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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) one time per year.

DHCS published Behavioral Health Information Notice 21-023[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, in accordance with the Annual Network Certification requirements set forth in 42 CFR Section 438.207, all DMC-ODS plans 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]

1.2. Assurance of Compliance Overview

[1] 2021 Federal Network Certification Requirements for County Mental Health Plans and DMC-ODS
[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)

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 plan 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 use 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.

In California, there are 30 individual 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

Additionally, there is one regional DMC-ODS model that require an annual network adequacy certification as a region:

- Partnership HealthPlan of California
  - Humboldt
  - Lassen
  - Mendocino
  - Modoc
  - Shasta
  - Siskiyou
  - Solano

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 or distance standards for outpatient services and opioid treatment program (OTP) services, also known as Narcotic Treatment Programs (OTPs) in California.

In addition, the Final Rule permits states to grant exceptions to the network adequacy standards.[5] If a DMC-ODS plan cannot meet one or more standard, it may submit a request for alternative access which, if approved, allows for an alternative standard for the unmet requirement (i.e., time or distance and/or availability of services).[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

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

In order to ensure DMC-ODS plans have adequate provider networks, DHCS leveraged the Annual Network Certification process to combine the network requirements 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 residing 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]
  - 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

DHCS' projected utilization methodology is based on monthly enrollment totals derived from MEDS. Utilizing two FYs of Medi-Cal enrollment data (e.g., for this certification, DHCS is using state FY 2018-19 and 2019-20), 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 2021/2022 certification the projection is through June 2022).

[9] W&I Section 14197(c)(4)(A)
[10] W&I Section 14197(c)(4)(B)
[11] 42 CFR Section 438.207(c)(3)
[12] 42 CFR Section 438.207(c)(1)

Utilizing the 2019 National Survey on Drug Use and Health[13] combined SUD 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 2022 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.

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* as a baseline for determining 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.

[13] 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.

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 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 alternative access standards (AAS) request (subject to approval by DHCS) for capacity and composition. The AAS request must outline the immediate plan (e.g. out of network providers, Federally Qualified Health Center) for provision of services and a long-term plan to obtain providers for all mandatory levels of care.

For further details about the DMC-ODS plans with approved AAS for capacity and composition, please see section 7.2, Attachment B.

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 or 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 or 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 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.

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 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.

For the 2020 network adequacy certification year, the geographic access mapping process had several data limitations, including that estimates were formed based on beneficiary zip codes, not actual resident addresses, and the system was not automated. For the 2021 network adequacy certification, the mapping process was automated using Environmental Systems Research Institute (ESRI) technology, which determines the precise distance between beneficiary and provider addresses. This precision led to significant differences from the prior year in the calculations of how many beneficiaries lived outside of time or distance standards from the nearest provider. However, the majority of the deficient zip codes outside of time or distance standards are covered via telehealth providers as an Alternative Access Standard.

DHCS notifies 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 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)[14]. DHCS will post all approved alternative access standards on its website.[15]

4.2.5. Telehealth

Pursuant to W&I 14197, DHCS is allowing DMC-ODS plans to use telehealth to demonstrate compliance with time or distance standards as an alternate access standard[16] 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.

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.

[14] 42 C.F.R sections 438.68(d)(2), 438.66(e)(2)(vi)
[15] WIC Section 14197(e)(3)
[16] 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 (e.g., Timely Access, Time or Distance, Capacity and Composition, Provider Contracts, Grievance and Appeals) was reviewed and deemed Pass or Conditional Pass.

- A Pass designation means the time or distance and capacity and composition standards were met, including approved alternative access standards requests.

- A Conditional Pass designation means the DMC-ODS plan did not meet the standard and will be required to submit a corrective action plan (CAP) upon notification of deficiencies; maintaining the status of "conditional pass" is dependent on a DHCS-approved CAP. DHCS requires DMC-ODS plans to refer and coordinate beneficiary access to out-of-network providers and/or services if services are not available in-network within standards. DMC-ODS plans may not deny access to out-of-network services on the basis of payment or rate disputes with the provider. 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.

The Time or Distance findings were further categorized as Passed, Passed with 10% Telehealth Allowance and Did not Pass with 10% Telehealth Allowance:

- A passed designation means that the DMC-ODS plan met all Time or Distance standards.

- Passed with 10% Telehealth Allowance means that the DMC-ODS plan met 90% of beneficiaries with on-site providers and the remaining 10% are covered by

telehealth providers. However, the plan cannot require telehealth and will arrange transportation for beneficiaries if they request on-site providers.

- A Did Not Pass with 10% Telehealth Allowance means that the DMC-ODS plan must submit an AAS request because the county does not have at least 90% coverage of beneficiaries with on-site providers that are within Time or Distance standards.

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 - All Network Adequacy Certification Requirements	Time or Distance Standard		
		Passed	Passed with 10% Telehealth Allowance	Did not Pass with 10% Telehealth Allowance – AAS Required
Alameda	Conditional Pass			X
Contra Costa	Conditional Pass			X
El Dorado	Conditional Pass			X
Fresno	Conditional Pass			X
Imperial	Conditional Pass		X	
Kern	Conditional Pass			X
Los Angeles	Conditional Pass			X
Marin	Conditional Pass*		X	
Merced	Conditional Pass			X
Monterey	Conditional Pass			X
Napa	Conditional Pass			X
Nevada	Conditional Pass			X
Orange	Conditional Pass			X
Partnership HealthPlan of California (PHC)	Conditional Pass			X
Placer	Conditional Pass		X	

DMC-ODS Plan	Overall Results - All Network Adequacy Certification Requirements	Time or Distance Standard		
		Passed	Passed with 10% Telehealth Allowance	Did not Pass with 10% Telehealth Allowance – AAS Required
Riverside	Conditional Pass			X
Sacramento	Conditional Pass			X
San Benito	Conditional Pass			X
San Bernardino	Conditional Pass			X
San Diego	Conditional Pass			X
San Francisco	Conditional Pass	X		
San Joaquin	Conditional Pass			X
San Luis Obispo	Conditional Pass			X
San Mateo	Conditional Pass			X
Santa Barbara	Conditional Pass			X
Santa Clara	Conditional Pass		X	
Santa Cruz	Conditional Pass		X	
Stanislaus	Conditional Pass			X
Tulare	Conditional Pass			X
Ventura	Conditional Pass			X
Yolo	Conditional Pass			X

*DMC-ODS plan conditionally passed due to administrative deficiency (i.e., contract expiration dates not aligned with the certification period.

6. Monitoring Network Adequacy: Post and Ongoing

6.1. Corrective Action Plans

DMC-ODS plans receive a conditional pass on its Annual Network Certification if the DMC-ODS plan is unable to meet the network adequacy requirements.

If DHCS determined that, at the time of the initial submission, or at any time thereafter, the DMC-ODS plan does not meet the applicable time or distance standards or a DHCS-approved alternate access standard and/or any of the network adequacy requirements, the DMC-ODS plan is required to submit a corrective action plan (CAP). The DMC-ODS plan's CAP must demonstrate action steps the DMC-ODS plan will immediately implement to ensure it complies with the standards. DHCS monitors the DMC-ODS plan's corrective actions, meets with the plan monthly, and requires updated monthly information and demonstration of progress until the plan is able to meet the applicable standards.

Furthermore, if the DMC-ODS plan was determined not to meet network adequacy requirements and the provider network is unable to provide timely access to necessary services within the applicable time or distance standards, the DMC-ODS plan must adequately and timely cover these services out-of-network for the beneficiary.[17] The DMC-ODS plan must permit out-of-network access for as long as the DMC-ODS plan's provider network is unable to provide the services in accordance with the standards.

If the DMC-ODS plan does not effectively implement corrective actions, DHCS may impose additional corrective actions pursuant to Welfare and Institutions Code Section 14712(e),[18] including fines, penalties, the withholding of payments, special requirements, probationary or corrective actions, or any other actions deemed necessary to promptly ensure compliance.

6.2. DHCS Monitoring

DHCS will regularly monitor compliance with network adequacy standards on an on-going basis. Network adequacy monitoring activities include, but are not limited to, the following:

- Annual NACT data submissions by DMC-ODS plans;
- Annual reviews of each DMC-ODS plan;

[17] 42, C.F.R., section 438.206(b)(4)
[18] See also Cal. Code Regs., tit. 9, sections 1810.380 and 1810.385

- Annual program assessment reports submitted to CMS in accordance with Title 42 Code of Federal Regulations section 438.66;
- Annual External Quality Review Organization reviews;
- DMC-ODS plan utilization data review;
- Corrective action monitoring and follow-up; and,
- Any other monitoring activities required by DHCS.

DHCS will post network adequacy documentation for each DMC-ODS plan on its website, including any approved alternative access standards.

6.3. External Quality Review

In order to ensure an unbiased review of DMC-ODS waiver services, DHCS has contracted with an External Quality Review Organization (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 or 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 plan 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 or Distance Standard by County Size[19]			
		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, 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 Joaquin, San Mateo, Santa Clara

[19] See Table 1

7.2. Attachment B: Approved Alternative Access Standard for Capacity and Composition

County	Age Group	Modality/Service Type
Contra Costa	0-17	Residential
El Dorado	0-17	Residential and Opioid Treatment Program
Fresno	0-17	Opioid Treatment Program
Kern	0-17	Residential and Opioid Treatment Program
Los Angeles	0-17	Residential
Merced	0-17	Residential and Opioid Treatment Program
Monterey	0-17	Residential and Opioid Treatment Program
Napa	0-17	Residential and Opioid Treatment Program
Nevada	0-17	Residential and Opioid Treatment Program
Orange	0-17	Opioid Treatment Program
Placer	0-17	Intensive Outpatient Treatment and Residential
San Benito	0-17	Intensive Outpatient Treatment, Residential, and Opioid Treatment Program
San Bernardino	0-17	Opioid Treatment Program
San Diego	0-17	Opioid Treatment Program
San Joaquin	0-17	Residential and OTP
San Luis Obispo	0-17	Residential and OTP
San Mateo	0-17	Residential
Santa Barbara	0-17	Opioid Treatment Program
Santa Cruz	0-17	Intensive Outpatient Treatment
Tulare	0-17	Residential and Opioid Treatment Program
Ventura	0-17	Opioid Treatment Program