**Frequently Asked Questions**

The Department of Managed Health Care (DMHC) has prepared frequently asked questions (FAQ) and responses arising from stakeholder comments, and pertinent to the amendments to Rules 1300.51 and 1300.67.2 and Incorporated Documents, including network adequacy requirements and mental health standards and methodology for RY 2024, as noticed in APL 23-023.

1. General FAQ Responses:
2. **Can the DMHC provide more summary tables explaining the applicability of the new standards and methodologies, to enhance clarity and ease of understanding?**

The DMHC has provided several tables within schedules attached to the incorporated mental health standards and methodology documents, to provide examples of the application of the standards and methodology.

Additionally, to help plans better understand the applicability of the new standards and methodology the DMHC is providing summary tables for the following new mental health standards for Reporting Year (RY) 2024: The Mental Health Geographic Access Standards and Methodology and the Counseling Non-Physician Mental Health Professionals Ratio Standards and Methodology. These tables are applicable to RY 2024 only. Please see the tables attached to this APL, entitled: **Mental Health Standards - Summary Tables for RY 2024**.

1. **The DMHC made amendments to Rule 1300.51, Rule 1300.67.2, and incorporated documents. Which of these amendments apply to filings for the purposes of licensure (e.g., new license application, significant network change amendment filings, and service area expansion and withdrawal filings set forth in Rules 1300.51, Items H & I, 1300.52(f), and 1300.52.4(d))?**

See sections III. and IV of APL 23-023 for specific information regarding the applicability of the standards and methodologies to network filings. As set forth in the amended Rule 1300.51 and Rule 1300.67.2, the following amendments are applicable to licensure filings:

* Amendments to Rule 1300.51(d) Item H; and
* Amendments to Rule 1300.67.2, unless specifically excluded. This includes the following:
  1. The definitions set forth in Rule 1300.67.2.2(b), and the Definitions section of the Annual Network Submission Instruction Manual shall apply to the plan’s network filings for the purpose of licensure.
  2. When evaluating a network for geographic accessibility the DMHC shall rely upon the methodology set forth in the document entitled Geographic Access Measurement Methodology, which is incorporated by reference.
  3. Within each network, the plan shall ensure sufficient providers are accepting new patients such as to ensure timely access to care for all enrollees.

The Mental Health Geographic Access Standards and Methodology, the Counseling Non-Physician Mental Health Professional Ratio Standards and Methodology, and the Mental Health Professionals Accepting New Patient Standards and Methodology incorporated in Rule 1300.67.2 specifically describe the review methodology for the Annual Network Review. Nevertheless, the DMHC may consider the mental health network adequacy standards and methodology documents incorporated in Rule 1300.67.2 when determining whether services are readily available and accessible to each of the Plan’s enrollees in its review of licensure filings.

1. **Does the DMHC review networks with no enrollment when reviewing Annual Network Report submissions from plans for compliance with the mental health standards and methodologies?**

If a Reporting Plan maintains a network in which there is no enrollment on the network capture date and the plan does not anticipate enrollment during the reporting year, the reporting plan may request a waiver of the requirement to submit to the DMHC all information set forth in Rule 1300.67.2.2(h)(7) for that network by submitting a Notice of Material Modification filing prior to the network capture date of the reporting year. Details concerning waiver requirements are set forth in DMHC APL 22-026 (November 4, 2022), and in the Annual Network Submission Instruction Manual for Reporting Year 2024.

For the RY 2024 Annual Network Review, the DMHC will review all counties within a plan’s network service area for compliance with the mental health standards and methodologies set forth in the documents released in the enclosed APL and incorporated in Rule 1300.67.2. If a county within a plan’s network service area has zero enrollment on the network capture date, the DMHC will review the county in accordance with the respective standards and methodology documents.

1. Counseling Non-Physician Mental Health Professionals Accepting New Patients FAQ Responses:
2. **When reviewing plans according to the Counseling Non-Physician Mental Health Professionals (Counseling MHPs) Accepting New Patients Standards and Methodology, why does the DMHC evaluate compliance for each county within the network service area, when enrollees travel and work across different counties?**

The accepting new patients compliance threshold for Counseling MHPs is reviewed both at the network level and the county level. This allows the DMHC to review the availability of providers to treat new patients throughout the counties in a plan's designated network.

If the compliance threshold was evaluated only at the network service area level, the DMHC would not be able to assure that enrollees in all portions of the network service area have adequate access. Network providers who are accepting new patients could be clustered in only one county or geographic region of the network service area. This is especially true for networks that operate a statewide network service area, as network providers are more likely to be clustered in the more populous regions, thereby increasing the chance a network could meet the network threshold but not have accessible network providers for patients in more remote counties. By calculating the percentage of network providers accepting new patients at the county level, there is some assurance that the available providers will be within a reasonable distance of all enrollees within the network.

To account for regions within the state where enrollees are likely to travel to adjacent counties to obtain care, the DMHC will apply an alternative review methodology to combine counties meeting certain criteria when evaluating compliance.

1. **When reviewing plans according to the compliance threshold for Counseling MHPs that are accepting new patients, the DMHC reviews according to both a minimum percentage of Counseling MHPs that are accepting new patients (75%), and a minimum percentage of MHP locations that are accepting new patients (80%). How does the DMHC review network and county data under each of these two requirements, and why do the percentages differ?**

Plans must establish that each reported network complies with the compliance threshold, both at the network level and at the county level. To establish compliance at each of these levels, the Plan’s reported data must demonstrate that either at least 75% of Counseling MHPs are accepting new patients within each network and applicable county, or at least 80% of the MHP locations, as defined, are accepting new patients within each network and applicable county.

Plans must meet the higher value of 80% when using the MHP locations threshold to allow for equivalence between the two compliance thresholds. This is because there are more MHP locations that will qualify as accepting new patients than there are individual Counseling MHPs that will qualify as accepting new patients. An MHP location meets the accepting new patients standard when at least 25% of the individual Counseling MHPs at that location are accepting new patients (or at least one Counseling MHP is accepting new patients at a smaller location with three or fewer Counseling MHPs). Thus, there is a greater likelihood that an MHP location has one or more individual Counseling MHPs accepting new patients when the compliance is calculated at the MHP location level.

1. **Will plan networks be able to meet the compliance threshold for Counseling MHPs that are accepting new patients?**

The Counseling Non-Physician Mental Health Professionals Accepting New Patients Standards and Methodology was developed after review of the distribution of providers that contract with managed care in California, including several years of data reported to the DMHC concerning the availability of Counseling MHPs in reported networks. Based on this review, the DMHC anticipates that most networks will be able to meet both the network and county standards for accepting new patients, or the alternative review methodology. However, networks with serious access concerns may face difficulty meeting the standards in one or more counties within the network service area.

1. **Why does the Counseling Non-Physician Mental Health Professionals Accepting New Patients Standards and Methodology allow plans to account for the availability of other providers within an office when determining whether the compliance threshold is met, but the Provider Appointment Availability Survey (PAAS) methodology does not allow plans to account for the next available appointment of other network providers within the surveyed office when determining compliance with the timely access standards?**

The PAAS rate-of-compliance methodology is based on a different statistical model than the MHP location compliance threshold within the Counseling Non-Physician Mental Health Professionals Accepting New Patients Standards and Methodology. Additionally, the two review methodologies measure a plan’s compliance with different network adequacy standards within the Knox-Keene Act.

With the PAAS, the rate of compliance a plan must achieve is established based on the objective that an enrollee must have access to a timely appointment within three attempts (i.e., within three “contacts”). It is essential that the PAAS methodology capture appointment data for only the individual provider being surveyed for the statistical model to apply at the established threshold. If plans could count a provider as having a compliant appointment based on the availability of a different provider within the same office, then the survey results may ultimately reflect more than one contact for each provider surveyed. This would thus impact the statistical assumptions regarding the availability of timely appointments. The MHP location threshold within the standards and methodology does not consider rate of compliance with timely appointment standards. Instead, it measures the total number of MHP locations with network providers accepting new patients that are readily available and accessible to enrollees, to support timely access to care. Therefore, compliance is calculated at the location level and takes into consideration the availability of all network providers at the location.

1. **When reviewing plans according to the Counseling Non-Physician Mental Health Professionals Accepting New Patients Standards and Methodology, how will the alternative review methodology be applied when a plan fails to meet the threshold in a CEAC or Rural County type?**

The alternative review methodology is described in the Counseling Non-Physician Mental Health Professionals Accepting New Patients Standards and Methodology as well as in the accompanying Schedule C. The alternative review methodology establishes the approach the DMHC will take when determining compliance with network adequacy requirements as part of its review obligations as described in Health & Safety Code section 1367.035. If a network meets the criteria described, the DMHC will automatically apply the alternative review methodology when determining compliance with this standard. It is not necessary for a plan to request application of an alternative review methodology for the DMHC to review the plan according to the methodology.

1. **When applying the alternative methodology for combining counties described in the Counseling Non-Physician Mental Health Professionals Accepting New Patients Standards and Methodology, how will the DMHC determine the counties to group, and why is a county only allowed one grouping?**

If a plan’s network fails to meet the compliance threshold for Counseling MHPs accepting new patients under the standard methodology, the DMHC will apply the alternative review methodology for combining counties set forth in Schedule C, when applicable.

When the DMHC groups counties as part of the alternative review methodology, the DMHC examines all possible groupings for any non-compliant CEAC or Rural counties in the network, and the optimal county grouping(s) are chosen from the set of possible groupings. For example, if there are two counties that are adjacent to a non-compliant CEAC or Rural county and compliance can be achieved by grouping with either one of the two compliant counties, then only one county will be combined with the non-compliant county. The DMHC will select the grouping that adds the fewest “MHP locations accepting new patients” from the adjacent county to achieve compliance. Similarly, if there are two deficient CEAC or Rural counties in the network and a grouping of counties could achieve compliance in one, but not both counties (i.e., Grouping A leads to County X passing and County Y failing, and Grouping B leads to County Y passing and County X failing), the county grouping that requires the fewest additional MHP locations will be selected (i.e., if Grouping A leads to County Y needing three additional MHP locations accepting new patients, and Grouping B leads to County X needing one additional MHP location accepting new patients, then Grouping B is selected).

A county may only be included in one county grouping to avoid double counting the providers in that county. If a county could exist in multiple different groupings, then the plan’s network would appear to have more network providers accepting new patients than are actually available in the network. Ultimately, the percentage of Counseling MHPs accepting new patients should reflect the availability of the total number of Counseling MHPs in the network, based on the complete roster of providers submitted for that network in the Annual Network Report.

1. **When applying the alternative review methodology described in the Compliance Threshold for Counseling MHPs, Accepting New Patients, will the DMHC disclose its findings to the plan?**

The DMHC will issue findings to plans based on the Annual Network Report submission. The DMHC will provide plans that do not meet the compliance threshold with information concerning the areas of non-compliance, and if applicable, any alternative review methodology applied to CEAC or Rural counties. Plans will also receive the results of the county groupings for any remaining non-compliant Rural/CEAC counties as part of the Network Findings Report issued to plans on an annual basis. Furthermore, the DMHC will provide a county adjacency file that will allow plans to assess what county groupings are possible. Plans will have the opportunity to respond to the findings and propose corrective action. A plan may propose a different county grouping combination as part of the plan’s response or proposed corrective action, as applicable. However, a new alternative access county grouping may impact other counties within the plan’s network service area that fell within the DMHC’s alternative review methodology for county groupings. The Plan’s corrective action would need to address how a new county grouping would impact all affected counties that are subject to the alternative review standard.

1. Mental Health Geographic Access Standards and Methodology FAQ Responses:
2. **How did the DMHC determine the distance standards for mental health facilities in Micro, Rural, and CEAC counties? Are there facility location limitations for these county classifications, or other specific data to support the longer driving miles?**

The Micro, Rural, and CEAC distance standards for mental health facilities reflect the actual availability of mental health facility locations in these county types, for the facility types subject to review under this standard. The distances for Micro, Rural, and CEAC counties have been reviewed and revised in response to stakeholder feedback. Additional mental health facility types have also been added to the definition of “mental health facility” resulting in greater availability in these county types.

1. **The Mental Health Geographic Access Standards and Methodology uses Medicare Advantage county types to inform the standards (i.e., Large Metro, Metro, Micro, Rural, and CEAC). Unlike the Medicare Advantage geographic access standards, the DMHC subdivides some counties based on ZIP Codes with lower population densities and allows for longer travel distances for enrollees residing in those ZIP Codes. How does the DMHC ensure that people living in the lower density ZIP Codes have reasonable access to care when plans are allowed to require those enrollees to travel a longer distance?**

Within the Mental Health Geographic Access Standards and Methodology, the DMHC will apply an alternative standard for certain county types, when the county contains both densely populated and sparsely populated areas and the distribution of these areas within the county makes a significant difference to the distance an individual would be required to travel to see a provider. The DMHC has developed this alternative distance methodology to account for the fact that there are fewer providers available in the low-density ZIP Codes and to hold plans to an achievable standard that is sufficiently rigorous to ensure enrollees still have reasonable access.

While it is true that the Medicare Advantage distance standards are uniform for each county type, the Medicare Advantage program also has a process for plans to request an exception to the established distance standards when a county’s supply of providers is such that the plan cannot meet the criteria. This approach has also been adopted by other oversight agencies, such as the Department of Health Care Services.

Rather than adopt an exception process, the DMHC developed the alternative distance methodology to address areas that cannot meet the established standards due to the supply of providers. The alternative distance standard allows for the application of alternative distances only for identified low-density ZIP Codes in specified counties. The requirement establishes clear and transparent alternative distance standards that are achievable and are applied only in those scenarios when the known availability of providers makes it extremely unlikely for plans to meet the established criteria.

Furthermore, an individualized exception process where plans must separately request alternative standards could result in inequitable access for enrollees in rural areas across plan networks, as each plan may have an approved alternative distance that varies from its competitors in the same area. Applying a uniform alternative distance methodology allows for equity across plans.

1. **When reviewing plans according to the Mental Health Geographic Access Standards and Methodology, why does the DMHC evaluate distances according to “representative population points” instead of current existing enrollee membership?**

The DMHC requires plans to meet geographic access requirements in the populated areas of a plan’s approved network service area, including places where actual and potential enrollees live and work. Since a plan can continue to market and sell products to enrollees who live and work anywhere within the approved network service area, the plan must therefore maintain an adequate network within the populated areas of its entire network service area. The population points, as defined in Rule 1300.67.2.2(b)(11), are how the DMHC ensures that actual and potential enrollees in a plan’s network service area have adequate geographic access to a plan’s network providers. Further information concerning the DMHC’s use of population points to measure geographic access can be found within the Geographic Access Measurement Methodology, incorporated in Rule 1300.67.2.

1. **When reviewing plans according to the Mental Health Geographic Access Standards and Methodology, ninety percent (90%) of the county population in a network must have access to a network provider within the distance standard defined for the county, as measured by population points. Can this threshold percentage be lowered for Rural and CEAC counties and low-density ZIP Codes in Metro counties?**

The DMHC accounts for access challenges in the Rural and CEAC counties by establishing a longer distance standard that is representative of the actual locations of providers and the population within those counties. A plan offering reasonable access to care should be able to meet these distances for 90% of the population points within these county types.

Similarly, some ZIP Codes within a county may be more rural or sparsely populated in nature when compared to other areas within the county. To accommodate this diversity, the DMHC will evaluate designated low-density ZIP Codes against an alternative distance standard, when applicable. The DMHC believes that this accommodation is sufficient to ensure enrollees in more rural areas of the county have adequate access to care while also being cognizant of the available supply of providers in those areas.

Some networks, particularly in CEAC, Rural, and Micro counties, will need to contract with mental health facilities in neighboring counties in order to meet the distance standard for the network county.

1. **When reviewing plans according to the Mental Health Geographic Access Standards and Methodology, can counties be grouped with adjacent counties to meet an alternative standard?**

The distance standards for mental health facilities and counseling non-physician mental health professionals (Counseling MHPs) set forth in the Mental Health Geographic Access Standards and Methodology do not allow for county groupings to meet alternative geographic access standards. Instead, the alternative standards are based on alternative distances for low-supply counties (for mental health facilities) and alternative distances for low-density ZIP Codes in Metro and/or Large Metro counties, as applicable. These alternative standards are set forth in the standards and methodology document. Please note that when measuring access for a population point within the county, the nearest network provider may have a practice location in a neighboring county. In such circumstances, when measuring geographic access for a particular county, the distance between that county’s population point and the nearest network provider will be based on the distance to the closest network provider, regardless of whether that network provider is located inside or outside of the county.

1. **With respect to the distance standards for Counseling MHPs and mental health facilities, can the DMHC increase the driving distances in recognition of the distinct characteristics of the various county type designations, in Large Metro, Metro, Micro, Rural, and CEAC county types? As currently listed, there is no distinction between Micro and Rural counties.**

The driving distances established for Counseling MHPs and mental health facilities are based on actual availability of providers and the total population within each of the county types. To the extent there is no difference in the distance standard between certain county types, this reflects the fact that the number and distribution of providers is not so significant as to impact the overall driving distance for enrollment in each of those county types. In some cases, while the driving distance standard may be the same across county types, there may be an alternative standard that is applicable to one specific county type to account for the unique factors impacting provider availability and population. For example, while Micro and Rural counties may have the same distance standard, Rural counties have an alternative standard that does not apply to Micro counties.

1. **With respect to the distance standards for Counseling MHPs, why are alternative distance standards for low-density ZIP Codes only available for Metro county types, and not all county types?**

The DMHC has established an alternative distance standard for Counseling MHPs for Metro counties because these county types have more significant differences in population and provider supply distribution throughout the county than other county types. Put another way, Metro counties have both very densely populated areas and very sparsely populated areas within the county borders—more so than any other county type. The providers are similarly grouped in the more densely populated areas, resulting in longer distances to access Counseling MHPs for individuals residing in more sparsely populated areas. These extreme differences in geographic population distribution therefore necessitated an alternative distance standard for Counseling MHPs.

1. **With respect to the distance standards for mental health facilities, why is the alternative standard for low-supply counties based on bed capacity, rather than bed occupancy?**

The alternative county standard for low supply counties is based on available mental health facility beds in the county because that data point illustrates the actual supply of inpatient mental health services in the county. “Available beds,” as reported in the data available through the Department of Health Care Access and Information (HCAI) and the Department of Health Care Services (DHCS), reflects the fixed supply of inpatient mental health services available at facilities in each county. In contrast, the bed occupancy rate is a measurement of bed utilization at one point in time and is subject to change throughout the year.

1. **In the Mental Health Geographic Access Standards and Methodology, the DMHC defines “Low-Density ZIP Codes” and “Normal-Density ZIP Codes.” Will the DMHC issue ZIP Code density types in future publications of the “California ZIP Code and County Combinations and Population Points” document?**

The DMHC confirms that future publications of “California ZIP Code and County Combinations and Population Points” will identify low density ZIP Codes.

1. **If a plan does not meet a distance standard set forth in the Mental Health Geographic Access Standards and Methodology, how may the plan monitor for compliance with the alternative standard, which is based on low density ZIP Codes?**

The alternative distance standards for low-density ZIP Codes provide the approach the DMHC will take when determining compliance with network adequacy requirements as part of its review obligations as described in Health and Safety Code section 1367.035. It is not necessary for a plan to fully operationalize monitoring for an alternative distance standard prior to RY 2024 in order for the DMHC to apply the alternative standard. If the DMHC determines a plan does not meet the geographic access standard or alternative standard based on the RY 2024 Annual Network Report submission, the plan will be informed of the findings and may be required to submit a corrective action plan or otherwise demonstrate that its network has mental health network providers in sufficient numbers and locations to ensure accessibility of services as required under the Knox-Keene Act and implementing regulations. Beginning in RY 2025, the DMHC may rely on this standard as a basis for carrying out and completing enforcement action.

The DMHC’s Mental Health Geographic Access Standards and Methodology, along with the incorporated Schedules, should provide plans with sufficient detail regarding how the DMHC is determining compliance to allow plans to develop methods to monitor areas of non-compliance and implement corrections for future reporting years. The DMHC will also include information regarding low-density ZIP Codes in its “California ZIP Code and County Combinations and Population Points” document to further assist plans in monitoring compliance with the established methodology.

1. Geographic Access Measurement Methodology FAQ Responses:
2. **With respect to the Geographic Access Measurement Methodology which is incorporated by reference in Rule 1300.67.2, can the DMHC provide additional information regarding the specific parameters and settings for the GIS software utilized, to allow for plans to mimic the DMHC’s geographic access calculations in internal monitoring?**

The Geographic Access Measurement Methodology sets forth the parameters the DMHC shall use when determining plan compliance with geographic accessibility standards and the software requirements for review. Plans should follow the description set forth therein to align with the DMHC’s methodology. The methodology does not prescribe a specific software program to conduct this review. Specific settings cannot be provided at this time because settings that are specific to one program may not be applicable to another program. The DMHC will share its results with plans if it identifies areas of non-compliance.

1. **Will the DMHC provide its geographic access measurements to plans?**

The DMHC provides plans with non-compliance findings arising out of the Annual Network Review on an annual basis. These findings will continue to include the DMHC's geographic access distances calculated under the review methodology. With respect to licensure filings, the DMHC will continue to review plans under existing geographic access standards, using the Geographic Access Measurement Methodology.

The DMHC releases all representative population points, including their geolocation, for all ZIP Code/county combinations in the state of California through the “California ZIP Code and County Combinations and Population Points” document that is published on the Resources page of the Timely Access and Annual Network Reporting Web Portal. These population points are provided for plans to use in their own monitoring of compliance in accordance with the methodology.

1. **Does the DMHC’s geographic access review using population points align with the DHCS?**

The DMHC coordinates with the Department of Health Care Services to provide maximum consistency in the review process. In general, both Departments have arranged to draw from the same set of population points when evaluating geographic access. There may be some variation in the population points used for distance measurements due to inconsistency in the timing of the review or the methodology for review based on program differences or differences in governing laws and regulation.

1. **With respect to the Geographic Access Measurement Methodology, how does the DMHC review ZIP Codes and Counties (CountyZIPs) that have no geography (such as P.O. Boxes)?**

The DMHC includes “single point” CountyZIPs, such as PO Box and firm ZIP Codes as single population points within the “California ZIP Code and County Combinations and Population Points” document distributed annually to plans pursuant to Rule 1300.67.2.2. Each single point CountyZIP has latitude and longitude coordinates and a population value based on United States Postal Service delivery statistics. Driving distances and expected driving times for single point CountyZIPs are measured in the same way other population points, as described in the Geographic Access Measurement Methodology.

1. **With respect to the Geographic Access Measurement Methodology, what is the process for validation of the CountyZIP list, and what course of action can be taken to correct issues?**

The DMHC compiles and releases the “California ZIP Code and County Combinations and Population Points” annually pursuant to Rule 1300.67.2.2. The ZIP Code/County combinations are derived from the list of all ZIP Code and county combinations in the state as published by the United States Postal Service. A plan that believes there is an error on the list is invited to contact the DMHC via the ANR Inbox (ANRTeam@DMHC.CA.GOV) and provide further information. In general, as stated in the Geographic Access Measurement Methodology, the DMHC’s list of ZIP Code/county combinations included in the “California ZIP Code and County Combinations and Population Points” document is considered the complete list of ZIP Codes published by the DMHC pursuant to Rule 1300.67.2.2(b)(11) and will be used when defining network service areas and measuring network adequacy for the relevant year, pursuant to Rule 1300.67.2.2(b)(6).

1. **Does the DMHC measure according to distance and driving time, or just distance? Some government programs measure both distance and driving time.**

Where the DMHC standard includes the option for a measurement based on driving time (for example, geographic access standards for PCPs and hospitals) plans may refer to the methodology described in the Geographic Access Measurement Methodology for instruction as to the methodology the DMHC will apply when measuring drive time.

Where the DMHC standard does not include a drive time standard (for example, geographic access standards for mental health professionals and mental health facilities), compliance will not be established via driving time, and the “expected driving time” methodology is not applicable. The Mental Health Geographic Access Standards and Methodology measures driving distance to promote consistency across plans and driving conditions.

The DMHC has not adopted the geographic access standards established by another state or federal agency. The DMHC coordinates with the Department of Health Care Services to provide maximum consistency in the geographic access review process. However, there may be some inconsistency in the methodology for review based on program requirements and differences in governing laws and regulations.

1. **The Geographic Access Measurement Methodology indicates that when the counties and ZIP Codes within a plan’s approved network service area are not reflected on the DMHC’s standardized list because they are outdated or otherwise not comparable, the DMHC may require plans to reconcile the CountyZIPs listed in the network service area on file with the DMHC through a filing pursuant to Health and Safety Code section 1352. When will a plan be notified and how long will the plan have before it must file?**

Pursuant to DMHC APL 23-005, “Network Service Area Confirmation Process” (February 13, 2023), reporting plans have been provided an opportunity to update their network service areas consistent with the definition of Network Service Area and to conform to the ZIP Code and County list published by the DMHC, as a result of the recent amendments to Rule 1300.67.2.2. A similar process will be established for profile-only plans at a later date. In future reporting years, the DMHC will inform plans of ZIP Code and County changes implemented by USPS. Plans are responsible for reviewing changes to the ZIP Code and County list published by the DMHC and ensuring the description of the plan’s network service area(s) on file with the DMHC is current.

1. **The Geographic Access Measurement Methodology indicates that plans may be required to re-file a past request for alternative standards of accessibility for PCPs and hospitals if the plan no longer meets the previous alternative standard when measured according to the DMHC’s standardized lists for ZIP Codes, counties, and population points. How will plans be notified if they have to re-file for alternative standards of accessibility?**

The DMHC evaluates reporting plans for geographic access to PCPs and hospitals as part of the Annual Network Review and evaluates a plan’s existing alternative access standards as part of this review. For plans subject to annual network reporting, the DMHC will identify whether a plan’s existing alternative access standards are inadequate using the standardized ZIP Code, County, and Population Points as set forth in Rule 1300.67.2.2 (as amended). Plans will then have an opportunity to file for updated alternative access standards to address any compliance concerns the plan has not already identified through internal network monitoring.

1. Counseling Non-Physician Mental Health Professional Ratio Standards and Methodology FAQ Responses:
2. **What is the DMHC’s rationale for setting a ratio of 1 FTE Counseling MHP to 1000 enrollees? Is this ratio achievable for plans in California given the availability of providers within the state?**

The 1:1000 ratio was set as the appropriate threshold based on a review of research related to mental health workforce trends, mental health utilization, and data submitted to the DMHC related to the number of mental health providers available from all plans, the location of those providers, and the number and location of enrollees throughout the state. The DMHC engaged statistical consultation to derive a ratio that adequately reflects the need for mental health services in the state and the actual availability of Counseling MHPs within the state. To address concerns about provider availability in certain regions within the state and other factors that impact the way patients access care, the DMHC has incorporated adjustments that can be applied to the full-time equivalency of network providers. Based on an analysis of annual network submissions from past years, the DMHC has a high degree of confidence that the 1:1000 ratio is achievable for plan networks, either currently or with reasonable corrective action.

1. **When the DMHC reviews plan networks according to the Counseling Non-Physician MHP Ratio Standards and Methodology for RY 2024, how will the DMHC apply the ratios and alternative standards, including for high enrollment counties, exclusive providers and combined counties? Will the DMHC factor in any other plan data or just use data from the plan that reported the data?**

The review methodology set forth in the Counseling Non-Physician MHP Ratio Standards and Methodology reflects the methodology the DMHC will apply when evaluating networks submitted as part of the Annual Network Report submission for compliance with the Knox-Keene Act, as required pursuant to Section 1367.035(d). Plans will not be required to apply this methodology independently until future years. The DMHC will apply any ratio modifiers or alternative methodologies that may be applicable when undertaking its evaluation of the network and will issue findings to plans when the established ratio for counseling non-physician mental health professionals is not met after undergoing this analysis. It is not necessary for a plan to request application of an alternative review methodology in order for it to be applied by the DMHC. In future years, when plans will be required to conduct this analysis independently, the DMHC will issue tools to assist plans in assigning the appropriate value to providers.

Plans will continue to be obligated to submit their complete networks for review in the Annual Network Report submission. To the extent plans choose to take steps to prepare for the DMHC’s network adequacy analysis, they are put on notice the methodology contained within the Counseling Non-Physician MHP Ratio Standards and Methodology is the method by which the DMHC will evaluate their networks for compliance.

The DMHC will rely on the data submitted by the plan in the Annual Network Report for its evaluation of Counseling MHP network capacity. The DMHC will issue findings to plans that do not meet the standards or alternative standards set forth in the Counseling Non-Physician Mental Health Professional Ratio Standards and Methodology, arising out of the Annual Network Review.

1. **When measuring full-time equivalent or “FTE” as part of the DMHC’s Counseling Non-Physician Mental Health Professional Ratio Standards and Methodology, does the FTE starting value methodology consider provider participation in other reported networks?**

Yes. The FTE starting value methodology assigns an FTE value to all reported counseling non-physician mental health professionals (Counseling MHPs) in a network based on factors relevant to all reported networks, including whether the reported network provider is full-time or part-time; whether the reported network provider practices in one county or multiple counties; and the typical number of networks a Counseling MHP contracts with by county type.

1. **When the DMHC reviews plan networks according to the Counseling MHP Ratio Standards and Methodology for RY 2024, how do plans verify the FTE starting values and FTE starting value adjustments are applied to each applicable network provider?**

When conducting the network adequacy review for the RY 2024 Annual Network Review, the DMHC will assign FTE starting values and FTE starting value adjustments according to the Counseling Non-Physician Mental Health Professional Ratio Standards and Methodology, and the accompanying Appendix A. The calculations for these adjustments and examples are set forth in Appendix A. The DMHC will issue findings to plans that do not meet the standards or alternative standards set forth in the methodology, arising out of the reporting year (RY) Annual Network Review. Those findings will include the results of the DMHC’s analysis. If a plan receives a finding in this area, they are encouraged to apply the Counseling MHP Ratio methodology to their data and compare their results against the DMHC’s findings. Plans may further indicate in their response to the Network Findings Report if they believe a different outcome was warranted under the methodology.

1. **When measuring full-time equivalent or “FTE” as part of the DMHC’s Counseling MHP Ratio Standards and Methodology, does the FTE methodology consider provider participation in all networks across all markets, including those that are not licensed under the Knox-Keene Act?**

The Counseling MHP FTE ratio of 1:1000 is intended to take into consideration the need for mental health services in California and the likely demand on network providers from other plan networks as well as demand from sources outside of Knox-Keene Act licensure. However, when measuring the starting value FTE, the DMHC primarily relies on provider availability information reported to the DMHC. The FTE starting value and starting value adjustments are based on the typical number of licensed plans and networks a Counseling MHP contracts with, by county type, based on network data reported to the DMHC. This calculation takes into account the total number of networks across all of the different plans with which a network provider is likely to be contracted in that county type.

The alternative methodologies that modify a network provider’s FTE, when applicable, do consider provider participation across all markets. The DMHC does not collect information regarding which providers have private pay patients or participate in Medicare or other fee-for-service or self-funded products. However, when an alternative methodology is applied to a network provider that modifies the provider’s original FTE starting value with adjustments, the application of the alternative methodology cannot generate an FTE value for the provider that exceeds 0.8. This is to account for the other populations the provider may serve that do not fall within the Annual Network Review, including Medicare populations, private pay patients, or enrollees of other product lines that are exempt from Knox-Keene Act licensure or annual reporting.

Additionally, the alternative standard that modifies a network provider’s FTE for high enrollment counties takes into consideration the total population in the county, including population not enrolled in a Knox-Keene Act licensed plan or subject to annual reporting. Please see Schedule A-3 of the standards and methodology for further information.

1. **When reviewing network adequacy according to the DMHC’s Counseling Non-Physician Mental Health Professional Ratio Standards and Methodology, why are there alternative methodologies for determining full-time equivalent (FTE) when a plan does not meet the ratio standard, rather than requiring the plan to meet the standard as established, including contracting with more providers, and requiring the plan to provide justification for why it cannot meet the standard?**

The FTE ratio standard of 1 FTE Counseling MHP per 1000 enrollees accounts for the current need for mental health services among enrollees in California, including unmet need, according to the relevant research published on the subject.

The alternative methodologies do not alter the 1 FTE:1000 enrollees requirement. As set forth in the methodology document, there may be other factors present in a plan network that impact the FTE availability of one or more providers within the network. The alternative ratio modifiers account for these additional factors. The DMHC is required to conduct an additional review using the alternative methodologies when certain factors are present in a plan’s network impacting provider capacity, including the existence of exclusive provider contracts, the distribution and availability of providers in the county and neighboring counties, and the percentage of the population the network serves within the county. These factors also reflect the pattern of practice in the impacted counties.

The DMHC will continue to examine application of the alternative review factors impacting provider ratios and FTE, to ensure that plans are incentivized to contract with available and accessible Counseling MHPs throughout the network service area.

1. **Can a plan meet the Counseling MHP ratio standards through network providers that practice outside of the network service area?**

The Counseling Non-Physician Mental Health Professional Ratio Standards and Methodology requires plans to meet the 1 FTE:1000 enrollees ratio standard at *both* the network level and the county level.

When calculating the FTE ratio at the network level (the ratio of FTE Counseling MHPs to enrollees for the entire licensed network), the methodology allows for the inclusion of network providers who practice outside of the network service area. Network providers are not required to be inside the network service area in order to be considered for the purposes of network adequacy. (See Rule 1300.67.2.2(b)(10): “a network provider means any provider… located inside or outside of the network service area of a designated network.”)

In contrast, when calculating the FTE ratio at the county level, the methodology allows for the inclusion only of network providers available in the county. The county ratio standard is designed to evaluate capacity within each network service area county. Additionally, the alternative ratio methodologies do not include network providers outside of the network service area, except for the combined county ratio modifier, when applicable. For the combined county ratio modifier, network providers outside of the network service area may be included in the FTE calculation but they must be located in an applicable adjacent county, according to the methodology.

1. **The alternative methodology for high enrollment counties allows a plan to assign a larger FTE value to its providers if the plan has more than 1% of the county population enrolled in its network. This would seem to lower the number of individual network providers that network would need to make available in that county in order to meet the 1:1000 ratio. Will this mean that enrollees in these high enrollment counties will have fewer Counseling MHPs available to treat them and impact their access to care?**

According to existing law, a provider’s FTE value in the calculation of provider ratios should be based on that provider’s actual availability to enrollees within the network being measured. (See Rule 1300.51(I)(1) & (4).) The FTE methodology set forth in the Counseling Non-Physician Mental Health Professional Ratio Standards and Methodology is intended to simulate the actual percentage of time a provider is available to a particular plan’s network enrollees. The FTE modifier for high enrollment counties allocates a higher FTE to network providers in a high enrollment county to account for the expectation that a larger share of a network provider’s time will be devoted to enrollees in networks with high levels of enrollment in the county. Based on a review of available data, most reported networks enroll a small share of a county population, typically around 0.07%. Only 15% of previously reported county networks enroll more than 1% of the county population.

In those scenarios where the FTE modifier for high enrollment counties is applicable, the individual FTE values of the providers will still be allotted a fractional value that is below 1 FTE. When an alternative methodology is applied to a network provider that modifies the provider’s original FTE starting value with adjustments, the application of the alternative methodology cannot generate an FTE value for the provider that exceeds 0.8. This is to account for the other populations the provider may serve that do not fall within the Annual Network Review, including Medicare populations, private pay patients, or enrollees of other product lines that are exempt from Knox-Keene Act licensure or annual reporting.

While a higher FTE value allocated to providers in a particular network could mean that it will take fewer providers to meet the ratio standard, the application of the FTE modifier better represents the actual number of FTE providers who may be available to treat these enrollees.

1. **In order for the DMHC to apply the Combined County Modifier to Large Metro, Metro, and Micro counties, why do plans only need to contract with 30% of the available licensed Counseling MHPs?**

The ratio standard of 1 FTE Counseling MHP per 1000 enrollees accounts for the current need for mental health services among enrollees in California, including unmet need. The ratio and FTE starting value methodology provides a fixed approach to the ratio standard and methodology. The DMHC conducts an additional review using alternative methodologies when factors are present in a plan’s network impacting provider capacity. For example, due to regional variation in supply of Counseling MHPs throughout California, the pattern of practice may be to travel to a neighboring county for care, particularly in rural areas. The alternative methodology allows adjacent counties to be combined for purposes of meeting the FTE ratio standard in Rural and CEAC counties.

However, in more populous county types such as Large Metro, Metro, and Micro counties, the alternative methodology requires the network to be contracting with a significant percentage of Counseling MHPs in the county (greater than 30% of the available licensed providers in California in the Department of Consumer Affairs database) before the DMHC will review the county under a combined county alternative standard. To determine the appropriate percentage of licensed providers contracting with a plan for the purposes of this threshold, the DMHC reviewed annual network submissions from past years to evaluate the typical percentage of licensed Counseling MHPs in the county included in each reported network, and how each network fared in the mental health network adequacy review. Based on that review, the DMHC determined that networks operating in Large Metro, Metro, and Micro counties that contract with at least 30% of licensed Counseling MHPs demonstrated reasonable access to mental health services in the DMHC’s Annual Network Review. Based on the number of networks that were able to contract with at least 30% of licensed Counseling MHPs, and their success in demonstrating reasonable access to mental health services, this threshold appeared to be achievable and represented reasonable contracting efforts.

Additionally, often a large percentage of licensed Counseling MHPs in a county are not contracted with managed care for various reasons, including choosing to only accept private pay clients, contracting only with Medi-Cal or Medicare, or contracting with plans that are not regulated by the DMHC.

The DMHC will continue to examine the alternative review methodology, to ensure that plans are incentivized to contract with available and accessible Counseling MHPs throughout the network service area.

1. **Why does the Counseling Non-Physician Mental Health Professional Ratio Standards and Methodology assign a minimum enrollment count to a county within the network service area, when a plan has little or no enrollment in the county?**

Once a plan is licensed and becomes operational, it is authorized to sell its product anywhere within the geographic bounds of its network service area. As a result, the DMHC must be continually assured that the plan can provide adequate access to services wherever population may exist within its approved network service area, as the plan may at any time sell a health care product to an enrollee anywhere within the approved service area. To ensure that networks have sufficient capacity to meet enrollee needs if the network were to add enrollment in these portions of the network service area, minimum enrollment levels are assigned by county types. These values are well below the typical enrollment levels of a product line or network. The DMHC has revised the minimum enrollment counts assigned to 25 enrollees for CEAC counties, and 50 enrollees for Rural, Metro, and Micro counties. The enrollment values assigned are intended to be nominal to require the minimal levels of network adequacy within the entire network service area.

Plans that have no enrollment in the entire network or will have no enrollment on the network capture date may apply in advance for a waiver from the Annual Network Report submission for the reporting year. Please see the RY 2024 Annual Network Submission Instruction Manual, incorporated in Rule 1300.67.2.2, for details. This information is also available in APL 22-026.

1. **When the DMHC reviews plan networks according to the Counseling MHP Ratio Standards and Methodology for RY 2024, why does the methodology reduce the FTE value of a network provider that provides only telehealth services (and no in-person services)?**

A telehealth-only provider is counted as a full “FTE” provider, unlike in-person network providers which are assigned a fractional FTE value. However, under the methodology, telehealth-only network providers cannot exceed 20% of the total FTE of network providers used to calculate the provider-to-enrollee ratios. The limitation on the telehealth ratio modifier reflects the need for network providers that can provide in-person mental health services when medically necessary, within counties throughout the network service area. It also avoids placing an undue burden on network providers that are providing medically necessary in-person mental health services that cannot be addressed via telehealth modalities. Schedule A-1 details how the Telehealth Ratio Modifier is applied.

1. **When the DMHC reviews networks for compliance with the Counseling MHP Ratio Standards and Methodology, how does the DMHC apply the FTE Modifier for exclusive providers (EPs) to multiple networks?**

Within the Counseling MHP Ratio Standards and Methodology, when reviewing an individual network provider’s FTE under the alternative access standard for EPs, the DMHC evaluates whether the provider is a network provider for only one reporting plan, for the reporting year. This reflects an EP contracting arrangement with a plan, and the alternative EP standard will apply to the network provider for which there is an exclusive contract. If the plan has more than one network in a county, the EP’s FTE value will account for the total number of networks the provider serves for that plan in the county being measured.

1. **When the DMHC applies the combined county ratio modifier as part of its review according to the Counseling Non-Physician MHP Ratio Standards and Methodology, why is a county unable to be grouped more than once?**

For the combined county ratio modifier in the Counseling Non-Physician MHP Ratio Standards and Methodology, a county may only be included in one county grouping because otherwise the county would be double counted, and the plan network would appear to have more FTE providers than are available in the network. The Counseling MHP ratio should reflect the total number of FTE Counseling MHP providers and the total number of enrollees in the county or network, based on the complete roster of network providers and enrollment data submitted for the county and the network in the Annual Network Report.

1. **Within the Counseling Non-Physician MHP Ratio Standards and Methodology, how does the exclusive provider (EP) modifier apply when a plan’s network includes both EP and subcontracted network providers?**

The EP modifier will only apply to network providers that meet the definition of exclusive provider in the methodology. This modifier will not apply to network providers that do not meet the definition of exclusive provider. The DMHC will rely upon the Annual Network Report submissions by all reporting plans to determine which providers are EPs.