**For Incorporation by Reference in 28 CCR § 1300.67.2:**

The following Counseling Non-Physician Mental Health Professional Ratio Standards and Methodology is hereby incorporated by reference in 28 CCR § 1300.67.2., sub. (d), pursuant to the exemption to the Administrative Procedures Act (APA) set forth in Health and Safety Code section 1367.03(f).[[1]](#footnote-2)

The document is depicted in **underline** format to demonstrate newly incorporated language. [[2]](#footnote-3)

**Counseling Non-Physician Mental Health Ratio Standards and Methodology**

1. Background

As part of its annual review of health care service plan (plan) networks, to assess the capacity of mental health networks to deliver services in accordance with access standards, the DMHC will evaluate the ratio of counseling non-physician mental health professionals (Counseling MHP)-to-enrollees against the ratio standard established under the methodology set forth in this document.[[3]](#footnote-4) The ratio standard identifies the minimum number of full-time equivalent (FTE) Counseling MHPs per enrollees needed to demonstrate a plan network has adequate capacity and availability of licensed health care providers to reasonably assure that covered mental health services will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollee, as required by Rule 1300.67.2, subd. (d).

Plans have a duty to ensure their networks have sufficient numbers of network providers with adequate capacity and availability of licensed health care providers to maintain compliance with timely access standards, as required under Health and Safety Code sections 1367.03(a)(1), (a)(5), and (a)(7).[[4]](#footnote-5) The ratios of mental health providers-to-enrollees in the geographic locations within a plan’s network service area have a direct impact on an enrollee’s ability to receive timely, available and accessible mental health services, as well as a plan’s ability to comply with initial and follow-up appointment standards.

1. Stakeholder Feedback and Future Updates

Stakeholders were invited to provide input on the draft version of Counseling Non-Physician Mental Health Professional Ratio Standards and Methodology for reporting year (RY) 2024, circulated on June 16, 2023. The DMHC thanks those stakeholders who elected to provide substantive feedback. The DMHC reviewed this feedback in conjunction with developing the final standards and methodology for RY 2024.

For future measurement years, the DMHC is continuing to evaluate potential updates to the standards and methodology to ensure the standards are sufficient to ensure adequate patient access to mental health services. The DMHC may modify these standards and methodology in future measurement years under the APA exemption.

1. RY 2024: Counseling Non-Physician Mental Health Professional Ratio Standards and Methodology

The DMHC will evaluate the ability of plan networks to demonstrate sufficient capacity of Counseling MHPs to ensure compliance with network adequacy standards referenced in Sections 1367.03, 1367.035, and 1374.72 and Rules 1300.67.2 and 1300.67.2.2. As part of this review, the DMHC will evaluate reported annual network data against a minimum capacity requirement, through a ratio standard for Counseling MHPs. [[5]](#footnote-6) The ratio standard takes into consideration the full-time equivalent (FTE) ratio of Counseling MHPs-to-enrollees within a network, and within counties in the network service area. Additionally, the ratio standard considers a plan’s reported network providers that offer Counseling MHP services exclusively via telehealth modalities within the network. In some cases, a plan network may not meet the established ratio standard but, due to specific circumstances, it is still able to provide reasonable access to care. To address these circumstances, the DMHC has set forth alternative methodologies and ratio modifiers that the DMHC will apply, when applicable, when conducting its compliance analysis.

If a plan’s network does not meet the standard in one or more counties within the network service area, 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 locations to ensure accessibility of services as required under the Knox- Keene Act and implementing regulations.[[6]](#footnote-7) In subsequent reporting years, the DMHC may also rely upon the geographic distance standards as a basis for taking enforcement action pursuant to the Administrative Procedures Act exemptions established in Section 1367.03(f).

1. **Defined Terms**

Plans will be assessed for compliance with this standard using the defined terms below:[[7]](#footnote-8)

1. “Applicable county” means the county or partial county within the plan’s network service area.
2. “Counseling Non-Physician Mental Health Professional” or “Counseling MHP” means a Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Clinical Counselor, or Psychologist. For purposes of application of this standard, the Counseling MHP must be a network provider.
3. “County Types” means the combination of counties that are similarly situated with regard to population size and density, as defined by the Centers for Medicare and Medicaid Services (CMS) in its published Medicare Advantage Network Adequacy Criteria, set forth in 42 CFR 422.116(c). County types are set forth according to the county designations released by CMS, available at www.cms.gov.
4. “Large Metro Counties” means counties designated as “large metro” by CMS in its published Medicare Advantage Network Adequacy Criteria, set forth in 42 CFR 422.116(c). The following counties are designated Large Metro Counties for the RY 2024 standards: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Francisco, San Mateo, and Santa Clara.
5. “Metro Counties” means counties designated as “metro” by CMS in its published Medicare Advantage Network Adequacy Criteria, set forth in 42 CFR 422.116(c). The following counties are designated Metro Counties for the RY 2024 standards: Butte, El Dorado, Fresno, Kern, Kings, Marin, Merced, Monterey, Napa, Nevada, Placer, Riverside, San Bernardino, San Diego, San Joaquin, San Luis Obispo, Santa Barbara, Santa Cruz, Solano, Sonoma, Stanislaus, Sutter, Tulare, Ventura, Yolo, and Yuba.
6. “Rural Counties” means counties designated as “rural” by CMS in its published Medicare Advantage Network Adequacy Criteria, set forth in 42 CFR 422.116(c). The following counties are designated Rural Counties for the RY 2024 standards: Calaveras, Colusa, Del Norte, Glenn and Mariposa.
7. “Micro Counties” means counties designated as “micro” by CMS in its published Medicare Advantage Network Adequacy Criteria, set forth in 42 CFR 422.116(c). The following counties are designated Micro Counties for the RY 2024 standards: Amador, Humboldt, Imperial, Lake, Madera, Mendocino, San Benito, Shasta, Tehama and Tuolumne.
8. “Counties with Extreme Access Consideration (CEAC)” means counties designated as “Counties with Extreme Access Considerations (CEAC)” by CMS in its published Medicare Advantage Network Adequacy Criteria, set forth in 42 CFR 422.116(c). The following counties are designated CEAC Counties for the RY 2024 standards: Alpine, Inyo, Lassen, Modoc, Mono, Plumas, Sierra, Siskiyou, and Trinity.
9. “Exclusive provider” means a provider that is a network provider for only one reporting plan for the reporting year.
10. “Full-time” shall have the definition set forth in the Definitions section of the Annual Network Submission Instruction Manual, as incorporated in 28 CCR § 1300.67.2.2.
11. “Full-Time-Equivalent” or “FTE” means a comparable approximation of the amount of time a provider is available to provide covered services to enrollees in a network service area and county.
12. “FTE value” means a numerical value assigned to approximate the percentage of a provider’s time allocated to enrollees within the network, derived through a repeatable methodology.
13. “Full-value count” or “full-value provider count” means a count of each individual provider, where each individual counts as one complete provider, without regard to full-time equivalent value.
14. “In-person appointments on an outpatient basis” shall have the meaning set forth in the Definitions section of the Annual Network Submission Instruction Manual, as incorporated in 28 CCR § 1300.67.2.2.
15. References to “in-person” network providers shall mean network providers who take in-person appointments on an outpatient basis.
16. “Network” shall have the definition set forth in 28 CCR § 1300.67.2.2(b)(5).
17. “Network adequacy” shall have the definition set forth in 28 CCR § 1300.67.2.2(b)(6).
18. “Network provider” shall have the definition set forth in 28 CCR § 1300.67.2.2(b)(10).
19. “Network service area” shall have the definition set forth in 28 CCR § 1300.67.2.2(b)(11).
20. “Part-time” shall have the definition set forth in the Definitions section of the Annual Network Submission Instruction Manual, as incorporated in 28 CCR § 1300.67.2.2.
21. “Practice address” or “practice location” shall have the definition set forth in the Definitions section of the Annual Network Submission Instruction Manual, as incorporated in 28 CCR § 1300.67.2.2.
22. “Reporting plan” shall have the definition set forth in the Definitions section of the Annual Network Submission Instruction Manual, as incorporated in 28 CCR § 1300.67.2.2.
23. “Telehealth” shall have the definition set forth in Business and Professions Code section 2290.5(a)(6).
24. “Telehealth modality” shall have the definition set forth in the Definitions section of the Annual Network Submission Instruction Manual, as incorporated in 28 CCR § 1300.67.2.2.
25. “Telehealth-only network provider” means a network provider that delivers services to enrollees only via telehealth modalities, in the reported network. A “telehealth-only network provider” does not include a Third-Party Corporate Telehealth Provider, as defined in Health and Safety Code section 1374.141(b)(4).
26. **Ratio Standard for Counseling MHPs**
27. The network, and each applicable county within the network service area, shall include network providers at a ratio of at least onefull-time equivalent Counseling MHP per 1000 enrollees, measured by the FTE value of each Counseling MHP.
28. The following additional factors shall apply:
	1. Counseling MHPs shall include network providers that offer in-person appointments on an outpatient basis, as defined. Counseling MHPs may also include telehealth-only network providers, as defined, subject to the limitations in section III. D. below.
	2. Each county within a plan’s network service area shall be allocated a minimum enrollment count of 25 enrollees for CEAC counties, and 50 enrollees for Rural, Metro, Large Metro and Micro counties, when the plan’s reported enrollment in the county for the network is below the minimum count.
29. **FTE Value for In-Person Network Providers**
30. FTE Value: The FTE Value for an in-person Counseling MHP shall comprise the FTE Starting Value and FTE Starting Value Adjustments that are applicable to the Counseling MHP, as follows:
	1. FTE Starting Value– In-person Counseling MHPs shall receive an FTE starting value based on the reported county type in which the network provider delivers services. County types are set forth according to the county designations released by CMS, available at www.cms.gov.
31. The FTE starting value is based on the typical number of 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 health plans with which a provider is likely to be contracted in the county type.
32. A complete list of potential FTE Starting Values, based on county type, is available in the attached **Schedule A**.
	1. FTE Starting Value Adjustments – the FTE starting value for each reported Counseling MHP within each county shall be adjusted for the following factors, as applicable:
33. **Part-Time** **and Practice Location(s) in One County** – Part-time network providers have an adjusted starting value of 60% of the starting value of full-time network providers with a practice location or locations in a single county of the same county type.
34. **Full-Time and Multiple County Practice Locations** – Full-time network providers reported at practice locations in two or more counties have an adjusted starting value of 50% of the starting value of a full-time provider with a practice location or locations in a single county of the same county type.
35. **Part-Time and Multiple County Practice Locations** – Network providers reported as part-time and having locations in two or more counties have an adjusted starting value of 30% of the starting value of a full-time provider with a practice location or locations in a single county of the same county type.
36. A complete list of a network provider’s potential Starting Value Adjustments as identified above, is available in the attached **Schedule A**.
37. **Ratio Modifier for Telehealth-Only Network Providers**
38. Telehealth-only network providers may be applied to meet the Counseling MHP Ratio Standard through a telehealth-only ratio modifier, in accordance with the following conditions:
39. The telehealth-only ratio modifier shall be applied to a county or network summed FTE in a manner proportional to the full-value count of telehealth-only network providers reported for the network divided by the full-value count of in-person Counseling MHPs reported for the network; and
40. Notwithstanding subsection a., the telehealth-only ratio modifier shall not exceed 20% of the summed FTE value of network providers used to meet a ratio standard within a county or network service area.
41. The ratio modifier for telehealth-only network providers is not subject to additional FTE adjustments or alternative ratio modifiers. The ratio modifier formula for telehealth-only network providers is set forth in the attached **Schedule A-1**.
42. **Alternative Methodology – Additional Ratio Modifiers**
43. When a Plan is not able to meet the 1:1000 FTE Counseling MHP ratio standard for an applicable county, the DMHC shall conduct a further review based on the presence of one or more of the following factors that may impact capacity in the applicable county or network:
44. The network includes Counseling MHP network providers that are exclusive providers (EP), as defined. Network providers that are EPs are expected to have higher FTE values for the reported network, as their time is not distributed across multiple reporting plans;
45. A plan’s enrollment in the county represents a large percentage of total population in the county compared to other reported networks. Networks that enroll a substantial share of the county population are expected to account for a larger share of a provider FTE compared to networks with relatively low levels of enrollment;
46. The county is a Rural or CEAC county, and the network has sufficient capacity in an adjacent county or counties to service enrollees in the combined counties;
47. The county is a Large Metro, Metro, or Micro county in which the Plan’s Counseling MHP network providers comprise a large percentage of the licensed Counseling MHPs in the county, and the network has sufficient capacity in an adjacent county or counties to service enrollees in the combined counties.
48. Each ratio modifier set forth below is an alternative review methodology for the DMHC to measure the capacity ratio for Counseling MHPs, based on the factors above.
49. FTE Modifier for exclusive providers (EP) – This FTE modifier is applicable to Counseling MHPs that are EPs, as defined. The starting value FTE is replaced by a modified FTE value for EPs that is equal to one divided by the number of the plan’s networks in the county. After the modified EP FTE value is calculated for each EP, any applicable FTE starting value adjustments set forth in section III. C(1)b will be applied to the modified EP FTE value.
	* + 1. The FTE modifier for EPs is set forth in **Schedule A-2.**
50. Provider FTE Modifier for High Enrollment Counties – A provider FTE modifier for high enrollment counties shall apply to counties in which enrollment for the network is reported above a threshold percentage of population value for the county, based on the county population counts reported in the DMHC’s *California ZIP Code and County Combinations and Population Points* document issued annually in the DMHC’s web portal, pursuant to Rule 1300.67.2.2(b)(11). The threshold percentage for eligibility is set forth in **Schedule A-3.** The following requirements apply to this review:
51. For county networks that are eligible, the DMHC shall multiply the network’s total FTE value for the county by a multiplier based on the percentage of county population enrolled in the network. The total FTE value includes the FTE starting values (or the alternative EP value if applicable) and FTE starting value adjustments. It does not include the telehealth ratio modifier, which is applied after the FTE alternative review methodologies are considered.
52. The DMHC shall use a pre-determined multiplier based on the percentage of county population enrolled in a network, according to enrollment levels. Enrollment levels are set forth in **Schedule A-3.**
53. The adjusted total FTE value for the county network shall not exceed 80% of the full-value count of Counseling MHPs the network reported for the county.
54. Provider FTE modifiers and threshold values for high enrollment network counties are set forth in **Schedule A-3**.
55. Combined County Ratio Modifier for CEAC and Rural counties – The ratio modifier for CEAC and rural counties allows certain adjacent counties to be combined for the purposes of calculating a single Counseling MHP ratio applied to each of the combined counties. The Combined County Ratio Modifier for CEAC and Rural counties is subject to the following requirements:
56. A combined pair or grouping of counties shall consist of one of the following:
57. Deficient County Anchor - Grouping: A single Rural or CEAC county that fails to meet the FTE ratio standard, combined with one or more adjacent counties which meet the ratio standard; or
58. Sufficient County Anchor - Grouping: A single county that meets the ratio standard, combined with one or more adjacent Rural or CEAC counties which do not meet the ratio standard.
59. No county shall be included in more than one county grouping within the same network for the purposes of meeting the Counseling MHP FTE ratio standard.
60. In order to be combined in a grouping, each Rural or CEAC county in the grouping that fails to meet the ratio standard (deficient county) must be geographically adjacent to each county in the grouping that meets the ratio standard (sufficient county).
61. A sufficient county may be a county outside of the network service area.
62. The formulas for the Combined County Ratio Modifier are set forth in **Schedule A-4.**
63. Combined County Ratio Modifier for Large Metro, Metro, and Micro counties – The ratio modifier for Large Metro, Metro, and Micro counties allows certain adjacent counties to be combined for the purposes of calculating a single Counseling MHP ratio applied to each of the combined counties. The Ratio Modifier for Large Metro, Metro, and Micro counties is subject to the following requirements:
64. Large Metro, Metro, and Micro counties may only be combined when Counseling MHP network providers within the county are equal or greater than 30% of the count of county Counseling MHPs listed in the DMHC of Consumer Affairs (DCA) database for the county as of the network capture date, available at <https://www.dca.ca.gov>. For further information, see **Schedule A-5**.
65. A combined pair or grouping of counties shall consist of one of the following:
	* 1. Deficient County Anchor - Grouping: A single Large Metro, Metro, or Micro county that fails to meet the FTE ratio standard, combined with one or more adjacent counties which meet the ratio standard; or
		2. Sufficient County Anchor - Grouping: A single county that meets the ratio standard, combined with one or more adjacent Large Metro, Metro, or Micro counties which do not meet the ratio standard.
66. The grouping of counties to meet the FTE ratio standard shall be subject to the following rules:
	* 1. No county shall be included in more than one county grouping within the same network for the purposes of meeting the Counseling MHP FTE ratio standard.
		2. In order to be combined in a grouping, each county in the grouping that fails to meet the ratio standard (deficient county) must be geographically adjacent to each county in the grouping that meets the ratio standard (sufficient county).
		3. A sufficient county may be a county outside of the network service area.
67. Large Metro, Metro, or Micro counties that meet the threshold requirement for a combined county grouping based on DCA data, shall be combined according to the formulas for the Combined County Ratio Modifier set forth in **Schedule A-4.**
68. Ratio Modifier for Partial Counties – Where the Plan’s network service area includes a partial county in which fewer than 20% of the ZIP Codes or fewer than 20% of the county population count are part of the network service area, and the network is unable to meet the ratio standard for the partial county, the DMHC may treat the county like a CEAC or Rural county for the purposes of applying the Combined County Ratio Modifier for CEAC and Rural Counties to the partial county.
69. **The Network Ratio Standard and Alternative Methodologies**
70. Reported networks shall meet the 1:1000 FTE ratio standard for the entire network. The network ratio is calculated by dividing the total enrollment reported for the network by the combined FTE values of all network providers reported for the network, subject to the following rules:
71. The combined FTE value for all network providers is the summation of the following two network provider FTE values:
	* 1. The total FTE values from each network service area county, including the telehealth-only modifier and applicable alternative methodologies that impact the FTE values; and
		2. If applicable, the FTE values for in-person network providers who have practice locations in counties outside of the network service area. The telehealth-only modifier and alternative methodologies are not applied to network providers in counties outside of the network service area.
72. When an alternative methodology is applied to a network provider that modifies the provider’s original FTE value, the application of the alternative methodology shall not generate an FTE value for the provider that exceeds 0.8.
73. **Schedule A-6** sets forth the calculations for a network ratio, including any applicable alternative methodologies.
1. *See* Senate Bill (SB) 221 (Wiener, Chap. 724, Stats 2021), and SB 225 (Wiener, Chap. 601, Stats 2022). [↑](#footnote-ref-2)
2. Section III. of this document is shown in underline to depict the new standards and methodology incorporated in Rule 1300.67.2. [↑](#footnote-ref-3)
3. The DMHC reviews health plan Annual Network Report submissions for compliance with the Knox-Keene Act, pursuant to Health & Safety Code sections 1367.03, 1367.035 and 28 CCR § 1300.67.2.2 (the “Annual Network Review”). [↑](#footnote-ref-4)
4. See also 28 CCR § 1300.67.2. The Knox-Keene Act is set forth in California Health & Safety Code sections 1340 et seq. References to “Section” are to sections of the Act. References to “Rule” refer to the California Code of Regulations, title 28. [↑](#footnote-ref-5)
5. For RY 2024, the ratio standards within this document will not apply to plan networks licensed exclusively for Medi-Cal. [↑](#footnote-ref-6)
6. *See* Rule 1300.67.2.2(i)(5). [↑](#footnote-ref-7)
7. Defined terms pertain to the DMHC’s review under the identified standard, and do not abrogate a Plan’s requirements for maintaining a provider directory, or other reporting requirements under the law. [↑](#footnote-ref-8)