to 30 miles or 60 minutes** from the beneficiary's place of residence.

G. Monitoring Network Providers and Capacity Assessment:

1. DHS-BHD will maintain and monitor a network of appropriate providers that is sufficient to provide clients adequate access to all services covered under the MHP and DMC-ODS, and contracts between Sonoma County and DHCS.
2. DHS-BHD will meet with network providers to review the following:
   a. Performance outcomes;
   b. Number of beneficiaries served;
   c. Units of services provided;
   d. Time and distance requirements;
   e. Timeliness to services requirements;
   f. Productivity and budget analysis.
3. DHS-BHD will conduct formal, periodic performance evaluations of providers. Identified deficiencies or areas of improvement will result in a corrective action plan for providers.
4. Evidence of monitoring network providers will be maintained by DHS-BHD. This evidence will be considered in reviewing DHS-BHD needs for the next contract year.
5. Assessment of Capacity:

a. DHS-BHD will assess the capacity of service delivery for its beneficiaries. This includes monitoring the number, type, and geographic distribution of mental health services within the delivery systems.

b. DHS-BHD will assess the accessibility of services within its service delivery area. This shall include the assessment of responsiveness of the 24-hour toll-free telephone number, timeliness of scheduling routine appointments, timeliness of services for urgent conditions, and access to after-hours care.

H. Minimum Provider Selection and Retention Criteria:

1. The provider and DHS-BHD must comply with selection and retention requirements set forth in DHS-BHD 7.1.3. Provider Network Enrollment, Retention and Referral Criteria;

2. The provider and DHS-BHD must adhere to the credential requirements set forth in DHS-BHD 7.1.1 Provider Credentialing Continuous Monitoring.

I. Single Case Agreements:

1. DHS-BHD facilitates access to needed services by entering into single case agreements with providers not currently part of the provider network. A single case agreement may be used to access a specialty service, to provide improved access in a geographic area (including out-of-county), to respond to client preference, and/or to accommodate services from out-of-network providers. Out-of-network coverage benefits are described in DHS-BHD Medi-Cal Informing Materials provided to all beneficiaries.

2. When the need for a single case agreement is identified, DHS-BHD Program Support staff will send an e-mail to the provider requesting a single case agreement. The e-mail will include a description of the services that DHS-BHD wants to purchase and the associated rates. In order to complete the contract, the individual or organization must:

a. Complete and return a W-9 form;

b. Provide the contractor’s legal name, identify what type of organization/entity they are, provide the name of the person who will sign the contract, and the clinical head of service (name and licensure type);

c. Provide information for the notice section of the contract: contact name, title, the organization’s street address, phone number, and email address;

d. Provide information about the person who will assist in processing the contract including the person's name, email address, and phone number;

e. Provide evidence that the organization is a certified Medi-Cal provider;

f. Provide the applicable National Provider Identifier(s) (NPI).

3. Prior to execution of the contract, DHS-BHD staff will conduct needed background checks including checking the Office of Inspector General excluded provider list, and List of Excluded Individuals/Entities, Medi-Cal Suspended and Ineligible Provider, The System for Award Management and Social Security Death Master File Lists.

4. DHS-BHD Program Support staff will work with the provider to complete the single case agreement.

J. Network Provider Termination: Refer to policy 7.1.3 Provider Network Enrollment, Retention, and Referral Criteria.

K. Alternative Access Standards:

1. In the event that DHS-BHD has exhausted all other reasonable options to obtain providers to meet the applicable time and distance standards and still cannot meet the standards, DHS-BHD shall submit a request for alternative access standards to DHCS. This request must include a description of the reasons justifying the alternative access standards (e.g. seasonal considerations or gaps in the county's geographic service area due to terrain).

a. This request for alternative access standards must be submitted to DHCS by most current Network Adequacy BHIN specified deadline.

b. To request an alternative access standard for time and distance, DHS-BHD must complete Attachment C, Alternative Access Standards Request Template in the NACT submission.

L. Significant Change to Network:

1. DHS BHD shall submit data and documentation to DHCS any time there has been a change in the MHP or DMC-ODS plan operations that would affect the adequacy or capacity of services as defined in BHIN 24-020 and any subsequent superseding BHIN.

2. QAPI to conduct an analysis of the significant change, submit the analysis and the DHCS Significant Change Disclosure Form to DHS Compliance for review and approval prior to submission to DHCS.

M. Telehealth Services: DHS BHD may use the synchronous mode of telehealth services to meet network adequacy standards or as a basis for Alternative Access Standards as specified in BHIN 24-020, meeting telehealth requirements outlined in BHIN 23-018, and in alignment with any superseding BHIN.

N. Non-Discrimination: The DHS-BHD network provider selection will not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

O. Excluded Providers: DHS-BHD will not employ or subcontract with providers excluded from participation in Federal health care programs.

P. Additional State Requirements: DHS-BHD will comply with any additional requirements established by the State Department of Health Care Services.

VI. Forms

None.

VII. Attachments

None.