2023 NETWORK ADEQUACY METHODOLOGY REPORT FOR DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEMS

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

2023 NETWORK ADEQUACY METHODOLOGY REPORT FOR DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEMS

1. Executive Summary

This report details the Department of Health Care Services' (DHCS) methodology description to certify Drug Medi-Cal Organized Delivery System (DMC-ODS) plan networks 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 2023 certification year, DHCS published Behavioral Health Information Notice (BHIN) 23-041 which prescribes the DMC-ODS plan network certification process and submission requirements. DHCS delayed the release of the FY 2023-24 annual network certification (ANC) BHIN in order to incorporate critical updates to timely access reporting requirements for DMC-ODS Plans, as described in Section 2.4 Appointment Wait Time: Timely Access Standards. DMC-ODS plans are required to submit documentation that demonstrates the capacity to serve the expected enrollment in each service area 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]

For the 2023 results, 27 DMC-ODS plans did not meet one or more network adequacy standard, which includes time or distance standards, network capacity and composition, timely access standards, or a combination thereof. Due to the delayed release of the ANC BHIN, at the time of NAAAR submission DHCS is only able to report on which DMC-ODS plans are currently out of compliance with ANC requirements. DMC-ODS plans are required to submit a plan of correction within 30 days to address the deficiency, which is subject to DHCS approval. DHCS will monitor the corrective action plan (CAP) to ensure the DMC-ODS plans submit the documentation required to meet network adequacy standards. NAAAR results currently do not include the number of plans that will go onto promptly resolve CAPs after receiving DHCS technical assistance. Based on experience, many CAPs issued to DMC-ODS plans are promptly resolved through addressing data reporting issues; such 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 monthly status updates that demonstrate action steps the DMC-ODS plan is undertaking to correct the CAP deficiency(ies);
- Authorize Out-of-Network (OON) access and demonstrate the ability to effectively provide OON access information to beneficiaries and ensure that its beneficiaries, services staff, network providers, and subcontractors are trained on the mandates, including the right for beneficiaries to request OON

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

access for substance use disorder (SUD) services and transportation to providers where the DMC-ODS plan is unable to comply with annual network certification requirements.
- Participate in technical assistance meetings with DHCS to discuss CAP progress.
- Plans will be periodically required to resubmit their network data until they can demonstrate they have achieved compliance.

DHCS is taking steps to strengthen oversight and enforce compliance with DMC-ODS network adequacy requirements. DHCS is authorized through Welfare and Institution Code 14197.7 to take enforcement actions, including imposing administrative and monetary sanctions on DMC-ODS plans. If the DMC-ODS plan is not making satisfactory progress toward resolving their deficiency(ies), DHCS may impose administrative and monetary sanctions, including the temporary withholding of funds. In 2022, DHCS issued BHIN 22-045 to provide guidance regarding the DMC-ODS sanctions policy.

2. Annual Network Methodology

2.1. Time or Distance Standards – Geographic Access Maps

The Final Rule required DHCS to establish network adequacy standards effective July 1, 2018. The California Welfare and Institutions Code (WIC) section 14197 outlines California's state-specific network adequacy standards, as set forth in Attachment A. They include time or distance standards based on county Medi-Cal population and are applicable to outpatient and opioid treatment program (OTP) service providers.

DHCS prepared geographic access maps for DMC-ODS plans based on Medi-Cal beneficiary and provider location data submitted to DHCS in a spreadsheet named the Network Adequacy Certification Tool (NACT) and using ArcGIS software. DHCS plotted time or distance for all network providers, stratified by service type (e.g., outpatient or opioid treatment programs) and geographic location, for both adults and children/youth. The mapping process was automated using Environmental Systems Research Institute technology, which determines the precise distance between beneficiary and provider addresses.

DHCS allowed DMC-ODS plans to utilize telehealth services as a means of meeting time or distance standards in cases where the DMC-ODS plan can demonstrate it has been unable to contract with an in-person provider or if they can demonstrate that its delivery structure is capable of delivering the appropriate level of care. However, 85% of beneficiaries must reside within the required time and distance standards for provider types by zip code. Although DHCS proposes that telehealth will be permitted to meet time or distance standards, all beneficiaries have the right to an in-person appointment, and telehealth can only be provided when medically appropriate, as determined by the provider and as allowed by the applicable delivery systems'

provider manual. Plans are not allowed to restrict in-person appointments in favor of telehealth.

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

2.1.1. Alternative Access Standards Requests

WIC 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 in order 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.

DMC-ODS plans that are unable to meet time or distance standards for assigned beneficiaries are notified 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 and county and include the driving time and/or the distance, in miles, between the nearest in-network provider(s) and the most remote beneficiaries. The request must detail the DMC-ODS plan's contracting efforts, including an explanation of the circumstances that inhibited the ability to obtain a contract.

Requests for AAS may include seasonal considerations (e.g., winter road conditions) when appropriate. As appropriate, any AAS requests from the DMC-ODS plans 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 a zip code and provider type basis. DHCS-approved AAS requests are valid for three years and must be resubmitted to DHCS for approval annually.

DHCS monitors beneficiary access on an ongoing basis and includes the findings to CMS in the Network Adequacy Certification Report required under Title 42 Code of Federal Regulations part 438.66(e).[2] DHCS will post all approved AAS requests on its website.[3]

2.2. Telehealth

Pursuant to WIC 14197, DHCS is allowing 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 plans submitted

[2] 42 CFR sections 438.68(d)(2), 438.66(e)(2)(vi)
[3] WIC Section 14197(f)(4)
[4] WIC Section 14197(e)(4)

information for telehealth providers to DHCS. The 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. Service Fulfillment – Capacity and Composition Methodology

DHCS developed a methodology to determine the projected enrollment for this contract year for each DMC-ODS plan. The methodology considers the DMC-ODS plan's network composition to determine that the number of facilities, and maximum number of beneficiaries, per modality can meet expected utilization.

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

DHCS' projected utilization methodology is based on monthly enrollment totals derived from the Medi-Cal Eligibility Data System (MEDS) database. Utilizing two state fiscal years (FY) of Medi-Cal enrollment data (e.g., for this certification period, DHCS is using FY 2020-21 and 2021-22), two sets of projections are produced for each county: one for children and youth (aged 0-17) and one for adults (aged 18 and over). Monthly enrollment totals are forecasted through the certification period (e.g., for FY 2023-24 certification period, the projection is through June 2024).

Utilizing the 2019 National Survey on Drug Use and Health[5] combined substance use disorder estimates, DHCS applied the percentage of those aged 12-17 (4.55%) and 18+ (9.23%) estimated to be in need of treatment services to the Medi-Cal enrollment projections through June 2024 for each age group. DHCS then applied 10% to the estimated beneficiaries in need of treatment services to estimate the number who will actually seek treatment. The 10% comes from the California-specific 2018 Edition — Substance Use in California - California Health Care Foundation (chcf.org).

For further validation of expected utilization, DMC-ODS plans were also required to provide projections of beneficiaries who will seek treatment.

To determine DMC-ODS plans' network capacity and sufficiency to serve the Medi-Cal population, DHCS compared the expected utilization (as calculated by DMC-ODS plans) and the seeking treatment estimate (as calculated by DHCS). If the DMC-ODS plan projected a higher number of beneficiaries expected to utilize services, that number was used to determine if the DMC-ODS plan's network composition was sufficient However, if the DMC-ODS plan's projections were lower than DHCS' estimate, DHCS

[5] Substance Abuse and Mental Health Administration sponsored research evaluates the use of illegal drugs, prescription drugs, alcohol, and tobacco and misuse of prescription drugs; substance use disorders and substance use treatment major depressive episode and depression care; serious psychological distress, mental illness, and mental health care using data from the National Survey on Drug Use and Health.

utilized the seeking treatment estimate as a baseline for determining if the DMC-ODS plan's network composition was sufficient.

The provider network evaluation consisted of reviewing the DMC-ODS plan's compliance with contractual, state and federal requirements for the Annual Network Certification, including network composition and additional certification requirements, as applicable.

In accordance with Title 42 of the Code of Federal Regulations (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 beneficiaries within the DMC-ODS plan. DMC-ODS plans are required to contract with the required provider types outlined in their intergovernmental agreement.

DHCS applied the methodology described in Section 4.1 to evaluate the DMC-ODS plan's provider network to ensure it will meet the needs of the anticipated number of beneficiaries.

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

- Outpatient substance use disorder services provided by 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 designated residential facilities.

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

DHCS reviewed the DMC-ODS plan's submissions and validated the information with DHCS data sources to ensure compliance. To strengthen oversight of capacity and composition requirements, DHCS is transitioning from the NACT, which is a manual 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 for outpatient, residential, and opioid treatment program services.

DHCS performs analyses utilizing a data-collection spreadsheet named the Timely Access Data Tool to calculate county compliance by using the date of first contact to request services and the number of days between that date and the assessment appointment first offer date, wherein 80% of new beneficiaries must have been offered appointments within 10 business days for outpatient and residential treatment and three business days for opioid treatment.

In a continuous quality improvement process, DHCS continues to strengthen and refine the timely access reporting and analysis methodology for analysis on an annual basis, with the goal of improving the validity of initial and follow-up appointment time data and strengthening DHCS' monitoring and compliance enforcement with network adequacy standards for DMC-ODS plan networks. Consequently, DHCS provides updated templates and reporting guidance for each annual network certification.

For 2023, DHCS made significant updates to the TADT to expand and improve timely access monitoring. These changes included:

- Revisions of terminology and instructions to align with DHCS' CalAIM policy changes and clarify that an array of appointment types should be tracked.
- Replacement of the County Client Numbers (CCNs) with the collection of Client Index Numbers (CINs), which sought to further ensure protection of PHI and facilitate more detailed data analysis by enabling DHCS to perform data matching with demographic data already available to the department.
- Addition of appointment data to align with updates to Senate Bill (SB) 221, which revised California Health and Safety Code §1367.03 to explicitly apply appointment time standards to follow-up appointments with a non-physician substance use disorder provider.
- Addition of out-of-network provider referral appointment data to ensure DMC-ODs plans are following access to care requirements as specified in the DMC-ODS Intergovernmental Agreement.

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 all covered services for all beneficiaries, including those with Limited English Proficiency.[6] Plans are also required to make oral interpretation and auxiliary aids, such as Teletypewriter (TTY), Telecommunications Device for the Deaf (TDD), and American Sign Language (ASL) services available and free of charge for any language.[7] To

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

demonstrate compliance with these requirements, the plans must submit subcontracts for interpretation and language line services. In addition, plans are required to report, in the Plan's 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 Title 42 Code of Federal Regulations, subsection 438.14(b)(1), Plans are required to demonstrate that there are sufficient Indian Health Care Providers (IHCP), formerly known as American Indian Health Facilities, participating in the Plan's network to ensure timely access to services for American Indian beneficiaries who are eligible to receive services. As such, Plans are required to offer to contract with each IHCP in their contracted service area (i.e., county).

The NACT reporting template includes required elements for each DMC-ODS counties. If the DMC-ODS plan did not have an executed contract with an IHCP, the plan was required to submit to DHCS an explanation and supporting documentation to justify the absence of a contract.

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

3. Upcoming Methodology Changes

To strengthen monitoring and oversight of DMC-ODS plans' network adequacy and improve member access to care, DHCS intends to add additional 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 on a monthly basis 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 438.68(f)) by January 2029, DHCS plans to standardize its process to use our independent External Quality Review Organization to perform validation of timely access, provider network data, and provider network directories across all Medi- Cal managed care delivery systems. Until then, DHCS intends to conduct a more limited scope

[8] 42 CFR § 438.10(h)(1)(vii)

secret shopper process in 2025 for DMC-ODS providers specific to the validation of timely access. **Automation of Timely Access Data Collection.** DHCS is exploring options to automate the collection of timely access data from the DMC-ODS counties and providers.

4. Appendices

Table 1: Network Adequacy Standards

Outpatient Substance Use Disorder Services

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

Up to **15 miles or 30 minutes** from the beneficiary'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 beneficiary'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 beneficiary's place of residence for the following counties: El Dorado, Fresno, Humboldt, Imperial, Kern, Lake, Lassen, Mendocino, Merced, Modoc, Monterey, Napa, Nevada, San Benito, San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Siskiyou, Tulare, and Yolo.

Opioid Treatment Programs

Up to **15 miles or 30 minutes** from the beneficiary'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 beneficiary'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 beneficiary'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 beneficiary's place of residence for the following counties: Humboldt, Imperial, Lassen, Mendocino, Modoc, San Benito, Shasta, and Siskiyou.