Table of Contents

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 each DMC-ODS plans network. DHCS will make available to Centers for Medicare and Medicaid Services (CMS), upon request, all documentation collected by the State from the DMC-ODS plans.

DHCS published Behavioral Health Information Notice 22-033 which prescribes the DMC-ODS plan network certification process and submission requirements. 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 2022 overall results, 11 DMC-ODS plans did not meet all network adequacy standards due to deficiencies in relation to time or distance standards, network capacity and composition (provider to beneficiary ratios), timely access standard, or combination thereof. These 11 DMC-ODS plans are placed on a Corrective Action Plan (CAP) to resolve their network adequacy deficiencies. CAP requirements for the 11 DMC-ODS plans include:

- 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 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 DHCS CAP progress.

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 withhold of funds. In 2022, DHCS issued BHIN 22-045 to provide guidance regarding the DMC-ODS sanctions policy.

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

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 upon Medi-Cal beneficiary and provider location data submitted in the Network Adequacy Certification Tool (NACT) 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 adult 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 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. DMC-ODS plans' AAS requests 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 which inhibited the ability to obtain a contract.

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 one contract year and must be resubmitted to DHCS for approval annually.

DHCS monitors beneficiary access on an on-going basis and include 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 alternative access standards 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 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 MEDS. Utilizing one FYs of Medi-Cal enrollment data (e.g., for this certification, DHCS is using state FY 2019-20 and 2020-21), two sets of projections are produced for each county: one for children and youth (aged 12-17) and one for adults (aged 18 and over). Monthly enrollment totals are forecasted through the certification period (e.g., for FY 2022-23 certification the projection is through June 2023).

[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)

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 2023 for each age group. DHCS then applied a percentage of 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 is sufficient. However, if the DMC-ODS plan's projections were lower than DHCS' estimate, DHCS utilized the *seeking treatment estimate* as a baseline for determining if the DMC-ODS plan's network composition is 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.

In addition to the application of the methodology described in section 4.1, where a DMC-ODS plan is determined deficient for any mandatory level of care, the plan is allowed to submit an AAS request (subject to approval by DHCS) for capacity and composition. The AAS request must outline the immediate plan (e.g., out of network

[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.

providers, Federally Qualified Health Center) for provision of services and a long-term plan to obtain providers for all mandatory levels of care.

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 substance uses disorder services provided by DMC-certified, state-licensed, and ASAM designated residential facilities.

DMC-ODS plans submitted 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 a manual data collection tool to a standardized, automated system to collect DMC-ODS plan provider network data via the 274 Health Care Provider Directory 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 timeliness of care, which includes timeliness to receive a first appointment for outpatient, residential, and opioid treatment program services.

DHCS performs analyses to calculate county compliance 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 beneficiaries must have been offered an appointment within ten business days for outpatient and residential treatment and three business days for opioid treatment.

DMC-ODS plans were required to submit timely access data for new beneficiaries who request services during the reporting period. Plans were not placed on a CAP for noncompliance with timely access standards for the FY 22-23 Annual Network Adequacy Certification. However, they did receive findings from DHCS regarding the percentage of requests meeting the standard. DMC-ODS plans that did not meet the timely access standard received technical assistance with their findings. For FY 23-24 Annual Network Adequacy Certification, DHCS will enforce compliance with DMC-ODS timely access and appointment wait time standards.

2.5. Language Capabilities

DMC-ODS' 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 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 - American Indian Health Facilities

In accordance with Title 42 Code of Federal Regulations, subsection 438.14(b)(1), Plans are required to demonstrate that there are sufficient American Indian Health Facilities (AIHF) 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 AIHF in their contracted service area (i.e., county).

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

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

[6] 42 CFR § 438.206(b)(1)
[7] 42 CFR Section 438.10(h)(1)(vii)
[8] 42 CFR Section 438.10(h)(1)(vii)

3. Upcoming Methodology Changes

To strengthen monitoring and oversight of DMC-ODS plans' network adequacy and improve member access to care, DHCS proposes 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 X12 274 Health Care Provider Directory 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 SMHS and increased frequency of analyses.
- **Use of third-party secret shopper surveys for timely access and network validation:** DHCS plans to standardize its process to use our independent EQRO to perform validation of timely and provider network data across all Medi-Cal managed care delivery systems. Until then, DHCS intends to conduct a more limited scope secret shopper process in 2025 for DMC-ODS providers. Additionally, DHCS will be developing additional validation activities to verify the accuracy of DMC-ODS provider network directories.
- **Compliance monitoring and enforcement for DMC-ODS Timely Access standards will commence in FY 23-24.** DHCS plans to monitor and enforce timely access compliance for appointment wait time standards using the Date of First Contact to Request Services and the number of days between that date and the Appointment First Offer Date, wherein, 80% of beneficiaries must have been offered an appointment within the appropriate standard.

4. Appendices

Table 1. Network Adequacy Standards

Provider Type	Time or Distance Standard by County Size[9]			
	Rural	Small	Medium	Large
Outpatient Services	60 miles or 90 minutes from the beneficiary's residence	60 miles or 90 minutes from the beneficiary's residence	30 miles or 60 minutes from the beneficiary's residence	15 miles or 30 minutes from the beneficiary's residence
Opioid Treatment Program Services	60 miles or 90 minutes from the beneficiary's residence	45 miles or 75 minutes from the beneficiary's residence	30 miles or 60 minutes from the beneficiary's residence	15 miles or 30 minutes from the beneficiary's residence

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