FINAL RULE: NETWORK ADEQUACY
FREQUENTLY ASKED QUESTIONS

The direction provided in these FAQs is based upon the latest information available from State Department of Health Care Services (DHCS) and is subject to change in future submissions of network adequacy information.

WHO DOES NETWORK ADEQUACY APPLY TO:

1. Which providers (agencies) are required to complete the network adequacy information?
   All providers (directly operated, contracted, and fee-for-service) that provide **outpatient Medi-Cal services** (Mental Health Services, Targeted Case Management, Medication Support Services, and Crisis Intervention) must complete the network adequacy information regardless of program (e.g. Wraparound, Psychiatric Mobile Response Teams) and/or funding source (e.g. Mental Health Services Act).
   - Programs that do not provide outpatient services (e.g. inpatient, residential, crisis stabilization, day treatment/rehabilitation only) do not need to submit information.
   - Programs that are Community Outreach Services (COS) only also do not need to submit information.

2. Which practitioners (rendering providers) are included in the network adequacy information?
   All practitioners who **currently provide direct services** must be included in the network adequacy information regardless of level (e.g. BA level staff), amount of time (e.g. a supervisor who rarely sees clients) and/or whether or not they carry a "caseload" (e.g. a housing coordinator).

PRACTITIONER (RENDERING PROVIDER)

1. If a practitioner worked part of FY 2017-18 but has been terminated, do you still want them included as a practitioner? Also, I am assuming we should delete all staff who are showing up on the list who were not deleted and who did not work FY 2017-18.
   Network Adequacy only applies to CURRENT practitioners. Practitioners who no longer work for the agency, may be deleted.

2. When entering the Full Time Equivalent (FTE) for practitioners, is this referring to 40 hours per week? Do we enter 40 hours if a practitioner is full-time? What if they see more than Medi-Cal beneficiaries during that time?
   Within the application, you <u>only enter the number of hours worked</u>. In the background, the application will convert the number of hours into Full Time Equivalent based on 40 hours equaling one (1) FTE.

   For practitioners hired to function primarily in a direct service capacity (e.g. a social worker), enter the number of hours a practitioner works in a week. You do not need to separate out the time spent seeing non-Medi-Cal beneficiaries and/or attending meetings.

   For practitioners hired to function primarily in an administrative capacity (e.g. supervisor), enter the number of hours spent providing direct client care. Time spent attending meetings and/or doing administrative work should be separated out.

3. Under licensing entity, what is the difference between licensing entity and certifying entity?
   Some practitioners (e.g. substance abuse counselors) get "certified" instead of licensed. If the practitioner is certified, enter the name of the agency that certified them (e.g. California Association of DUI Treatment Programs). The licensing entity would then be left blank.

If the practitioner is licensed (e.g. social worker), enter the name of the agency that licensed them (e.g. Board of Behavioral Sciences). The certifying entity would then be left blank.

4. How do we identify students?
   Students should be included under "Other Qualified Provider"

5. For a registered practitioner, do we include their registration number under "license number"? Or do we leave it blank?
   Include registration numbers under license number.

NUMBERS OF BENEFICIARIES

NOTE: For numbers 1 and 2, "number of beneficiaries assigned" refers only to those Medi-Cal clients that are active (i.e. have not had services terminated per DMH Policy 312.01).

1. How do we define maximum number of beneficiaries an Organization (e.g. Legal Entity) will accept?
   This is the number of beneficiaries assigned to the organization at the single point in time in which the organization had the most beneficiaries assigned during the past 12 month period. If the organization has multiple provider sites, this is the total number of beneficiaries assigned to all provider sites added together. There is no need to make adjustments for beneficiaries seen at multiple provider sites when calculating the total for the organization (i.e. to de-duplicate).

2. How do we define current number of beneficiaries an Organization (e.g. Legal Entity) will accept?
   This is the number of beneficiaries assigned to the organization at the present time (i.e. the point in time in which the NACT is completed). If the organization has multiple provider sites, this is the total number of beneficiaries assigned to all provider sites added together. There is no need to make adjustments for beneficiaries seen at multiple provider sites when calculating the total for the organization (i.e. to de-duplicate).

   NOTE: For numbers 3 and 4, "beneficiaries assigned to the practitioner" refers to clients who the rendering provider is responsible for providing services to, or for following-up on.

3. How do we define maximum number of beneficiaries a practitioner will accept?
   This is the number of beneficiaries assigned to the rendering provider at the single point in time in which the rendering provider had the most beneficiaries assigned during the past 12 month period. This may or may not be referred to as "caseload."

4. How do we defined current number of beneficiaries a practitioner will accept?
   This is the number of beneficiaries assigned to the rendering provider at the present time (i.e. the point in time in which the NACT is completed). This may or may not be referred to as "caseload."

5. Should non-Medi-Cal clients be excluded from practitioner client assignments?
   Yes, indigent and other clients not covered by Medi-Cal should be excluded.

6. Should we just put "0" if the practitioner does not have a set list of Medi-Cal clients assigned, for example in the case of psychiatric mobile response team staff or clinic supervisors.

No, entering a "0" for any practitioner will automatically disqualify that practitioner from being counted toward fulfilling our County's network adequacy requirement for providing specialty mental health services to its Medi-Cal beneficiaries.

CONTRACT DATES

1. What should be entered for contract dates at the provider level and the practitioner level?
   For Legal Entities and Fee For Service, this will be the start and end date of the agency's contract for the current year. This would not be the original contract.

   For Directly Operated, this will be the first and last day of the current fiscal year.

COMMUNITY BASED SERVICES

1. How are satellite sites defined? If someone provides services at a site other than their assigned provider site, would that be considered a satellite site?
   If there are sites that practitioners go to on a regular basis, then they should list those in community based organizations. This should EXCLUDE client's homes. For the purpose of this question, the term "satellite site" is defined as a regularly visited location whether the site is Medi-Cal certified or not, and as such, this definition differs from the standard definition.

CULTURAL COMPETENCY REQUIREMENTS

1. It was our understanding that we could use our internal cultural competency training as long as it contained certain elements. This is how we have done our cultural competency training. Is this acceptable, or do I need to have all my staff take these specific courses sent via links right now?
   You have the option of utilizing any cultural competence training the practitioner may have completed during the reporting time period. Please make sure that you enter the specific number of hours of completed CC trainings for each of your practitioners.