Behavioral Health Department
Alameda County Health

ACBHD Timely Access Data Collection Requirements and Definitions

Contents

Reporting Requirements

On an annual basis, the Department of Health Care Services (DHCS) issues new requirements and guidance related to Network Adequacy data collection for Medi-Cal and Medi-Cal eligible members. For services rendered to members in FY 25-26, Timely Access data reporting is required for:

- **New or established member requests for Psychiatry SMHS Appointments**
    - **Psychiatry Services** are medication support services (prescribing, dispensing, administering) rendered by psychiatrists/physicians (MD, DO), physician assistants (PA), pharmacists (RPH, APH), or licensed nurse types (PMHNP, APN, NPF, NP, CNS).
- **New member requests for Non-Psychiatry SMHS Appointments**
    - **New** is defined as Medi-Cal and Medi-Cal-eligible members who are new to the Mental Health Plan (MHP), or who have not received outpatient services through the MHP in the **last 6 months**.
- **All members requesting a DMC-ODS Substance Use Disorder (SUD) service**

Scope

Timeliness data collection and measurement is intended to determine system ability to offer and provide timely initial and ongoing treatment services.

For SMHS, the following programs are **exempt** from timeliness tracking requirements:

- In-Home Outreach Team (IHOT)/Outreach
- Mobile Crisis
- Enhanced Care Management (ECM)
- SMHS Residential (i.e. Crisis Residential Treatment, Adult Residential Treatment, Short-Term Residential Therapeutic Program)

For DMC-ODS, DHCS requires timely access data collection for the following services:

- Outpatient (OS) and Intensive Outpatient Services (IOS)
- Residential (ASAM 3.1, 3.5, 3.2-WM)
- Opioid Treatment Program (OTP)

Timely Access Standards

Mental Health Plan (MHP)/Specialty Mental Health Services (SMHS) Timely Access Standards	
Service Type	**Standard**
Outpatient Non-Urgent Non-Psychiatry	Offered appointment is within 10 business days of request for services
Psychiatry	Offered appointment is within 15 business days of request for services
Non-Urgent Follow-Up Appointments	Offered follow-up appointment with a non-physician is within 10 business days of the prior appointment
All Urgent SMHS Appointments	• 48 hours for services not requiring prior authorization • 96 hours for services requiring prior authorization

Drug Medi-Cal Organized Delivery System (DMC-ODS) Timely Access Standards	
Service Type	**Standard**
Outpatient SUD Services	Offered appointment is within 10 business days of request for services
Residential	Offered appointment is within 10 business days of request for services
Opioid Treatment Program	Offered appointment is within 3 business days of request for services
Non-Urgent Follow-Up Appointments with a Non-Physician	Offered follow-up appointment with a non-physician is within 10 business days of the prior appointment
All Urgent SUD Appointments	• 48 hours for services not requiring prior authorization • 96 hours for services requiring prior authorization

Prior Authorization

The following services require county review and approval prior to service delivery:

- **SMHS:** Intensive Home-Based Services (IHBS), Day Treatment Intensive (DTI), Day Rehabilitation (DR), Therapeutic Behavioral Services (TBS), Therapeutic Foster Care (TFC), Short-Term Residential Treatment Program (STRTP), outpatient Electroconvulsive Therapy (ECT).
- **DMC-ODS:** SUD Residential **(**ASAM LOCs 3.1, 3.3, 3.5).

Timely Access Data Collection Definitions

Referral Source

This is the person, program, or organization who referred the member to services.

Urgency

Determination of URGENCY is required for all appointments. To provide Behavioral Health Plan standardized guidance, below are urgent service operational questions. One (1) "yes" response to any of the questions indicates a service request is urgent.

SMHS Urgent Service Operational Questions

1. Is the member pregnant or suffering from a severe medical condition and at risk for complications if mental health symptoms are not addressed within the next 48-96 hours (i.e. 2-4 days)?
2. Does the member appear to be at imminent risk of suicide, homicide, grave disability, significant property destruction, loss of housing, risk of incarceration in the next 48-96 hours?
3. Is the member indicating running out of antipsychotics, mood stabilizers, and/or benzodiazepines within the next 7 days? See Appendix for medication list.
4. Is there indication the member needs urgent mental health treatment services for other reasons?

DMC-ODS Urgent Service Operational Questions

1. Does the member require withdrawal management services (ASAM LOC 3.2-WM)?
2. Is the member pregnant?
3. Does the member appear to be at imminent risk of overdosing on any substance in the next few hours or days?
4. Is the member indicating that they are running out of any anti-craving medication such as naltrexone, buprenorphine, or methadone?
5. Is there indication that the member needs urgent substance use treatment services for other reasons?

For DHCS's definition of urgent services, see CA Health & Safety Code 1367.01 (h)(2).

Referred to an Out-of-Network Provider

- If ACBHD is unable to provide necessary services to a member using an in-network provider, the county must allow the member to access services out-of-network.
- This field is only required when a member is referred to an out-of-network provider.
- For information about the out-of-network referral process, contact ACCESS (SMHS) or Center Point (SUD).
- See DHCS BHINs 19-024, 21-008 for more information about out-of-network requirements.

Date of First Contact to Request Services

Requests for services may occur through various pathways, to include but not limited to ACCESS/information and referral helplines and member self-initiation to a service provider.

- If a request for service routes through ACCESS or other referral helplines/Portals, the DATE OF FIRST CONTACT TO REQUEST SERVICES is the date when minimum necessary member-identifying and clinical information is received to determine that Access and Medical Necessity criteria are met for the requested service.
- Requests through ACCESS or other referral helplines/Portals may be made on behalf of a member with the member's consent. In these cases, the DATE OF FIRST CONTACT TO REQUEST SERVICES is the date that the third party provides the minimum necessary information for ACCESS/other helplines/Portals to determine that Access and Medical Necessity criteria are met for the requested service.

Time of First Contact to Request Services

- This is the time of day of the member's FIRST CONTACT TO REQUEST SERVICES.
- The time is only required for URGENT appointment requests. For Urgent appointments, the time from request to first service appointment offered is measured in hours.

First Service Appointment Offer Date

- This is the first available appointment date that is offered to a member at the program (e.g. an intake or assessment appointment), even when a member chooses a different and future appointment date.
- The FIRST SERVICE APPOINTMENT OFFER DATE *cannot* be before the DATE OF FIRST CONTACT TO REQUEST SERVICES, or after the FIRST SERVICE APPOINTMENT RENDERED DATE.

First Service Appointment Offer Time

- This is the actual time of day of the first available appointment that is offered to a member.
- Time is only required for URGENT appointment requests.

First Service Appointment Rendered Date

- This is the date when the program first provides non-administrative clinical services (intake, assessment, crisis, treatment, etc.). It may or may not be the date the clinician starts or completes the assessment. It may also be different from the first service appointment that was offered to the member.
- This information is required when the first service appointment is rendered.
- If the member does not show up for their appointment and the appointment is not rescheduled, the provider should document a Closure Reason and Date and finalize timeliness tracking.

Wait List and Wait List Reason

- A Yes or No response is required for all appointments.
- A Yes response indicates the wait time for the appointment was extended beyond the standard and requires that a reason be provided, with the following options:
    - Member choice: Treatment modality unavailable (e.g. evidence-based practices model, therapy modality, etc.)
    - Member choice: Preferred provider unavailable
    - Member choice: Preferred service medium unavailable (e.g. requested in-person services in lieu of telehealth)
    - No available provider
    - Another reason (please specify)

Follow-Up Appointment

- A FOLLOW-UP APPOINTMENT is the second service appointment. It may be a continuation of the assessment or a treatment session.
- A Yes or No response is required for all requests, except psychiatry.
- A Yes response indicates a follow-up appointment was offered to the member.
- A No response indicates the member was not offered a follow-up appointment.
- If a follow-up appointment was *not* offered, the provider should document a Closure Reason and Date and finalize timeliness tracking.

First Follow-Up Appointment Offer Date

- This is the date of the earliest follow-up appointment that is offered to the member, regardless of whether it is accepted.
- The FIRST FOLLOW-UP APPOINTMENT OFFER DATE cannot be before the first service appointment offer and render dates.
- This field is required whenever a first follow-up appointment is offered.
- If a member declines the first follow-up appointment that is offered, providers should offer alternative dates but enter the earlier appointment that was offered in this field, even though it was not accepted.
- If a member declines all follow up appointments, opting not to engage in treatment, the provider should document a Closure Reason and Date and finalize timeliness tracking.

First Follow-Up Appointment Render Date

- This is the second service that the member receives. It may be the continuation of an assessment or a treatment session.
- It may be different than the first follow up appointment that the member was offered.
- The FIRST FOLLOW-UP APPOINTMENT RENDER DATE cannot be before the first service

appointment offer and render dates.

- This field is required whenever a follow-up appointment is rendered.
- If, despite multiple attempts at rescheduling, a FIRST FOLLOW-UP APPOINTMENT is not rendered, the provider should document a Closure Reason and Date and finalize timeliness tracking.

Follow-Up Appointment Wait Time Extended

- A Yes or No response is required for all appointments.
- A Yes response indicates the wait time for a non-urgent follow-up appointment with a non-physician was extended beyond the standard of 10 business days from the prior appointment.
- If the wait time is extended beyond the standard, a licensed health care provider documents whether the extended wait time was clinically appropriate.
- See CA Health & Safety Code 1367.03 and 28 CCR § 1300.67.2.2 for more information.

Closure Date

- CLOSURE DATE and CLOSURE REASON are only required when there is an unsuccessful connection to services. They are not required if a member successfully engages in treatment.
- If a member does not accept any offered appointments or does not attend the initial or follow up appointments, CLOSURE DATE and CLOSURE REASON are required.
- CLOSURE DATE is the date Closure Reason was determined, and timeliness tracking is no longer required.
- CLOSURE REASON allows for identification of service access issues, such as gaps in member supports (e.g. transportation, childcare) and lends to system improvement opportunities.
- Closure reasons include:
    - Member did not accept any offered appointment dates
    - Member accepted offered appointment date but did not attend initial appointment
    - Member attended initial appointment but did not complete assessment process
    - Member attended first service appointment but declined treatment
    - Member did not meet medical necessity criteria
    - Out-of-county/presumptive transfer
    - Unable to contact (e.g. deceased or unresponsive)
    - Other (please specify)

Scenarios

- **Scenario 1:** ACCESS provides a member with a referral to a provider. The member contacts the provider by phone. The provider initiates a billable service (e.g. assessment, crisis or case management) by phone and offers the member a follow-up appointment.
    - **Date of First Contact to Request Services**: This is the date the member provides ACCESS

with the minimum necessary information to determine that Access and Medical Necessity criteria were met for the requested service.

  - **First Service Appointment Offer Date**: Since a billable service is provided via telehealth, the first service appointment offered and rendered dates are the date the provider initiated the service with the member.
  - **First Follow-up Appointment Offer Date**: This is the earliest follow-up appointment date the provider offered the member, regardless of whether it was accepted.

- **Scenario 2:** ACCESS provides a member with a referral to a provider. The member contacts the provider by phone. The provider checks in briefly with the member and offers an intake appointment.
  - **Date of Contact to Request Services**: This is the date the member provided ACCESS with the minimum necessary information to determine that Access and Medical Necessity criteria were met for the requested service.
  - **First Service Appointment Offer Date**: This is the earliest appointment date the provider offered the member, regardless of whether it was accepted.
- **Scenario 3:** ACCESS provides a member with a referral to a provider. The member contacts the provider by phone. The provider offers the member an intake appointment. The provider contacts the member's psychiatrist to obtain additional clinical information.
  - **Date of Contact to Request Services**: This is the date member provided ACCESS with the minimum necessary information to determine that Access and Medical Necessity criteria were met for the requested service.
  - **First Service Appointment Offer Date**: This is earliest appointment date the provider offered the member. Timeliness tracking is specific to the member's access to care, therefore contact with the member's psychiatrist is not relevant to timeliness tracking.
- **Scenario 4:** An intake appointment is offered to the member by a SUD Portal through a 3-way call with a provider. The member does not attend the intake appointment. The provider contacts the member by phone the next week and schedules a new appointment.
  - **Date of Contact to Request Services**: This is the date the member provided the SUD Portal with the minimum necessary information to determine that Access and Medical Necessity criteria were met for the requested service.
  - **First Service Appointment Offer Date**: This is the earliest date that was offered to the member during the 3-way call for their intake appointment.
  - **First Service Appointment Render Date**: This is the date the member attended the intake appointment.

- **Scenario 5:** A member walks into an outpatient SUD program. The provider gives the member an intake appointment for that same day. The member attends both an individual and group counseling session that first day.
    - In this scenario all dates required for timely access data reporting are the same because they all happened on the same day, the date of admission.

Timeliness Tracking Process

Timely access data entry must be finalized and submitted by providers within **no more than 30 calendar days of having all required data elements**, whether or not the member engages with treatment.

The process for documenting timeliness data is different for SMHS and SUD providers. The following training modules posted on the QA Training page of Provider website contain detailed information for each process:

- MH Timeliness Tracking FY 2025/2026 and Web Application Demo
- Substance Use Disorder Services Timeliness Tracking FY 2025/2026

Note to SUD Providers: **If completing the timeliness tracking template in Clinician's Gateway after the member is discharged from the program, ensure that the *Document Date* on the template is within the member's program enrollment dates.**

Additional Resources

- BHIN 25-013 2025 Network Certification Requirements

Revision History

Date	Details	Responsible Dept.
October 2025	Added the following new sections: Scope, Scenarios, Timeliness Tracking Process, Additional Resources and Appendix	Quality Assurance
October 2025	Updated Reporting Requirements	Quality Assurance
October 2025	Updated Urgent Services Operational questions	Quality Assurance
October 2025	Removed SMHS Services Types/Modalities and DMC-ODS Modalities	Quality Assurance

Appendix

ATTACHMENT 1: Medication List (Antipsychotics, Mood Stabilizers, Benzodiazepines)

ANTIPSYCHOTICS/MOOD STABILIZERS

Active Ingredient	*Brand Name*
aripiprazole	Abilify Maintena
aripiprazole lauroxil	Aristada
aripiprazole	Abilify
chlorpromazine	Thorazine
clozapine	Clozaril
fluphenazine	Prolixin
fluphenazine decanoate	Prolixin Decanoate
haloperidol	Haloperidol
haloperidol decanoate	Haldol Decanoate
loxapine	Loxitane
lurasidone	Latuda
molindone	Moban
olanzapine	Zyprexa
paliperidone palmitate	Invega Hafyera
paliperidone palmitate	Invega Sustenna
paliperidone palmitate	Invega Trinza
perphenazine	Trilafon
pimozide	Orap
quetiapine	Seroquel
risperidone	Perseris
risperidone	Risperdal
risperidone	Risperdal Consta
thioridazine	Mellaril
thiothixene	Navane
trifluoperazine	Stelazine
ziprasidone	Geodon

BENZODIAZEPINES

Active Ingredient	Brand Name
alprazolam	Xanax
clonazepam	Klonopin
diazepam	Valium
flurazepam	Dalmane
lorazepam	Ativan
temazepam	Restoril
triazolam	Halcion