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1. Executive Summary

The Department of Health Care Services (DHCS) is responsible for certifying Drug Medi-Cal Organized Delivery System (DMC-ODS) provider networks on an annual basis. The network certifications are required to be submitted to the Center for Medicare and Medicaid Services (CMS) prior to July 1 of each year.

DHCS published Information Notice #18-011[1] 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.[2]

DHCS conducted a comprehensive review of each DMC-ODS plan's provider networks. Based on this review, DHCS found that each DMC-ODS plan complied with the Annual Network Certification requirements set forth in 42 CFR Section 438.207 or that the DMC-ODS plan will receive a conditional pass with Corrective Action Plan (CAP) mandates. DHCS submits this report as an assurance of compliance and includes attachments that are examples of criteria DHCS used to certify the DMC-ODS plan's provider networks. DHCS will make available to CMS, upon request, all documentation collected by the State from each DMC-ODS plan.[3]

1.1. Medicaid Managed Care Final Rule

The Final Rule required DHCS to implement regulations related to network adequacy standards and certification, and established requirements for DMC-ODS plan network certification that expanded on previous provider network monitoring efforts and contractual provider network requirements. The Final Rule required that states not only meet the federal requirements of 42 CFR Sections 438.68, 438.206(c), and 428.207, but also establish state specific network adequacy standards to ensure that DMC-ODS plans are meeting the current needs of the beneficiaries and projected future beneficiaries.

To assure compliance with established federal and State standards, the Final Rule requires DHCS to submit to CMS an annual network certification of the DMC-ODS plans. Additionally, DHCS must submit a network certification anytime there has been a significant change as defined by DHCS in the DMC-ODS plans operations that would affect the adequacy of capacity and services, including changes in DMC-ODS plan services, benefits, geographic service area, composition of, or payments to its provider network; or enrollment of a new population in the DMC-ODS plan.[4]

[1] MHSUDS Information Notice 18-011 Federal Network Adequacy Standards for Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Pilot Counties.
[2] Managed care Final Rule, Federal Register, Vol. 81, No. 88.
[3] Title 42 Code of Federal Regulation (CFR) section 438.207(e)
[4] 42 CFR Section 438.207(c)

1.2. Assurance of Compliance Overview

The assurance of compliance report reviews the network certification process and validation activities that DHCS has conducted. The report is organized by the following sections:

- Section 1: Medicaid Managed Care Final Rule: Network Adequacy Standards and Certification Requirements;
- Section 2: State Medicaid Program: State Network Adequacy Standards and DMC-ODS plan Contractual Requirements;
- Section 3: Network Certifications for newly enrolled populations, changes to existing benefits, and increases in DMC-ODS plan scope;
- Section 4: Annual Network Certification Process and Evaluation;
- Section 5: CAP Process and Monitoring Activities; and
- Section 6: Annual Network Certification Results.

2. California Medicaid Program

2.1. Drug Medi-Cal Organized Delivery System in California

The DMC-ODS provides a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services, enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced-based practices in substance abuse treatment, and coordinates with other systems of care.

This approach provides the beneficiary with access to the care needed in order to achieve sustainable recovery. DMC-ODS will demonstrate how organized substance use disorder care increases the success of DMC beneficiaries while decreasing other system health care costs.

In California, there are 30 DMC-ODS plans that require an annual network adequacy certification:

- Alameda County
- Contra Costa County
- El Dorado County
- Fresno County
- Imperial County
- Kern County
- Los Angeles County
- Marin County
- Merced County
- Monterey County
- Napa County
- Nevada County
- Orange County
- Placer County
- Riverside County
- Sacramento County
- San Benito County
- San Bernardino County

- San Diego County
- San Francisco County
- San Joaquin County
- San Luis Obispo County
- San Mateo County
- Santa Barbara County
- Santa Clara County
- Santa Cruz County
- Stanislaus County
- Tulare County
- Ventura County
- Yolo County

2.2. Network Adequacy Standards

In July 2017, DHCS published guidance establishing Network Adequacy Standards in compliance with the network adequacy provisions of the Final Rule. The network adequacy standards were subsequently codified in Welfare and Institutions Code (W&I). The network adequacy standards are outlined in Attachment A, including time and distance standards for outpatient services and opioid treatment program (OTP) services.

In addition, the Final Rule permits states to grant exceptions to the network adequacy standards.[5] If a DMC-ODS plan cannot meet the time and distance standards, it may submit a request for alternative access which, if approved, allows for an alternative time and distance standard for a specific zip code.[6] DHCS may grant requests for alternative access standards (AAS) if the DMC-ODS plan has exhausted all other reasonable attempts to contract with providers to meet the applicable network adequacy standard or if DHCS determines that the DMC-ODS plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access with the current provider network.[7] DHCS will continually monitor beneficiary access to providers and communicate the findings to CMS in the managed care program assessment report required under 42 CFR 438.66(e). DHCS will post all approved AAS on its website.[8]

2.3. Requirements

In order to ensure DMC-ODS plans have adequate provider networks, DHCS leveraged the Annual Network Certification process to combine network requirements that are required under the contract with DHCS and State and federal law.

- DMC-ODS Plan Contractual Requirements
  - Network capacity, which ensures there is an adequate network to serve all beneficiaries that reside in the DMC-ODS Plan.
- State Requirements
  - Outpatient substance use disorder services other than OTPs must meet time or distance standards set forth in W&I 14197.[9]

[5] 42 CFR section 438.68(d)(1)
[6] Welfare and Institutions Code (W&I), Section 14197(e)(2)
[7] W&I 14197(e)(1)(A) and (B)
[8] W&I 14197(e)(3)
[9] W&I Section 14197(c)(4)(A)

- OTPs must meet time or distance standards set forth in W&I 14197.[10]

3. Additional Network Certifications

DHCS is required to certify the provider network when a new population is enrolled, there is a change in services or benefits,[11] or when a DMC-ODS plan enters into a new contract with DHCS.[12]

4. Annual Network Certification

4.1. Annual Network Certification 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.

4.1.1. Projected Network Composition

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.

4.1.2. Projected Utilization

The projected utilization methodology is based on monthly enrollment totals derived from the Medi-Cal Eligibility Data System (MEDS). Utilizing two fiscal years of enrollment Medi-Cal enrollment data (e.g., state fiscal year 2017-18 and 2018-19), two sets of projections were produced for each county: one for children and youth (aged 12-17) and one for adults (aged 18 and over). Monthly enrollment totals were forecast through June 2021.

Utilizing the National Survey on Drug Use and Health combined SUD estimates, DHCS applied the percentage of those aged 12-17 and 18+ estimated to be in *need of treatment services* to the Medi-Cal enrollment projections for each age group. DHCS then applied a percentage of 10.8 to the estimated beneficiaries in need of treatment to estimate the number who will actually *seek treatment*. The 10.8% comes from the SAMHSA's "America's Need for and Receipt of Substance Use Treatment in 2015" report (https://www.samhsa.gov/data/sites/default/files/report_2716/ShortReport-2716.html).
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[10] W&I Section 14197(c)(4)(B)
[11] 42 CFR Section 438.207(c)(3)
[12] 42 CFR Section 438.207(c)(1)

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

4.1.3. Network Capacity

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* to determine if the DMC-ODS plan's network composition is sufficient.

DHCS validated the prior year number of beneficiaries served, actual utilization, and number of facilities that provided the services for adult and youth in outpatient and OTP service delivery.

4.2. Provider Network Evaluation

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.

4.2.1. Provider Network Composition

In accordance with 42 CFR Section 438.207(b)(1), DMC-ODS plans are required to have a provider network that is 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.

4.2.2. 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 use disorder services provided by DMC certified, state licensed, and ASAM designated residential facilities.

DMC-ODS plans submitted Exhibit A-2, 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.

4.2.3. Time and Distance Standards

The Final Rule required DHCS to establish network adequacy standards effective July 1, 2018. Welfare and Institutions Code (W&I) 14197 outlines California's state-specific network adequacy standards, as set forth in Attachment A. They include time and distance standards based on county Medi-Cal population, and are applicable to outpatient and OTP service providers. Additionally, DHCS allowed DMC-ODS plans to utilize telehealth services as a means of meeting time and 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.

DHCS prepared geographic access maps for DMC-ODS plans based upon Medi-Cal beneficiary and provider location data submitted in Exhibit A-2 of the NACT using ArcGIS software. DHCS plotted time and distance for all network providers, stratified by service type (i.e., outpatient or opioid treatment programs) and geographic location, for both adult and children/youth.

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

4.2.4. Alternative Access Requests

W&I 14197 allows DMC-ODS plans to submit AAS requests for time and 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 and distance standards for assigned beneficiaries submitted AAS requests to DHCS, using a DHCS reporting template. DMC-ODS plan's AAS requests were organized by zip code and county, and included the driving time and/or the distance, in miles, between the nearest in-network provider(s) and the most remote beneficiaries. The requests detailed the DMC-ODS

plan's contracting efforts, including an explanation of the circumstances which inhibited the ability to obtain a contract.

DHCS reviewed the requests for AAS and approved or denied 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.

4.2.5. Telehealth

Pursuant to W&I 14197, DHCS is allowing DMC-ODS plans to use telehealth to demonstrate compliance with time and distance standards. DMC-ODS plans will be authorized to begin using telehealth as an alternative access to care for contractual time and distance standards[13] if they meet the contractual and State requirements.

DMC-ODS plans using telehealth to meet network adequacy standards submitted information for telehealth providers with the annual submission to DHCS. The DMC-ODS plan indicated the provider type, whether the provider is available for in-person services, as well as telehealth services, and the service area the telehealth provider serves.

4.2.6. Access and Availability Policies and Procedures

DHCS is required to ensure that DMC-ODS plans meet timely access requirements outlined in 438.206(c)(1). DHCS evaluates DMC-ODS plans' timely access compliance as follows:

- The DMC-ODS plan and its network providers meet state mandated standards for timely access to care and services;
- That network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid Fee-for-Service if the provider serves only Medicaid beneficiaries;
- That services are available 24 hours a day, 7 days a week when medically necessary;
- There are mechanisms to ensure compliance from network providers;
- There is monitoring of network providers regularly to determine compliance; and
- Corrective action is taken if there is failure to comply by a network provider.

DHCS reviews findings and, where deficiencies are identified, follows up with the DMC-ODS plans. DHCS' monitoring of the timeliness findings are thereby incorporated into the Annual Network Certification process.

[13] W&I Section 14197(e)(4)

4.3. Provider Network Validation

As part of the network certification process, DHCS validated each DMC-ODS plan's provider network to ensure there is an executed contract between the provider and DMC-ODS plan. Prior to entry on the provider database, each DMC-ODS plan submits the appropriate form with identification for contracted services per each network provider.

In order to certify each DMC-ODS plan's provider network, DHCS confirmed that the facilities had an executed contract with the DMC-ODS plan based on the provider database entry.

4.4. Provider Network Evaluation Findings

Each DMC-ODS plan's provider network submission was reviewed and deemed Pass, Conditional Pass, or N/A.

- A Pass designation means the standard was met and no further action is needed from the DMC-ODS plan.
- A Conditional Pass designation means the DMC-ODS plan did not meet the standard but will be notified of deficiencies and be required to submit a plan of correction for DHCS' review. DHCS imposed a temporary standard requiring the DMC-ODS plan to authorize access to out-of-network providers and/or services if services are not available in-network within the timely access standards. DMC-ODS plans may not deny access to out-of-network services on the basis of payment or rate disputes with the provider. The temporary standard was communicated through a corrective action plan (CAP). DMC-ODS plans are required to authorize out-of-network providers and services until all CAP items have been corrected and the CAP is closed.

  Note: A Conditional Pass designation can also result from any deficiency in the requisite supporting documentation that each DMC-ODS plan submits as part of the certification process.
- A N/A designation means that the network certification requirement does not apply to the DMC-ODS plan.

5. DMC-ODS Plan Network Certification Results

The following charts are the results of the Annual Network Certification on a Pass or Conditional Pass basis.

DMC-ODS Plan	Overall Results	Alternative Access Standard
Alameda	Conditional Pass	In Review
Contra Costa	Conditional Pass	In Review
El Dorado	Conditional Pass	Not Required
Fresno	Conditional Pass	Not Required
Imperial	Conditional Pass	Not Required
Kern	Conditional Pass	Not Required
Los Angeles	Conditional Pass	Approved
Marin	Conditional Pass	Not Required
Merced	Conditional Pass	Not Required
Monterey	Conditional Pass	Not Required
Napa	Conditional Pass	Not Required
Nevada	Conditional Pass	Not Required
Orange	Conditional Pass	Not Required
Placer	Conditional Pass	Approved
Riverside	Conditional Pass	Not Required
Sacramento	Conditional Pass	Did not Submit as Required
San Benito	Conditional Pass	Not Required

DMC-ODS Plan	Overall Results	Alternative Access Standard
San Bernardino	Conditional Pass	In Review
San Diego	Conditional Pass	In Review
San Francisco	Conditional Pass	Not Required
San Joaquin	Conditional Pass	Not Required
San Luis Obispo	Conditional Pass	Not Required
San Mateo	Conditional Pass	Did not Submit as Required
Santa Barbara	Conditional Pass	Not Required
Santa Clara	Conditional Pass	Not Required
Santa Cruz	Conditional Pass	Did not Submit as Required
Stanislaus	Conditional Pass	Not Required
Tulare	Conditional Pass	Not Required
Ventura	Conditional Pass	Did not Submit as Required
Yolo	Conditional Pass	Not Required

6. Monitoring Network Adequacy: Post and Ongoing

6.1. Corrective Action Plans

DHCS granted DMC-ODS plans a conditional pass on Annual Network Certifications if the DMC-ODS plan was unable to meet the network certification requirements. DHCS will impose temporary standards for the DMC-ODS plan to implement immediately and impose a CAP for any network certification deficiencies. The temporary standard requiring authorization of out-of-network services allows the DMC-ODS plan to correct all deficiencies during the CAP process while at the same time ensuring that Medi-Cal members are allowed to access out-of-network services within the timely access standards. DMC-ODS plans may not deny access to out-of-network services based on payment or rate disputes with a provider. The temporary standard remains in full effect until all network certification deficiencies have been corrected and DHCS approves closure of the CAP.

DHCS issued CAPs to the DMC-ODS plans with a description of each deficiency. The DMC-ODS plan will need to submit a response to the CAP and include the following items: a proposed solution; specific deliverables to be met and completed; a timeline for each deliverable; an attestation that the DMC-ODS plan will approve out of network services for the beneficiaries affected by the deficiencies for the duration of the CAP; and the timeline for progress updates. Network Certification CAPs will remain effective until all deficiencies are resolved.

If the DMC-ODS plan fails to comply with CAP requirements, DHCS may initiate additional corrective action measures, including sanctions, in accordance with the DMC-ODS plan contract, State, and federal law.

6.2. DHCS Monitoring

DHCS will monitor Prepaid Inpatient Health Plan provider network compliance through annual reviews of each plan and a cross-section of network providers. Timely access, time and distance standards, and grievances/complaints will be evaluated to determine compliance. CAPs will be required for any areas of non-compliance.

6.3. External Quality Review

In order to ensure an unbiased review of DMC-ODS waiver services, DHCS has contracted with an EQRO pursuant to 42 CFR Part 438. Related to Network Adequacy, the EQRO will review and validate the data collected by DHCS related to the:

- Number of requests for AAS in the plan’s service area for time and distance, categorized by all provider types, including specialists, and by adult and youth.

- Number of allowable exceptions for the appointment time standard, if known, categorized by all provider types, including specialists, and by adult and youth.
- Distance and driving time between the nearest network provider and zip code of the beneficiary furthest from that provider for requests for AAS.
- Approximate number of beneficiaries impacted by AAS or allowable exceptions.
- Number of requests for AAS approved or denied by zip code and provider and specialty type, and the reasons for the approval or denial of the request for AAS.
- The process of ensuring out-of-network access.
- Descriptions of contracting efforts and explanation for why a contract was not executed.
- Timeframe for approval or denial of a request for AAS by the department.
- Consumer complaints, if any.

The EQRO will complete an annual report and submit the results to DHCS. The annual report will cover the following:

1) Identify areas of systematic strengths and weaknesses within each county DMC-ODS plan's service delivery system and strategies to improve performance.
2) Identify and recommend strategies that are strength-based, solution-focused, culturally sensitive, action oriented and common sense driven.
3) Provide recommendations to increase accurate data collection, verification, analysis and integration/connectivity between state, county and provider-level health information systems.
4) Be posted to county DMC-ODS websites to ensure transparency.
5) Be used to support counties with programmatic and fiscal decision-making.

7. Appendices

7.1. Attachment A: Network Adequacy Standards

Network Adequacy Standards					
Provider Type	Timely Access Standard	Time and Distance Standard by County Size[14]			
		Rural	Small	Medium	Dense
Outpatient Services	Within 10 business days to apt. from request	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	Within 3 business days to apt. from request	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*

Table 1: County Size Categories by Population

Size Category	Population Density	# of Counties	Counties
Rural	<50 people per square mile	21	Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Tuolumne, Trinity
Small	51 to 200 people per square mile	19	Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa, Barbara, Sutter, Tulare, Yolo, Yuba
Medium	201 to 600 people per square mile	9	Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, Ventura
Dense	≥600 people per square mile	9	Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, Santa Clara

[14] See Table 1