



Access to Medi-Cal Specialty Mental Health Services: Network Adequacy Requirements and Other Beneficiary Rights

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INTRODUCTION

Medi-Cal covers Specialty Mental Health Services (SMHS) for beneficiaries who need them.¹ SMHS are mental health services that are administered through County Mental Health Plans (MHPs) under the authority of a Section 1915(b) waiver.² Currently, Medi-Cal covered SMHS include a variety of mental health services, ranging from crisis services, rehabilitation services, medication support, to case management services, peer support services, and more.³ Medi-Cal beneficiaries under the age of 21 are entitled to additional services under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit of the Medicaid Act (now also known as “Medi-Cal for Kids & Teens” in California).⁴ In addition to the SMHS that are available to Medi-Cal beneficiaries of all ages, beneficiaries under 21 are also entitled to intensive care coordination, intensive home based services, therapeutic foster care, and therapeutic behavioral services.⁵ The Department of Health Care Services (DHCS) contracts with county-operated MHPs to provide SMHS to Medi-Cal beneficiaries of all ages.⁶ Each county has one MHP that provides SMHS to all Medi-Cal beneficiaries who reside in the county.⁷

This issue brief analyzes the legal requirements that require MHPs to ensure Medi-Cal beneficiaries’ access to SMHS and maintain adequate provider networks. It also discusses the different types of enforcement and monitoring tools to hold MHPs accountable.⁸

LEGAL REQUIREMENT AND CONSUMER RIGHTS

Network Adequacy

All MHPs are required to provide or arrange for the provision of SMHS to all eligible beneficiaries in their counties. Federal Medicaid laws require states to develop and enforce

qualitative network adequacy standards for health plans' provision of mental health services.⁹ California also has additional guardrails in place to ensure all eligible Medi-Cal beneficiaries' access to SMHS.¹⁰ MHPs are required to comply with all federal and state network adequacy requirements, which we will discuss below.

Timely Access Standards

Federal laws require all contracted health plans to make covered services available and accessible to enrollees in a timely manner.¹¹ In California, all health plans, including MHPs, must comply with state-established Timely Access Standards.¹² MHPs must make SMHS available 24 hours a day, seven days a week.¹³ Urgent appointments must be provided within 48 hours or, if prior authorization is required, within 96 hours.¹⁴ For non-urgent appointments, MHPs must provide beneficiaries: (i) a non-urgent psychiatric appointment within 15 business days of the request for an appointment; (ii) a non-urgent non-physician mental health appointment within 10 business days of the request for an appointment; and (iii) a non-urgent non-physician mental health follow up appointment within 10 business days of the prior appointment.¹⁵

Time or Distance Standards

To ensure that beneficiaries eligible for SMHS have geographic access to the services they need, DHCS requires all MHPs to meet the Time or Distance Standards.¹⁶ Under the Time or Distance Standards, each MHP must have a minimum number of in-network mental health service providers located within a geographical area. The specific time or distance requirements vary by counties based on county size and population.¹⁷ For example, beneficiaries in large urban counties (e.g. Los Angeles and Alameda) must have access to outpatient SMHS providers within 15 miles and 30 minutes from their place of residence, while beneficiaries in rural counties (e.g. Imperial and Alpine) must have access to outpatient SMHS providers within 60 miles and 90 minutes from their place of residence.¹⁸

If a MHP cannot meet the Time or Distance Standards for all coverage areas, the MHP shall submit an Alternative Access Standards (AAS) request to DHCS.¹⁹ An AAS request must include a description of the reasons justifying the request based on the facts and circumstances surrounding a ZIP Code or Provider type, description on how the plan would arrange a specific service type for Medi-Cal beneficiaries who reside in that coverage area, as well as an explanation about gaps in the county's geographic service area, if applicable.²⁰ DHCS may grant the AAS request, if it deems that the MHP has exhausted all other reasonable options to obtain providers to meet the applicable standard or that the MHP has demonstrated a delivery

structure that is capable of delivering the appropriate level of care and access.²¹ AAS requests approved by DHCS are posted on DHCS's website each certification year.²²

Provider Ratio Requirements

Federal regulations require all MHPs to maintain a provider network that is sufficient in number and types of providers that can provide SMHS to beneficiaries of all ages.²³ Federal regulations also require that all MHPs have sufficient Indian Health Care Providers (IHCPs) in their provider network.²⁴ To ensure that MHPs can adequately provide SMHS to all eligible beneficiaries, DHCS has developed a statewide provider-to-beneficiary ratio requirement.²⁵ Each MHP must meet the minimum provider-to-beneficiary ratio and proportionately adjust the number of providers to support any anticipated changes in enrollment and utilization of SMHS.²⁶ MHPs are allowed to utilize telehealth-only providers to meet the ratio requirement but must provide on-site providers for 90% of the beneficiaries per zip code.²⁷ For example, if 100 beneficiaries reside in a specific zip code, MHPs must ensure that 90 of those beneficiaries have access to at least one provider who can provide the same service in-person.²⁸ Also, MHPs cannot require a beneficiary to access services via telehealth if the beneficiary prefers to receive care in-person, and it must inform the beneficiary of the availability of transportation services. Additionally, MHPs must provide needed transportation assistance for in-person visits.²⁹

Access to Out-of-Network Providers

MHPs must have an adequate network of providers who may provide SMHS to eligible beneficiaries. If a MHP does not have an in-network provider who can provide beneficiaries SMHS that meets the Timely Access and the Time or Distance Standards, it must permit and refer the beneficiary to an out-of-network provider that can meet all of the standards.³⁰ MHPs may request to use an out-of-network provider through submitting an AAS request.³¹ In the AAS request, MHPs must detail the name of the two nearest identified out-of-network providers, the date the MHP contacted the providers to discuss contracting with the MHP, and the number of contracting attempts the MHP made.³² If an out-of-network provider is not available within the Time or Distance Standards, the MHP must arrange for a telehealth visit or transportation to an in-person visit to an appropriate provider for the beneficiary.³³ MHPs that cannot meet network adequacy standards without a pre-approved AAS are required to comply with a Corrective Action Plan.³⁴

Provider Directory Requirement

Federal laws require each MHP to make its provider directory available to potential and current enrollees, either in paper or electronic form.³⁵ MHPs must include behavioral health providers in its directory and the provider directory must include: the provider's name, group affiliation, street address, telephone number, website link (if applicable), specialty (if applicable), whether the provider will accept new enrollees, the provider's cultural and linguistic capabilities, and whether the provider's office can provide accommodations to people with physical disabilities.³⁶ DHCS also requires MHPs to include in its provider directory each provider's type of practitioner, national provider identification number, California license number, and an indication of whether the provider has completed cultural competence training.³⁷

To ensure that beneficiaries can select the providers who can meet their needs and access SMHS timely, MHPs are required to update their provider network directories regularly.³⁸ Provider directory in paper form must be updated at least monthly (or quarterly, if the MHP has an electronic provider directory).³⁹ Provider directory in electronic format must be updated no later than 30 calendar days after the MHP receives updated provider information.⁴⁰ MHP must make its provider directory available on its website in a format that is easily understood and readily accessible.⁴¹ The provider directory also must be made available in the prevalent non-English languages in the MHP's county.⁴²

Network Certification Requirements

MHPs are required to submit documentation to DHCS to demonstrate its compliance with the state's network adequacy requirements annually.⁴³ MHPs also have responsibility to ensure that all of their subcontractors are certified to meet the state's standards.⁴⁴ Upon review of the documentation plans submitted and information from multiple sources, DHCS certifies the network of each MHP and submits assurances of adequacy to the Centers for Medicare and Medicaid Services (CMS), the federal Medicaid agency.

DHCS monitors MHPs' compliance with network adequacy standards on an ongoing basis and post network adequacy documentation (including any approved AAS and CAP reports) for each MHP on its website annually.⁴⁵ If DHCS determines that a MHP is out of compliance with any of the network adequacy requirements, it issues the MHP a written report that include a list of findings with description of each finding, a description of corrective action(s) needed, and the timeframes that the MHP must comply with to correct the areas of non-compliance.⁴⁶ MHPs must submit a Plan of Correction (POC) to address all non-compliance items to DHCS within 60 days of the MHP's receipt of the CAP.⁴⁷ DHCS also requires MHPs to report any significant change in the MHP's ability to comply with the network adequacy standards within 10 business days.⁴⁸

Continuity of Care

MHP beneficiaries have a right to the continuity of care for their SMHS when the beneficiary moves to another county.⁴⁹ Within seven business days of receiving the change of county of residence notification from a beneficiary, the county who receives the notification (either the county from which the beneficiary moved from or the county that the beneficiary is moving to) has the responsibility to initiate an inter-county transfer process.⁵⁰ During the time of transfer process, counties must ensure that the beneficiary experiences no benefit lapse and no service interruption.⁵¹

In addition, beneficiaries have the right to continue care when their condition changes, and to coordinated care. In Medi-Cal, while MHPs provide SMHS, Medi-Cal managed care plans (MCPs) provide NSMHS (e.g. individual, group, and family psychotherapy, psychological testing, psychiatric consultation, and outpatient medication support), emergency room professional services, substance use disorder services, and physical health services.⁵² MHPs are required to enter into a Memorandum of Understanding (MOU) with any MCPs that enroll beneficiaries covered by the MHP to ensure that the entities coordinate care and transition responsibilities for providing services to beneficiaries as appropriate.⁵³

Under California's No Wrong Door Policy, Medi-Cal beneficiaries may concurrently receive mental health services from a MHP and a MCP (or Fee-For-Service provider), when the services are clinically appropriate, coordinated, and not duplicative.⁵⁴ MHPs and MCPs must coordinate care for beneficiaries receiving services from both systems.⁵⁵ Even when there is a dispute between a MHP and a MCP, MHP and MCP cannot delay the provision of medically necessary services to a beneficiary.⁵⁶ For beneficiaries who are not enrolled in MCPs, MHPs are required to coordinate the services the MHP provides with the services the beneficiary receives from a Fee-For-Service (FFS) provider.⁵⁷

MHPs and MCPs have a duty to ensure continuity of care for beneficiaries. If beneficiaries choose to transition from one service type to another (such as from receiving SMHS to NSMHS and vice versa), MHPs and MCPs must facilitate care transitions and guide referrals for beneficiaries, including notifying the beneficiary about the process that will occur during the transition 30-calendar days before the end of the continuity of care period.⁵⁸

Access to Culturally Competent Care and Care in Languages Other Than English

To ensure that Medicaid beneficiaries receive health care services that are "respectful of and responsive to their cultural and linguistic needs," states must make available free-of-charge oral interpretation in all non-English languages and written translation in all prevalent non-

English languages in the state.⁵⁹ Each MHP must develop and implement a Cultural Competence Plan, which includes a listing of SMHS available for beneficiaries in their primary language by location of the services and a plan for cultural competency training for the persons providing SMHS.⁶⁰ MHPs must provide oral interpreter services at key points of contact to assist beneficiaries to access SMHS.⁶¹ MHPs also must make written materials that are critical to obtaining services (i.e. provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices) available in the prevalent non-English languages in each particular service area.⁶²

Access to Providers and Facilities for People with Disabilities

To ensure people with disabilities have access to a full range of health care services, MHPs must ensure that provider locations are accessible to people with disabilities.⁶³ MHPs also must provide reasonable accommodations to potential and current beneficiaries who need them.⁶⁴ Reasonable accommodations may include sign language interpreters, documents in Braille or audio, and accessible website materials. At a minimum, MHPs must provide free written materials that are critical to obtaining services in alternative formats upon request.⁶⁵ MHPs also have the duty to inform potential or current beneficiaries how to request auxiliary aids and services, and upon request, MHPs must provide auxiliary aids and services free-of-charge.⁶⁶ Additionally, MHPs must provide accommodations necessary to ensure beneficiaries' programmatic access to health care.⁶⁷

Problem Resolution Processes

Federal and state laws require MHPs to develop and provide beneficiaries a grievance, appeal, and expedited appeal system to resolve any problems or concerns related to the delivery of SMHS.⁶⁸ In addition to the MHP's internal problem resolution system, Medi-Cal beneficiaries may also resolve issues through the state fair hearing process.⁶⁹

Internal Plan Resolution Processes: Appeal and Grievance

Beneficiaries who experience issues with access to SMHS may attempt to address these issues through an internal resolution process with the MHP. There are two types of internal resolution processes: appeals (for addressing adverse benefits determinations) and grievances (for other problems). MHPs must include information describing the grievance, appeal, and expedited appeal processes in the MHP's beneficiary handbook.⁷⁰ MHPs also must maintain a grievance and appeal log, record all grievances and appeals in the log within one working day of receiving the grievance or appeal, and acknowledge receipt of each grievance and appeal in writing.⁷¹

Beneficiaries may file an **appeal** with the MHP to review an “adverse benefit determination” orally or in writing.⁷² An adverse benefit determination is the denial, reduction, termination, or suspension of a requested service; the failure to provide services in a timely manner; or the denial of a beneficiary to exercise the right to obtain out-of-network services.⁷³ Each MHP may only have one level of appeal for beneficiaries and must provide the beneficiary a decision on an appeal no more than thirty calendar days from having received the appeal.⁷⁴ All beneficiaries are entitled to obtain a second opinion from a qualified health care professional.⁷⁵ Beneficiaries must exhaust the MHP’s internal appeals process before requesting a state fair hearing.⁷⁶

A beneficiary may request an **expedited appeal**, if the beneficiary’s condition puts the beneficiary in an imminent and serious threat to life or health, or that the regular appeal timeline would be detrimental to the beneficiary’s life, health, or ability to regain maximum function.⁷⁷ The MHP must resolve an expedited appeal no longer than 72 hours after having received the appeal.⁷⁸ If the MHP denies a request for expedited appeal resolution, the MHP must provide a beneficiary with a written notice of the expedited appeal disposition, and the appeal will proceed through the regular appeal process.⁷⁹

In certain circumstances, a beneficiary who was receiving the service at issue prior to the adverse benefit determination may request for continuation of benefits while the appeal is pending.⁸⁰ If an appeal is not resolved wholly in favor of the beneficiary, the MHP must notify the beneficiary about the right to a fair hearing and the procedure for filing for a fair hearing.⁸¹ On the other hand, if the decision of the appeal reversed a decision to deny, limit, or delay services, MHPs must promptly provide or arrange and pay for the disputed services.⁸²

Beneficiaries may file a **grievance** to express “dissatisfaction about any matter other than an “adverse benefit determination” either orally or in writing at any time.⁸³ Within sixty calendar days of receipt of the grievance, MHPs must provide a decision on the grievance and notify the beneficiary of the decision in writing.⁸⁴

Fair Hearing

Medi-Cal beneficiaries have the right to request a **state fair hearing** anytime they are dissatisfied with the receipt of Medi-Cal services.⁸⁵ A state fair hearing is an independent review conducted by an Administrative Law Judge.⁸⁶ If the beneficiary is requesting a fair hearing regarding an adverse benefit determination, the beneficiary *must* exhaust the MHP’s internal appeals process described above before requesting a hearing.⁸⁷ For a fair hearing involving a previously authorized service, the beneficiary may continue the service at issue

until the fair hearing is resolved (or until the authorization for the service expires, whichever comes first).⁸⁸

A beneficiary may request an **expedited hearing**, if the standard timeline could jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.⁸⁹ If a beneficiary is not satisfied with the outcome of a fair hearing, the beneficiary is entitled to file a request for a rehearing, or may proceed to state court.⁹⁰

Enforcement and Monitoring

Federal law requires states to have a monitoring system on all managed care and health plans.⁹¹ Below are some tools that California utilizes to monitor MHPs' compliance with network adequacy standards.

Triennial Review

DHCS conducts the Medi-Cal SMHS system and chart reviews every three years to determine if MHPs are in compliance with federal and state laws, regulations, as well as their contractual duties with the state.⁹² DHCS's Triennial review includes an evaluation of the MHP's "Network Adequacy and Availability of Services" and "Care Coordination and Continuity of Care."⁹³ If any problems are identified during the Triennial Review, MHPs must maintain a Quality Improvement Work Plan (QIWP) that addresses those problems.⁹⁴ QIWPs should include any quality improvement or evaluation strategies the MHP is pursuing to improve the access to and delivery of SMHS, such as the referral and coordination process with MCPs.⁹⁵

In addition, if DHCS determines that a MHP is out of compliance with network adequacy and access requirements during a triennial review, it will provide the MHP with a written Notice of Noncompliance and require the MHP to develop a Corrective Action Plan.⁹⁶ DHCS may temporarily withhold a portion of payments due to a non-compliant MHP, impose civil monetary sanctions, terminate the MHP contract, or/ and take additional actions against a non-compliant MHP.⁹⁷ Violating a QIWP requirement could also subject the MHP to sanctions.⁹⁸

Data Collection & Reporting

Currently, DHCS reports some information about MHPs' compliance with time and distance standards, network capacity and provider ratios, linguistic capacity, timely access, and mandatory provider type requirements in its network certification reports.⁹⁹ DHCS provides more detailed information about MHPs' compliance with timely access requirements in its

triennial review System Review Findings Reports.¹⁰⁰ (To the extent an MHP was required to enter a Corrective Action Plan based on its review, this information may also be reported in that MHP's Corrective Action Plan Report.)¹⁰¹ Starting with reviews for 2021-22, DHCS reviews a sample of appointment requests to determine whether MHPs are complying with timely access requirements for physician services and urgent care (previously, DHCS reviewed MHP policies to evaluate compliance). Since those reviews are performed only once every three years, however, the data is not available regularly.

Stakeholder Engagement

Stakeholder engagement is another way California oversees and monitors MHPs compliance with federal and state regulations. Through engaging with a diverse group of leaders and representatives from local agencies and community-based organizations, DHCS can gain valuable insights and feedback on how SMHS is delivered and whether MHPs are complying with their legal mandates and contractual duties. For example, DHCS has a Behavioral Health Stakeholder Advisory Committee that convenes every quarter to discuss behavioral health topics.¹⁰² The Medi-Cal Children's Health Advisory Panel also meets to discuss SMHS issues impacting Medi-Cal beneficiaries under age 21.¹⁰³ Additionally, DHCS allows stakeholder comment processes for the Mental Health & Substance Use Disorder Services and Behavioral Health Information Notices (BHIN) that are issued to the MHPs.¹⁰⁴

CONCLUSION

California has made significant progress in ensuring that Medi-Cal beneficiaries have access to SMHS. Advocates should work with DHCS and policymakers to monitor and enforce California's strong consumer protections that aim to ensure access to SMHS when needed by Medi-Cal beneficiaries.

ENDNOTES

¹ See Cal. Dep't Health Care Servs., *Medi-Cal Specialty Mental Health Services*, https://www.dhcs.ca.gov/services/Pages/Medi-cal_SMHS.aspx (last visited May 10, 2023) [hereinafter *DHCS Medi-Cal Specialty Mental Health Services*]; See also Nat'l Health Law Program, *An Advocate's Guide to Medi-Cal Services: Chapter III* 3-6 (Dec. 2022) [hereinafter *An Advocate's Guide to Medi-Cal Services: Chapter III*], <https://healthlaw.org/resource/an-advocates-guide-to-medi-cal-services/>. Medi-Cal beneficiaries must typically meet medical necessity or access criteria to qualify for SMHS, but will sometimes qualify when there is no diagnosis or when the beneficiary has co-occurring mental health and substance use disorder conditions. Cal. Welf. & Inst. Code § 14184.402(f); see Cal. Dep't Health Care Servs., *Behavioral Health Information Notice No: 21-073* 3-5 (Dec. 10, 2021), <https://www.dhcs.ca.gov/Documents/BHIN-21-073-Criteria-for-Beneficiary-to-Specialty-MHS-Medical-Necessity-and-Other-Coverage-Req.pdf> [hereinafter *Behavioral Health Information Notice No: 21-073*]. Medi-Cal also covers Non-Specialty Mental Health Services (NSMHS), typically provided to beneficiaries with less intensive mental health needs. NSMHS are provided either by the beneficiary's Medi-Cal managed care plan (MCP), or by the state, for beneficiaries in Fee-For-Service (FFS) Medi-Cal. See Cal. Welf. & Inst. Code § 14132.03; see also Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual: Non-Specialty Mental Health Services: Psychiatric and Psychological Services* (Dec. 2021) [hereinafter *Medi-Cal Provider Manual: NSMHS*], <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/nonspecmental.pdf>.

² The 1915(b) Waiver allowed the State to require beneficiaries to receive covered mental health services through one Prepaid Inpatient Health Plan (PIHP) per county. PIHPs are known as MHPs in California. See Sarah Arnquist & Peter Harbage, Cal. Health Care Found., *A Complex Case: Public Mental Health Delivery and Financing in California* 15–18 (2013), <https://www.chcf.org/wp-content/uploads/2017/12/PDF-ComplexCaseMentalHealth.pdf> (describing the 1915(b) waiver history); California most recently renewed its 1915(b) waiver for a five-year period starting on January 1, 2022. See CMS, *Approval Letter for California Advancing & Innovating Medi-Cal Section 1915(b) Waiver* (Dec. 29, 2021), <https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1915b-Approval-Letter.pdf>; see also Cal. Dep't Health Care Servs., *CalAIM Section 1915(b) Waiver*, [https://www.dhcs.ca.gov/services/MH/Pages/1915\(b\)_Medi-cal_Specialty_Mental_Health_Waiver.aspx](https://www.dhcs.ca.gov/services/MH/Pages/1915(b)_Medi-cal_Specialty_Mental_Health_Waiver.aspx) (last visited May 10, 2023).

³ See *An Advocate's Guide to Medi-Cal Services: Chapter III*, *supra* note 1, at 4.

⁴ See 42 U.S.C. 1396d(r); CAL. WELF. & INST. CODE § 14132(v); CAL. WELF. & INST. CODE § 14684(7); see also Cal. Dep't Health Care Servs., *Medi-Cal for Kids & Teens*, <https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/home.aspx> (last visited May 10, 2023).

⁵ Cal. Dep't Health Care Servs., *Specialty Mental Health Services for Children and Youth* (Feb 23, 2023), https://www.dhcs.ca.gov/services/MH/Pages/Specialty_Mental_Health_Services.aspx (last visited May 10, 2023).

⁶ See generally DHCS Medi-Cal Specialty Mental Health Services, *supra* note 1.

⁷ See Cal. Dep't Health Care Servs., *Contract & Mental Health State Plans: Mental Health Plan Contract*, https://www.dhcs.ca.gov/services/MH/Pages/Contracts_Medicare_State_Plan.aspx (last visited May 10, 2023) [hereinafter MHP Contract].

⁸ This issue brief contains updated information on SMHS from a previous NHeLP publication. See Héctor Hernández-Delgado, Nat'l Health Law Prog., *Advocate Fact Sheet: Evaluating Mental Health Plans' Provision of Medi-Cal Specialty Mental Health Services* (Dec. 18, 2019), <https://healthlaw.org/resource/advocate-fact-sheet-evaluating-mental-health-plans-provision-of-medi-cal-specialty-mental-health-services/>. For network adequacy laws for Medi-Cal MCPs, see Abbi Coursolle, Nat'l Health Law Prog., *Network Adequacy Rules for Medi-Cal Managed Care Plans* (May 7, 2018), <https://healthconsumer.org/wp/wp-content/uploads/2016/10/050718-1-mcal-net-ad-final-Managed-Care-in-California-Series-UPDATED.pdf>.

⁹ 42 C.F.R. § 438.68; Cal. Dep't Health Care Servs., *Behavioral Health Information Notice No: 22-033* (June 24, 2022) [hereinafter *Behavioral Health Information Notice No: 22-033*], <https://www.dhcs.ca.gov/Documents/BHIN-22-033-2022-Network-Adequacy-Certification-Requirements-for-MHPs-and-DMC-ODS.pdf>.

¹⁰ CAL. CODE REGS. tit. 9, § 1810.345.

¹¹ 42 C.F.R. § 438.206.

¹² *Id.*

¹³ CAL. CODE REGS. tit. 9, § 1810.405.

¹⁴ CAL. CODE REGS. tit. 28, § 1300.67.2.2(c)(5)(A)–(B).

¹⁵ See CAL. WELF. & INST. CODE § 14197 (incorporating requirements in CAL. CODE REGS. tit. 28, § 1300.67.2.2 to apply to all Medi-Cal plans including MHPs); see also Cal. Dep't Health Care Servs., *Behavioral Health Information Notice No: 21-012* (May 24, 2021), <https://www.dhcs.ca.gov/Documents/BHIN-21-023-2021-Network-Adequacy-Certification-Requirements-for-MHPs-and-DMC-ODS.pdf>.

¹⁶ "Time" refers to the number of minutes it takes a beneficiary to travel from home to the nearest provider site, and "Distance" is the number of miles it takes a beneficiary to travel from home to the nearest provider site. See Cal. Dep't Health Care Servs., *Annual Network Certification Specialty Mental Health Services* (2021), <https://www.dhcs.ca.gov/Documents/2021-MHP-Network-Certification-Summary-Methodology-and-Findings.pdf>. The Time or Distance Standards is sometimes called the Time and Distance Standards. See Cal. Dep't Health Care Servs., *All Plan Letter 20-003: Network Adequacy Standards Attachment A* (2021), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-006AttA.pdf>.

¹⁷ *Id.*

¹⁸ For a full list of the standards by county, see *id.* at 22-23.

¹⁹ See CAL. WELF. & INST. CODE § 14197(e)(2); see also Behavioral Health Information Notice No: 22-033, *supra* note 9, at 26.

²⁰ *Id.*

²¹ See CAL. WELF. & INST. CODE § 14197(e)(1); see also Behavioral Health Information Notice No: 22-033, *supra* note 9, at 26.

²² See Cal. Dep't Health Care Servs., *2021 MHP Approved Alternative Access Standards* 7-9 (2021), <https://www.dhcs.ca.gov/Documents/2021-MHP-Approved-Alternative-Access-Standards.pdf> [hereinafter *2021 MHP Approved Alternative Access Standards*]; see also Cal. Dep't Health Care Servs., *Network Adequacy*, <https://www.dhcs.ca.gov/formsandpubs/Pages/NetworkAdequacy.aspx> (last visited Apr. 18, 2023).

²³ 42 C.F.R. § 438.206(b)(1).

²⁴ 42 C.F.R. § 438.438.14(b)(1); see also Cal. Dep't Health Care Servs., Behavioral Health Information Notice No: 22-020 (Apr. 27, 2022), <https://www.dhcs.ca.gov/Documents/BHIN-22-020-County-Mental-Health-Plan-Obligations-Related-to-Indian-Health-Care-Providers.pdf>. Indian Health Care Provider is a "health care program operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization." See 42 C.F.R. § 438.438.14(a).

²⁵ For 2021, which is the most recent certification period, the ratio standard for children and youth outpatient SMHS is 1:43, and the ratio standard for adult outpatient SMHS is 1:85. See Cal. Dep't Health Care Servs., *Annual Network Certification Specialty Mental Health Services* 12 (2021), <https://www.dhcs.ca.gov/Documents/2021-MHP-Network-Certification-Summary-Methodology-and-Findings.pdf> [hereinafter 2021 SMHS Annual Network Certification Report].

²⁶ *Id.*

²⁷ See Behavioral Health Information Notice No: 22-033, *supra* note 9, at 29

²⁸ *Id.*

²⁹ *Id.*

³⁰ An out-of-network provider is a provider or group of providers without a network or subcontract agreement with the MHP. See 42 C.F.R. § 438.206; see also Cal. Dep't Health Care Servs., *Behavioral Health Information Notice No: 21-008* (Feb. 19, 2021), <https://www.dhcs.ca.gov/Documents/BHIN-21-008-Federal-Out-of-Network-Requirements-for-Mental-Health-Plans.pdf> [hereinafter *Behavioral Health Information Notice No: 21-008*]; see *2021 MHP Approved Alternative Access Standards*, *supra* note 22, at 3.

³¹ Behavioral Health Information Notice No: 21-008, *supra* note 30, at 2.

³² see *2021 MHP Approved Alternative Access Standards*, *supra* note 22, at 22-23.

³³ Cal. Dep't Health Care Servs., *2017-2022 MHP Contract Exhibits A, B, and E- Boilerplate* (2017), https://www.dhcs.ca.gov/services/MH/Documents/PPQA%20Pages/Boilerplate_2017-2022_MHP_Contract-Exhibits_A_B_and_E.pdf [herein *MHP Contract Exhibits A, B, and E-Boilerplate*].

³⁴ See Behavioral Health Information Notice No: 21-008, *supra* note 30, at 7; see also Cal. Dep't Health Care Servs., *2021 Annual Network Certification Mental Health Plan Corrective Action Plan Report* 7-46 (2022), <https://www.dhcs.ca.gov/Documents/MHP-2021-Annual-Network-Certification-CAP-Report.pdf> [hereinafter *2021 MHP Network Certification CAP Report*].

³⁵ 42 C.F.R. §§ 438.10(e)(2)(vii), 438.10(h)(2).

³⁶ 42 C.F.R. § 438.10(h).

³⁷ Cal. Dep't Health Care Servs., *MHSUDS Information Notice NO: 18-020* (Apr. 24, 2018), <https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN%2018->

[020%20PROVIDER%20DIRECTORY%20REQUIREMENTS/MHSUDS Information Notice 18-020 Final Rule Provider Directory Requirements.pdf](#).

³⁸ A recent study assessed California health plans' existing provider directories and found that "mental health provider directories are highly inaccurate." See Abigail Burman et al., *Provider Directory Inaccuracy and Timely Access for Mental Health Care*, *Am J Manag Care* 29(2) 96-102 (2023), <https://doi.org/10.37765/ajmc.2023.89318>.

³⁹ 42 C.F.R. § 438.10(h).

⁴⁰ *Id.*

⁴¹ 42 C.F.R. §§ 438.10(c)(1), 438.10(c)(6),

⁴² 42 C.F.R. §§ 438.10(h)(4), 438.10(d).

⁴³ 42 C.F.R. § 438.207.

⁴⁴ CAL. CODE REGS. tit. 9 § 1810.435; see MHP Contract Exhibits A, B, and E- Boilerplate, *supra* note 33, at 2-5.

⁴⁵ See Cal. Dep't Health Care Servs., *Network Adequacy*, <https://www.dhcs.ca.gov/formsandpubs/Pages/NetworkAdequacy.aspx> (last visited May 10, 2023); see Cal. Dep't Health Care Servs., *Medi-Cal Specialty Mental Health Services Plans of Correction*, https://www.dhcs.ca.gov/services/MH/Pages/County_MHP_POC.aspx (last visited May 10, 2023) [hereinafter *SMHS Plans of Correction*].

⁴⁶ *Id.*

⁴⁷ See Cal. Dep't Health Care Servs., *Behavioral Health Information Notice No: 22-063* (Dec. 19, 2022) [thereinafter *Behavioral Health Information Notice No: 22-063*], <https://www.dhcs.ca.gov/Documents/BHIN-22-063-Annual-Review-Protocol-for-FY-2022-23.pdf>.

⁴⁸ See Behavioral Health Information Notice No: 22-033, *supra* note 9, at 4.

⁴⁹ For information about the right to Continuity of Care in Medi-Cal generally, see Abbi Coursolle & Shyaam Subramanian, Nat'l Health L. Prog., *Managed Care in California Series, Issue 6: Continuity of Care in Medi-Cal Managed Care* (2016), <https://healthlaw.org/resource/managed-care-in-california-series-issue-6-continuity-of-care-in-medi-cal-managed-care>.

⁵⁰ CAL. WELF. & INST. CODE § 10003(a).

⁵¹ *Id.*; see also Cal. Dep't Health Care Servs., *Letter No: 18-02E7-10* (Feb. 23, 2021), <https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/18-02E.pdf>.

⁵² CAL. WELF. & INST. CODE § 14184.402(b)(1); CAL. CODE REGS. tit. 22, § 53855; see also generally Medi-Cal Provider Manual: NSMHS, *supra* note 1, at 6.

⁵³ See Cal. Code Regs. tit. 9, § 1810.370; see also CAL. WELF. & INST. CODE § 14684(4); see also Cal. Dep't Health Care Servs., *All Plan Letter 18-015 1-2* (Sept. 19, 2018), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-015.pdf>; see also Cal. Dep't Health Care Servs., *All Plan Letter 18-015 Attachment 2: Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and County Mental Health Plans* at 2-3 (Sept. 19, 2018), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-015Att2.pdf>.

⁵⁴ California implemented a No Wrong Door Policy through the California Advancing and Innovating Medi-Cal (CalAIM) initiative to ensure that all Medi-Cal beneficiaries receive timely

mental health services without delay regardless of the delivery system where they seek care and that beneficiaries are able to maintain treatment relationships with trusted providers without interruption. *See* Cal. Welf. & Inst. Code § 14184.402(f)(1); *see also* Cal. Dep't Health Care Servs., *CalAIM*, <https://www.dhcs.ca.gov/calaim> (last visited May 10, 2023); *see also* Cal. Dep't Health Care Servs., *Behavioral Health Information Notice No. 22-011* (March 31, 2022), <https://www.dhcs.ca.gov/Documents/BHIN-22-011-No-Wrong-Door-for-Mental-Health-Services-Policy.pdf>; *see also* Cal. Dep't Health Care Servs., *All Plan Letter 22-005* (March 30, 2022), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-005.pdf>.

⁵⁵ *Id.*; *see also* Cal. Dep't Health Care Servs., *MHSUDS Information Notice: 18059* (Dec. 17, 2018), https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN_18-059_Continuity_of_Care/MHSUDS_Information_Note_18-059_Continuity_of_Care.pdf.

⁵⁶ CAL. WELF. & INST. CODE § 14184.402(g).

⁵⁷ 42 C.F.R. § 438.208(b)(2)(iii).

⁵⁸ *See* Cal. Dep't Health Care Servs., *All Plan Letter 22-032* (Dec. 27, 2022), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-032-Continuity-of-Care.pdf>.

⁵⁹ Prevalent language is defined as “a non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient.” *See* 42 C.F.R. § 438.10(a). The Office of Minority Health of the U.S. Department of Health and Human Services issued a set of National Standards for culturally competent and linguistically appropriate services in health care. *See* HHS, *National Standards for Culturally and Linguistically Appropriate Services in Health Care* (March 2011), <https://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf>.

⁶⁰ CAL. CODE REGS. tit. 9, § 1810.410(c).

⁶¹ “Key points of contacts” is defined as common points of access to SMHS from the MHP, and “Threshold language” is defined as “a language that has been identified as the primary language... of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.” *See* CAL. CODE REGS. tit. 9 § 1810.410(a).

⁶² 42 C.F.R. § 438.10(d)(3).

⁶³ *See* 42 U.S.C. 12131-12134; *see also* Disability Rights California, *Access to Health Care for People with Disabilities under the ADA and other Civil Rights Laws* (May 1, 2021), https://www.disabilityrightsca.org/publications/access-to-health-care-for-people-with-disabilities-under-the-ada-and-other-civil#footnoteref10_t7ldtf9.

⁶⁴ *Id.*

⁶⁵ 42 C.F.R. § 438.10(d)(3).

⁶⁶ *Id.*

⁶⁷ Programmatic Access to health care means “the policies and practices that are part of the delivery of healthcare do not hinder the ability of patients with disabilities to receive the same quality of care as other persons.” *See* Nancy R. Mudrick et al., Disability Rights Education & Defense Fund, *Defining Programmatic Access to Healthcare for People with Disabilities* (2007), <https://dredf.org/public-policy/health-access-to-care-old/defining-programmatic-access-to-healthcare-for-people-with-disabilities/>.

⁶⁸ 42 C.F.R. §§ 438.228(a); 42 C.F.R. § 438.402(a); CAL. CODE REGS. tit. 9, § 1850.205(a)-(b); *see also* Cal. Dep't Health Care Servs, *MHSUDS Information Notice No: 18-010E* (March 27, 2018), https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/NOABD%20IN/MHSUDS_IN_18-010_Federal_Grievance_Appeal_System_Requirements.pdf. This problem resolution process requirement is also outlined in each MHP's contract with the state. *See* MHP Contract, *supra* note 7. For more details on problem resolution rules and processes that apply to Medi-Cal plans, *see* Abbi Coursolle, Nat'l Health Law Prog., *Managed Care in California Series, Issue 4: Internal and External in Medi-Cal Managed Care Plans* (2017), <https://healthlaw.org/wp-content/uploads/2015/08/InternalExternalCareMediCal-Managed-Care-Series-UPDATED.pdf> (note that some of the laws and guidance cited in this paper have since been updated). For MCPs specific grievance and appeal requirements, *see* Cal. Dep't Health Care Servs., *All Plan Letter 21-011 (Revised)* (Aug. 2022), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPsandPolicyLetters/APL2021/APL21-011.pdf>.

⁶⁹ CAL. WELF. & INST. CODE § 10950.

⁷⁰ CAL. CODE REGS. tit. 9, § 1850.205(c)(1)(A).

⁷¹ 42 C.F.R. § 438.406(b)(1); CAL. CODE REGS. tit. 9, § 1810.405(d).

⁷² 42 C.F.R. § 438.400. The beneficiary must follow up an oral appeal with a written appeal. The date the MHP receives the oral appeal is considered the filing date. *See* CAL. CODE REGS. tit. 9 §§ 1850.207(a)-(b).

⁷³ 42 C.F.R. § 438.400(b).

⁷⁴ CAL. WELF. & INST. CODE § 14197.3(b).

⁷⁵ MHPs must provide beneficiaries a second opinion from a network provider or arrange for the beneficiary to obtain a second opinion from an out-of-network provider at no cost to the beneficiary. *See* 42 C.F.R. § 438.206(b)(3).

⁷⁶ *See* 42 C.F.R. § 438.402(c)(i)(A); 42 C.F.R. § 438.408(f)(1); CAL. WELF. & INST. CODE § 10951(b)(1). If a MHP fails to comply with the notice requirement, the beneficiary is deemed to have exhausted the MHP's appeal process and may initiate a State fair hearing. *See* 42 C.F.R. § 438.408(c)(i)(A).

⁷⁷ CAL. WELF. & INST. CODE § 14197.3(c).

⁷⁸ CAL. WELF. & INST. CODE § 14197.3(c).

⁷⁹ CAL. CODE REGS. tit. 9, § 1850.208(e).

⁸⁰ 42 C.F.R. §§ 431.230, 438.420; CAL. CODE REGS. tit. 22, § 51014.2.

⁸¹ *Id.*

⁸² *Id.*

⁸³ A grievance may also be filed by a provider or an authorized representative who is acting on behalf of the beneficiary. 42 C.F.R. § 438.400; 42 C.F.R. § 438.402(c)(2); CAL. CODE REGS. tit. 9, § 1850.206(a).

⁸⁴ *See* CAL. CODE REGS. tit. 9, § 1850.206(b). This timeline may be extended to up to 14 calendar days, if the beneficiary requests for more time or the MHP needs additional information and the delay is in the beneficiary's best interest. *See* 42 C.F.R. § 438.408(c).

⁸⁵ *See* CAL. WELF. & INST. CODE § 10950.

⁸⁶ Cal. Dep't Health Care Servs., *Medi-Cal Fair Hearing*, <https://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx> (last visited May 10, 2023).

⁸⁷ See 42 C.F.R. § 438.402(c)(i)(A); 42 C.F.R. § 438.408(f)(1); CAL. WELF. & INST. CODE § 10951(b)(1). If a MHP fails to comply with the notice requirement, the beneficiary is deemed to have exhausted the MHP's appeal process and may initiate a State fair hearing. See 42 C.F.R. § 438.408(c)(i)(A).

⁸⁸ To be considered for continued service, the beneficiary must request a fair hearing within 10 days from the date of the Notice of Appeal Resolution or before the date of the proposed adverse benefit determination. See 42 C.F.R. § 438.420; see also CAL. CODE REGS. tit. 22, § 51014.2.

⁸⁹ 42 C.F.R. § 431.224(a).

⁹⁰ CAL. WELF. & INST. CODE § 10960.

⁹¹ 42 C.F.R. § 438.66; see also CMS, *CMCS Informational Bulletin: Medicaid and CHIP Managed Care Monitoring and Oversight Tools* (June 28, 2021), <https://www.medicare.gov/federal-policy-guidance/downloads/cib06282021.pdf>.

⁹² CAL. CODE REGS. tit. 9, § 1810.380; see also generally Behavioral Health Information Notice No: 22-063, *supra* note 47. The triennial review schedule is posted on DHCS's website. See Cal. Dep't Health Care Servs., *BHIN 22-063 Enclosure 2: Triennial Review Schedule* (Dec. 1, 2022), <https://www.dhcs.ca.gov/Documents/Enclosure-2-SMHS-Triennial-Schedule-7-15-22.pdf>.

⁹³ Behavioral Health Information Notice No: 22-063, *supra* note 47, at 2-3; see also Cal. Dep't Health Care Servs., *BHIN No: 22-063 Enclosure 1* (Dec. 1, 2022), <https://www.dhcs.ca.gov/Documents/BHIN-22-063-Enclosure-1-SMHS-Protocol-FY-22-23.pdf>.

⁹⁴ QIWP may also be referred to as "Quality Management Work Plan." See CAL. CODE REGS. tit. 9, § 1810.440; see also Cal. Dep't Health Care Servs., *Mental Health Plan Quality Improvement Plans*, https://www.dhcs.ca.gov/services/MH/Pages/MHP_QI_Plans.aspx (last visited Apr. 24, 2023) [hereinafter QIWP].

⁹⁵ *Id.*

⁹⁶ CAL. WELF. & INST. CODE § 14197.7. DHCS posts the review findings and plan of correction per county on its website. See Cal. Dep't Health Care Servs., *Medi-Cal Specialty Mental Health Services Plans of Correction*, https://www.dhcs.ca.gov/services/MH/Pages/County_MHP_POC.aspx (last visited Apr. 20, 2023).

⁹⁷ *Id.*

⁹⁸ QIWP, *supra* note 98.

⁹⁹ See generally 2021 SMHS Annual Network Certification Report, *supra* note 25; see also generally 2021 MHP Network Certification CAP Report, *supra* note 34; see also Cal. Dep't Health Care Servs., *2020 Annual Network Certification Mental Health Plan Corrective Action Plan Report 3* (2021), <https://www.dhcs.ca.gov/Documents/MHP-2020-Annual-Network-Certification-CAP-Report.pdf>.

¹⁰⁰ See SMHS Plans of Correction, *supra* note 45.

¹⁰¹ *Id.*

¹⁰² See Cal. Dep't Health Care Servs., *DHCS Behavioral Health Stakeholder Advisory Committee*, <https://www.dhcs.ca.gov/Pages/BHStakeholderAdvisoryCommittee.aspx> (last visited May 10, 2023).

¹⁰³ See Cal. Dep't Health Care Servs., *Medi-Cal Children's Health Advisory Panel*, https://www.dhcs.ca.gov/services/Pages/Medi-Cal_Childrens_Health_Advisory_Panel.aspx (last visited May 10, 2023).

¹⁰⁴ See Cal. Dep't Health Care Servs., *Mental Health & Substance Use Disorder Services and Behavioral Health Information Notices*, https://www.dhcs.ca.gov/formsandpubs/Pages/Behavioral_Health_Information_Notice.aspx (last visited May 10, 2023).