Table of Contents

1. Overview

This report details the methodology of the Department of Health Care Services (DHCS) to certify the provider network of Drug Medi-Cal Organized Delivery System (DMC-ODS) plans in accordance with Title 42 Code of Federal Regulations (CFR) section 438.207. DHCS reviewed data and information from multiple sources, including network data submissions by the DMC-ODS plans, to conduct an analysis of the adequacy of the network of each DMC-ODS plan. DHCS will make available to the Centers for Medicare and Medicaid Services (CMS), upon request, all documentation collected by DHCS from the DMC-ODS plans.

For the 2024 certification year, DHCS published Behavioral Health Information Notice (BHIN) 24-020 which outlines the DMC-ODS plan network certification process and submission requirements. Under this guidance, DMC-ODS plans are required to submit documentation that demonstrates their capacity to serve the anticipated enrollment in each service area. This must be done in accordance with DHCS' standards for access to care, established under the authority of CMS Medicaid and CHIP Final Rule, CMS-2390-F (Final Rule) Sections 438.68, 438.206, and 438.207.[1]

2. Annual Network Methodology

2.1 Time or Distance – Geographic Access Maps

DHCS prepared geographic access maps for DMC-ODS plans using ArcGIS software and Medi-Cal member and provider location data submitted to DHCS from the DMC-ODS plans through the Network Adequacy Certification Tool (NACT) spreadsheet. Network providers were mapped by service type (e.g., outpatient or opioid treatment programs [OTP] service providers) and geographic location, with separate analyses performed for both the adult and children/youth population. The mapping process was automated using Environmental Systems Research Institute technology to calculate the distance between member and provider addresses.

DHCS allowed DMC-ODS plans to utilize telehealth services to meet time or distance standards in cases where the DMC-ODS plan could demonstrate it was unable to contract with an in-person provider, or when its delivery model could still provide the appropriate level of care. Even with this flexibility, at least 85% of members must reside within the required time or distance standards for each provider type by zip code. Although telehealth is permitted to meet time or distance standards under specific circumstances, all members have the right to an in-person appointment, and telehealth can only be provided when medically appropriate, as determined by the provider and as

[1] Managed Care Final Rule, Federal Register, Vol. 81, No. 88

allowed by the applicable provider manual of the delivery system provider manual. DMC-ODS plans are not allowed to restrict in-person appointments in favor of telehealth.

DHCS notified DMC-ODS plans of any deficient zip codes by provider type for both adults and children/youth.

2.1.1 Field-Based Services

DMC-ODS services are to be provided in the least restrictive setting, consistent with the goals of recovery and resiliency. DHCS considered providers traveling to the member or a field-based setting to deliver services in its time or distance methodology. For services where the provider travels to the member to deliver services, the DMC-ODS Plan must ensure services are provided in a timely manner and in accordance with the timely access standards.

2.1.2 Alternative Access Standards Request

Welfare and Institutions Code (WIC) section 14197 allows DMC-ODS plans to submit alternative access standards (AAS) requests for time or distance standards for outpatient and OTP service providers. AAS requests may only be submitted when the DMC-ODS plan has exhausted all other reasonable options for contracting with providers to meet the applicable standards, or if DHCS determines that the requesting DMC-ODS plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access for its members.

DMC-ODS plans that are unable to meet time or distance standards for assigned members are notified by DHCS and must submit an AAS request to DHCS using a DHCS reporting template. The AAS requests of the DMC-ODS plans are organized by zip code, county, service modality, and age group and include the driving time and/or the distance, in miles, between the nearest in-network provider(s) and the most remote members. The request must detail the contracting efforts of the DMC-ODS plan, including an explanation of the circumstances that prevented the plan from obtaining a contract, as well as how the DMC-ODS plan intends to provide services to members who request in-person services.

Requests for AAS may include seasonal considerations (e.g., winter road conditions) when appropriate. As appropriate, any AAS requests from the DMC-ODS plans must include an explanation about gaps in the county's geographic service area, including information about uninhabitable terrain within the county (e.g., desert, forest land).

DHCS reviews the request for AAS and approves or denies each request on each zip code, provider type, and age group basis. DHCS-approved AAS requests are valid for three years. DHCS will annually reassess the compliance of the DMC-ODS plan with time

or distance standards and provide the DMC-ODS plan with updates of any zip codes that are deficient, by age group, and provider type, that are not part of the approved three-year AAS.

DHCS monitors member access on an ongoing basis and includes the findings to CMS in the Network Adequacy Certification Report required under 42 CFR section 438.66(e).[2] DHCS posts all approved AAS requests on its website.[3]

2.2 Telehealth

Pursuant to WIC section 14197, DHCS allows DMC-ODS plans to use telehealth to demonstrate compliance with time or distance standards as an alternate access standard[4] if they meet the contractual and state requirements and the DMC-ODS plans submitted information for telehealth providers to DHCS. DMC-ODS plans are required to submit annual provider data that indicates provider type, and whether the provider is available for in-person services, as well as telehealth services.

2.3 Capacity and Composition

In accordance with Title 42 CFR section 438.207(b)(1), DMC-ODS plans are required to have a provider network composed of the appropriate range of outpatient services, residential services, and OTP services for the expected number of members serviced by the DMC-ODS plan. DMC-ODS plans are required to contract with the required provider types outlined in their Intergovernmental Agreement.

DMC-ODS plans must contract with the following provider types or facilities based on contractual, State, or federal requirements:

- Outpatient substance use disorder (SUD) Services provided by Drug Medi-Cal (DMC)-certified outpatient and intensive outpatient facilities.
- Opioid Use Disorder Services provided by DMC-certified OTP facilities.
- Residential SUD Services provided by DMC-certified, state-licensed, and American Society of Addiction Medicine (ASAM) designated residential facilities.

DMC-ODS plans submitted the NACT, which included the name of the provider or facility, the location of the provider or facility, and the contract status of the DMC-ODS plan with the provider or facility.

As part of the process of evaluating the capacity and composition of DMC-ODS plans, DHCS calculated the projected utilization of services by the DMC-ODS plan, evaluated

---

[2] 42 CFR sections 438.68(d)(2), 438.66(e)(2)(vi)
[3] DHCS: Network Adequacy AAS Submissions
[4] WIC Section 14197(e)(4)

contracted facilities to determine the maximum number of members that could be served in those facilities, and developed a seeking treatment estimate, which was compared against an expected utilization projection developed by the DMC-ODS plans.

The DHCS projected utilization methodology based on monthly Medi-Cal enrollment totals obtained from the Medi-Cal Eligibility Data System (MEDS) database. Using the Medi-Cal enrollment data of two state fiscal years (FY), two sets of projections were produced for each county: one for children and youth (aged 0-17) and one for adults (aged 18 and over). Monthly enrollment totals were forecasted through the end of the network certification period. For the FY 2024-25 network certification period, the projection is through June 2025).

Each DMC-ODS plan was required to provide a list of contracted facilities as part of their annual submission. To verify the network composition of the DMC-ODS plan, DHCS analyzed the list of facilities submitted and the maximum number of members that can be served at any given time for each facility.

To develop what is referred to as the seeking treatment estimate, DHCS used the 2019 National Survey on Drug Use and Health[5] and combined substance use disorder (SUD) estimates, then applied the percentage of individuals aged 12-17 (4.55%) and 18+ (9.23%) estimated to need treatment services to the Medi-Cal enrollment projections through June 2025 for each age group. DHCS then applied 10%, which comes from the California-specific 2022 Edition - Substance Use in California - California Health Care Foundation (chcf.org), to the estimated number of members in need of treatment services to estimate the number who will seek treatment.

DMC-ODS plans were also required to provide their expected utilization projections. To determine the network capacity and sufficiency of DMC-ODS plans to serve the Medi-Cal population, DHCS compared the expected utilization calculated by DMC-ODS plans, and the seeking treatment estimate, calculated by DHCS. If the DMC-ODS plan projected a higher number of members expected to utilize services, that number was used to determine if the network composition was sufficient for the DMC-ODS plan. However, if the projected total per age group for the DMC-ODS plan were lower than the seeking treatment estimate total per age group from DHCS, DHCS applies the percent difference between the seeking treatment estimate and the expected utilization projection of the DMC-ODS plan per treatment modality and per age group to increase the estimate to meet or exceed the seeking treatment estimate total. This final figure (new need estimate) was then used to determine if the network composition of the DMC-ODS plan was sufficient.

[5] 2019 NSDUH Annual National Report | CBHSQ Data

To strengthen oversight of capacity and composition requirements, DHCS is transitioning from the NACT, which is a Microsoft Excel based data collection tool, to a standardized, automated system to collect DMC-ODS plan provider network data. Data will be collected via the X12 274 Health Care Provider Directory Standard (274 Provider Network Data), an electronic data interchange standard. This will ensure DMC-ODS provider network data submitted to DHCS is consistent, uniform, and aligns with national standards. It will also support expanded tracking and monitoring of the full array of DMC-ODS services and increased frequency of analyses.

2.4 Appointment Wait Time: Timely Access Standards

DHCS requires each DMC-ODS plan to have a system in place for tracking and measuring the timeliness of care, which includes timeliness to receive a first appointment and follow-up appointment for outpatient, residential, and OTP services.

DHCS performs timely access analyses utilizing a data-collection tool named the Timely Access Data Tool (TADT). The TADT calculates compliance with timely access standards by using the date of first contact from new members (as defined by each county) and the date of the first offered available appointment, which qualifies as a billable service. The number of business days between these two numbers is evaluated for adherence to standards. DMC-ODS plans must have offered appointments within timely access standards for the modalities of outpatient SUD services, residential services, OTP, all urgent SUD appointments, and non-urgent follow-up appointments with a non-physician, at a minimum rate of 80% to be considered compliant with standards.

In a continuous quality improvement process, DHCS continues to strengthen and refine the timely access reporting and analysis methodology for analysis, with the goal of improving the validity of initial and follow-up appointment time data.

2.5 Language Capabilities

DMC-ODS plans are required to maintain and monitor a network of providers that is supported by written agreements and is sufficient to provide adequate access to covered services for all members, including those with Limited English Proficiency.[6] DMC-ODS plans are also required to make oral interpretation and auxiliary aids, such as Teletypewriter, Telecommunications Device for the Deaf, and American Sign Language (ASL) services available to members, free of charge, for any language.[7]

To demonstrate compliance with these requirements, DMC-ODS plans must submit its contracts with interpreters for interpretation and language line services. In addition,

[6] 42 CFR section 438.206(b)(1)
[7] 42 CFR section 438.10(h)(1)(vii)

DMC-ODS plans are required to report, in their provider directory and in the NACT, the cultural and linguistic capabilities of network providers, including languages (ASL inclusive) offered by the provider or a skilled medical interpreter at the provider's office and whether the provider has completed cultural competence training.[8]

2.6 Mandatory Provider Types – Indian Health Care Providers

In accordance with 42 CFR section 438.14(b)(1), DMC-ODS plans were required to demonstrate that there were sufficient Indian Health Care Providers (IHCP), participating in the network of the DMC-ODS plan to ensure timely access to services for American Indian members who were eligible to receive services. As such, DMC-ODS plans were required to offer to contract with an IHCP in their contracted service area.

The NACT includes required elements for each DMC-ODS plan. If the DMC-ODS plan did not have an executed contract with an IHCP, the DMC-ODS plan was required to submit an explanation to DHCS and documentation of its efforts to contract with one or more IHCPs.

DHCS reviewed the submissions of the DMC-ODS plan and verified the information with approved data sources to ensure compliance. DHCS verified the reported efforts of the DMC-ODS plan to contract with an IHCP in the county by comparing reported providers with a list of facilities known to DHCS.

3. Network Adequacy Determinations

DHCS evaluates the data submitted by the DMC-ODS plans to determine compliance with network adequacy standard and makes the following determinations:

- A determination of "Met" means the DMC-ODS plan achieved the required threshold for the assessed standard necessary to be deemed compliant with that standard.
- A determination of "Unmet" means the DMC-ODS plan did not achieve the required threshold for the assessed standard needed to be deemed compliant with that standard.

DMC-ODS plans that have a designation of Unmet for any network adequacy standard or requirement will be issued a Corrective Action Plan (CAP). DMC-ODS plans are required to submit a plan of correction within 30 calendar days to address the deficiency, which is subject to the approval of DHCS. DHCS monitors the CAP to ensure the documents submitted by the DMC-ODS plans are sufficient to demonstrate that the network adequacy standards identified as deficient have been resolved. The Network Adequacy and Access Assurances Report (NAAAR) data for this reporting period does

[8] 42 CFR section 438.10(h)(1)(vii)

not include the number of plans that resolved the deficiencies identified in their CAP. Based on experience, many CAPs issued to DMC-ODS plans are promptly resolved through addressing data reporting issues. As such, these CAPs are not indicative of bona fide network deficiencies. CAP requirements for the DMC-ODS plans that remain non-compliant are as follows:

- Provide DHCS with status updates, when requested by DHCS depending on the nature of the deficiency, that demonstrate the progress made by the DMC-ODS plan towards correcting the identified deficiencies.
- Authorize Out-of-Network (OON) access and demonstrate that the DMC-ODS plan provide OON access information to its members and ensure that its members, services staff, network providers, and subcontractors received training on the OON requirements, including the right for members to request OON access for SUD services and transportation to providers when the DMC-ODS plan is unable to comply with ANC requirements.
- Participate in technical assistance meetings with DHCS, when requested, to discuss CAP progress.
- The DMC-ODS plan may, at the discretion of DHCS, be required to submit updated network data until it demonstrates compliance with network adequacy standards.

DHCS continues taking steps to strengthen its oversight and enforce compliance with network adequacy requirements. Pursuant to WIC section 14197.7, DHCS has the authority to take enforcement actions such as imposing temporary withholds, monetary sanctions, and administrative sanctions on DMC-ODS plans for network adequacy deficiencies or failure to adhere to annual network certification requirements. In 2025, DHCS issued BHIN 25-023 to outline how it may impose administrative and monetary sanctions and contract terminations with MHPs. DHCS will utilize the enforcement tiers described in this guidance when determining what enforcement action to take against an MHP that fails to meet network adequacy certification requirements.

4. Next Steps for Improvement

To strengthen monitoring and oversight activities and improve member access to care, DHCS seeks to update or add methodologies for network adequacy monitoring and timely access compliance:

- **Data standardization and integrity:** DHCS is moving to a single standard for plans to submit network and program data to DHCS monthly using the 274 Provider Network Data. This will ensure DMC-ODS provider network data submitted to DHCS is consistent, uniform, and aligns with national standards. It

will also support expanded tracking and monitoring of the full array of DMC-ODS and increased frequency of analyses.

- **Use of third-party secret shopper surveys for timely access and network validation:** To comply with the new Final Rule (42 CFR section 438.68(f)) by January 2029, DHCS will leverage its External Quality Review Organization to perform validation of timely access standards, provider network data, and provider network directories across all Medi-Cal managed care delivery systems using a third-party secret shopper survey method. By the end of the 2025 calendar year, DHCS intends to implement a limited scope secret shopper process for DMC-ODS providers specific to the validation of timely access.
- **Automation of Timely Access Data Collection:** DHCS continues to explore options to automate the collection of timely access data from the DMC-ODS plans.
- **Time or Distance Census Methodology:** DHCS will be updating the time or distance methodology for DMC-ODS plans to align with the managed care delivery system and the California Department of Managed Health Care. The updated methodology will utilize population points instead of member addresses.

5. Appendices

Time or Distance Standards

Outpatient Substance Use Disorder Services include Outpatient Treatment (also known as Outpatient Drug Free or ODF services), and Intensive Outpatient Services.[9]

- Up to **15 miles or 30 minutes** from the member's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.
- Up to **30 miles or 60 minutes** from the member's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Stanislaus, and Ventura.
- Up to **60 miles or 90 minutes** from the member's place of residence for the following counties: El Dorado, Fresno, Humboldt, Imperial, Kern, Lake, Lassen, Mariposa, Mendocino, Merced, Modoc, Monterey, Napa, Nevada, San Benito,

[9] WIC Section 14197(c)(4)(A)

San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Siskiyou, Tulare, and Yolo.

Opioid Treatment Programs[10]

- Up to **15 miles or 30 minutes** from the member's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.
- Up to **30 miles or 60 minutes** from the member's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Stanislaus, and Ventura.
- Up to **45 miles or 75 minutes** from the member's place of residence for the following counties: El Dorado, Fresno, Kern, Lake, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Tulare, and Yolo.
- Up to **60 miles or 90 minutes** from the member's place of residence for the following counties: Humboldt, Imperial, Lassen, Mariposa, Mendocino, Modoc, San Benito, Shasta, and Siskiyou.

Table: Timely Access Standards for DMC-ODS Plans[11]

Modality Type	Standard
Outpatient Services – Outpatient Substance Use Disorder Services	Offered an appointment within 10 business days of request for services.
Residential	An appointment within 10 business days of request for services.
Opioid Treatment Program*	Within three business days of request
Non-urgent Follow-up Appointments with a Non-Physician	Offered an appointment within 10 business days of the request for services.
*For OTP patients, the OTP standards apply equally to both buprenorphine and methadone where applicable. Buprenorphine is not specified in several areas of the current regulations, so we default to the federal regulations. (For example, with take-home medication, time in treatment requirements is not applicable to buprenorphine patients.) Urgent care means health care provided to a member when the member's condition is such that the member faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the member's life or health or could jeopardize their ability to regain maximum function.	

[10] WIC Section 14197(c)(4)(B)
[11] WIC Section 14197(d)(1)