

From: DMHC Licensing eFiling
Subject: APL 22-007 DPN Monitoring and Annual Reporting Changes
Date: Friday, March 4, 2022, 4:55 PM
Attachments: APL 22-007 DPN Monitoring and Annual Reporting Changes (3.4.22).pdf

Dear Health Plan Representative:

Please find attached All Plan Letter (APL) 22-007 regarding recent changes to monitoring and the submission requirements for the Timely Access Compliance Report and Annual Network Report resulting from Senate Bill (SB) 221, Assembly Bill (AB) 457, and the Amendments to 28 CCR § 1300.67.2.2.

Thank you.

ALL PLAN LETTER

DATE: March 4, 2022

TO: All Health Care Service Plans

FROM: Nathan Nau
Deputy Director, Office of Plan Monitoring

SUBJECT: APL 22-007 Monitoring and Annual Reporting Changes due to SB 221, AB 457 and Amendments to Rule 1300.67.2.2

This All Plan Letter (APL) provides an overview of the changes to monitoring and annual reporting of the Timely Access Compliance Report and the Annual Network Report, as required under the Knox-Keene Act.¹

I. Application

This APL applies to health care service plans (plans) regulated by the Department of Managed Health Care (DMHC).² It does not apply to plans that are licensed to offer only Medicare Advantage or Employee Assistance Programs (EAP). Unless otherwise stated, this APL applies to all other Knox-Keene Act licensed plans, including plans that offer only Medi-Cal products.

The full scope of monitoring and reporting requirements described herein apply to full-service or specialized mental health plans, unless otherwise stated.³ Beginning in Reporting Year (RY) 2023,⁴ subcontracted plans, and specialized dental, vision, chiropractic, or acupuncture plans will also be required to submit information in the Network Access Profile section of the Timely Access and Annual Network Reporting

¹ The Knox-Keene Act is set forth in California Health and Safety Code sections 1340 et seq. References herein to "Section" are to sections of the Act. References to "Rule" refer to the California Code of Regulations, title 28.

² This includes licensed full-service and mental health plans, licensed subcontracted plans, and licensed specialized plans, including dental, vision, chiropractic and acupuncture plans. "Subcontracted plan" is defined in Rule 1300.67.2.2, sub. (b), as amended in 2022.

³ Rule 1300.67.2.2, subs. (a)(1), (b)(17), (d), and (h)(1).

⁴ Reporting year means the calendar year in which the plan's Timely Access Compliance Report and Annual Network Report is submitted to the Department of Managed Health Care. (Rule 1300.67.2.2, sub. (b)(18).)

Web Portal (Web Portal).⁵ More information related to these reporting obligations is provided in the sections below.

II. New Statutes and Amendments to Regulations

Changes to plan reporting obligations begin in RY 2023. Plans are expected to begin the necessary preparations to comply with changes to upcoming reporting requirements and to familiarize themselves with the following new laws:⁶

1. Senate Bill (SB) 221 (Weiner, Chapter 724, Statutes of 2021) amended Sections 1367.03 and 1367.031;
2. Assembly Bill (AB) 457 (Santiago, Chapter 439, Statutes of 2021) amended Business and Professions Code section 650 and Section 1374.14, and added Section 1374.141;⁷ and
3. Amendments to Rule 1300.67.2.2, Timely Access to Non-Emergency Health Care Services and Annual Timely Access and Network Reporting Requirements, effective April 1, 2022.

III. Overview of Submission Timeframes

The overview below provides key submission timeframes for timely access compliance and annual network reporting, due to the amendments to Rule 1300.67.2.2. To avoid confusion, the submission requirements in this APL are identified by reporting year.⁸ References to measurement year (MY) are to ensure plans are aware of the corresponding measurement timeframe.

- For RY 2022, the reporting dates and obligations will not change as a result of the amended regulation. Plans shall submit all required annual reporting according to Rule 1300.67.2.2, as amended in 2009.⁹ The deadline for submission for RY 2022 is March 31, 2022.¹⁰

⁵ Rule 1300.67.2.2, subs. (a)(1), (b)(17) and (h)(1)(B). Subcontracted plan, plan-to-plan contract, and primary plan are defined in Rule 1300.67.2.2, sub. (b)(13). Subcontracted plans may include restricted and limited licensed plans as defined in Section 1300.49. Subcontracted plans that meet the definition of “reporting plan” set forth in in Rule 1300.67.2.2, sub. (b)(17), must comply with the full scope of reporting plan obligations.

⁶ All Plan Letter 21-025, issued on December 20, 2021, discussed newly enacted statutes impacting plans (2021 Legislative Session). The final text setting forth the amendments to Rule 1300.67.2.2 are effective April 1, 2022, and available on the [DMHC’s public webpage](#).

⁷ All Plan Letter 22-003, issued on January 21, 2022, addresses the full scope of requirements under Assembly Bill 457, Protection of Patient Choice in Telehealth Provider Act.

⁸ Due to the change in the network capture date set forth in Rule 1300.67.2.2, sub. (b)(7), beginning in Reporting Year 2023, the Annual Network Report measurement year, as defined, will no longer be aligned with the Timely Access Compliance Report measurement year.

⁹ See Section IV 1 below for additional requirements related to the Timely Access Compliance Report.

¹⁰ March 31, 2022, is a holiday. As a result, the MY 2021 Timely Access Compliance Report and Annual Network Report must be submitted by April 1, 2022.

- In RY 2023, full-service and mental health plans shall report annual network data for the Annual Network Report and all licensed health plans (including all specialized and restricted full-service health care service plans) shall complete the network access profile pursuant to Rule 1300.67.2.2, subs. (h)(7) and (h)(8) and incorporated documents, as amended in 2022. Due to the retrospective nature of the information reported in the Timely Access Compliance Report, in RY 2023, plans will submit the required information and data according to Rule 1300.67.2.2, sub. (g)(2)(A)-(F), as amended in 2009, and the DMHC-issued MY 2019 Timely Access Compliance Report methodology and documents.¹¹ The deadline for submission for RY 2023 is May 1, 2023.
- In RY 2024, plans will submit both the Timely Access Compliance Report and the Annual Network Report, and all associated data and information, in accordance with Rule 1300.67.2.2, subs. (h)(6), (h)(7) and (h)(8), as amended in 2022. The deadline for submission for RY 2024 is May 1, 2024.

¹¹ See Section IV 2 below for additional requirements related to the Timely Access Compliance Report.

Submission Timeframe Overview Table

The table below provides an overview of timeframes related to the transition from plan reporting under Rule 1300.67.2.2, as amended in 2009, and plan reporting under Rule 1300.67.2.2, as amended in 2022. Implementation of certain reporting dates is postponed for one year because the amended regulation's effective date of April 1, 2022, takes place after one or more of the effective dates set forth within the regulation.¹²

Reporting Year (RY)	Submission Date	Timely Access Compliance Report Measurement Year (MY) ¹³	Annual Network Report Measurement Year
RY 2022	March 31, 2022 ¹⁴	MY 2021: January 1 – December 31, 2021 Network Capture Date: ¹⁵ December 31, 2020	MY 2021 Network Capture Date: December 31, 2021
RY 2023	May 1, 2023	MY 2022: January 1 – December 31, 2022 Network Capture Date: December 31, 2021	MY 2023 Network Capture Date: ¹⁶ January 15, 2023
RY 2024	May 1, 2024	MY 2023: January 1 – December 31, 2023 Network Capture Date: January 15, 2023	MY 2024 Network Capture Date: January 15, 2024

¹² In addition to the notice provided to health plans via this All Plan Letter, the DMHC also intends to clarify the necessary postponement of certain reporting timeframes through amendment by a File and Print filing and publication with the Secretary of State. (See Gov. Code, section 11343.8.)

¹³ Measurement year means the time periods within which a plan shall collect the required information for the Timely Access Compliance Report and the Annual Network Report. (Rule 1300.67.2.2, sub. (b)(4).) The Timely Access Compliance Report measurement year applies to the data within the Out-of-Network Payment Report Form and the Timely Access and Network Adequacy Grievance Report Form, as set forth in Rule 1300.67.2.2, subs. (h)(A)(iv) and (h)(B). Plans submit these report forms as part of the Annual Network Report in accordance with the amended Rule 1300.67.2.2, beginning in RY 2023.

¹⁴ Rule 1300.67.2.2, sub. (g)(2) (as enacted in 2009). March 31, 2022, is a holiday. As a result, required annual reporting must be submitted by April 1, 2022.

¹⁵ A plan shall complete the PAAS Contact List and TA Profile with the providers and network information as of the Network Capture Date set forth in the chart below.

¹⁶ Subcontracted plans, including the limited and restricted plans that meet the definition of subcontracted plan, and specialized dental, vision, chiropractic, or acupuncture plans shall use the Annual Network Report network capture date to complete the network access profile for each reporting year. (Rule 1300.67.2.2, subs. (b)(13) and (h)(1)(B).)

The remaining sections of this APL provide further information pertaining to these submission timeframes and implementation of new legislation.

IV. Changes to Timely Access Compliance Reporting:

To ensure plans have adequate time to implement the amendments to the timely access compliance reporting obligations in amended Rule 1300.67.2.2, subs. (d) and (h)(6), implementation will occur RY 2024/MY 2023. Plans must be ready to comply with the amendments in Rule 1300.67.2.2, subs. (d) and (h)(6) for MY 2023 and submit all required information by May 1, 2024.¹⁷ Please be advised, effective April 1, 2022, plans must comply with all other requirements under the amended regulation, including the annual network reporting obligations for RY 2023.¹⁸

1. RY 2022: Timely Access Compliance Report – No Changes

For RY 2022/MY 2021, plans are required to gather and submit the Timely Access Compliance Report information and data in accordance with the 2009 version of Rule 1300.67.2.2, sub. (g)(2)(A)-(F), and the MY 2019 Timely Access Compliance Report methodology and documents posted in the Web Portal in December of 2019.^{19, 20} Plans are required to submit the MY 2021 Timely Access Compliance Report no later than March 31, 2022.²¹

2. RY 2023: Incorporate SB 221 Standards into the MY 2019 Timely Access Compliance Monitoring and Documents – Overview of Changes

For RY 2023/MY 2022, plans shall continue to monitor compliance with the timely access standards, and gather and submit the Timely Access Compliance Report information in accordance with the 2009 version of Rule 1300.67.2.2, subs. (d) and (g)(2)(A)-(F) and the DMHC-issued MY 2019 Timely Access Compliance Report

¹⁷ The Timely Access Compliance Report requirements were enacted in 2009 under Rule 1300.67.2.2, subs. (g)(2)(A)-(F). The amendments to the Timely Access Compliance Report submission requirements are enacted under Rule 1300.67.2.2, sub. (h)(6), effective April 1, 2022.

¹⁸ Rule 1300.67.2.2, sub. (h). Annual network reporting data is due by May 1, 2023, as detailed below.

¹⁹ For RY 2022/MY 2021, use the MY 2019 Timely Access Compliance Report Web Portal Instructions (For use in MY 2019 to MY 2021) (Issued December 23, 2019).

²⁰ See Section 1367.03, sub. (f)(3).

²¹ March 31, 2022, is a holiday. As a result, the MY 2021 Timely Access Compliance Report must be submitted by April 1, 2022.

methodology and documents.^{22, 23} In addition, plans shall begin incorporating the SB 221 requirements set forth below into their timely access quality assurance and monitoring processes.^{24, 25} To ensure plans have adequate time to implement this change, plans shall start implementing the new SB 221 requirements, as applicable, into monitoring processes beginning July 1, 2022.²⁶

- ✓ **Plans shall incorporate the new SB 221 standards into their monitoring processes, as applicable.**²⁷ The new SB 221 standards, include, but are not limited to, the additions described below:
- Substance use disorder providers have been added to the standards applicable to mental health care providers set forth in Section 1367.03, including the time-elapsed non-urgent appointment standard.²⁸
 - Plans that use a tiered network shall demonstrate compliance with the standards established by Section 1367.03 based on providers available at the lowest cost-sharing tier.²⁹
 - Coordination of interpreter services with appointments, as required by Section 1367.04 and Rule 1300.67.04, shall not delay the scheduling of the appointment.³⁰
 - A plan shall ensure that its network has adequate capacity and availability of licensed health care providers to meet timely access standards.³¹

²² The MY 2019 Timely Access Compliance Report methodology and documents, include the Provider Appointment Availability Survey (PAAS) Methodology, Templates and other supporting documents, which shall be used by plans to gather and submit the MY 2021 and 2022 Timely Access Compliance Report, are available on the Resources section of the Web Portal. (Section 1367.03, sub. (f)(3) and Rule 1300.67.2.2, subs. (g)(2)(A)-(F), as enacted in 2009.) The MY 2019 Timely Access Compliance Report Web Portal Instructions will be updated for use in MY 2022. With the exception of these instructions and the Frequently Asked Questions document, the DMHC does not anticipate updating any other MY 2019 Timely Access Compliance Report methodology or documents.

²³ Section 1367.03, sub. (f)(3) (enacted by SB 221) requires the DMHC to develop standardized methodologies for reporting that shall be used by health care service plans to demonstrate compliance with the timely access standards set forth in Section 1367.03, sub. (a). The development and adoption of these methodologies is not subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) until July 1, 2025.

²⁴ Section 1367.03, sub. (f)(3).

²⁵ See Sections 1367.03, sub. (a)(1) and 1370. Rules 1300.67.2.2, subs. (d) and (g)(2)(A) (as enacted in 2009), 1300.68, subs. (b) and (e), and 1300.70.

²⁶ Due to the date of implementation, a plan may be unable to fully implement the new standards into existing monitoring mechanisms for MY 2022 (e.g., the plan may have already administered the enrollee experience survey and provider satisfaction survey, set forth in Rule 1300.67.2.2, subs. (d)(2)(B) and (C), prior to this date. As a result, a plan may only be able to implement the new standards into quarterly grievance monitoring). Thus, a plan shall demonstrate to the DMHC that the plan has implemented monitoring of the new SB 221 standards for MY 2022 to the extent feasible.

²⁷ See also APL 21-025 - Newly Enacted Statutes Impacting Health Plans (12/20/2021).

²⁸ Section 1367.03, subs. (a)(5)(E), (F) and (I), (a)(7) and (a)(8).

²⁹ Section 1367.03, sub. (a)(1).

³⁰ Section 1367.03, sub. (a)(4).

³¹ Section 1367.03, sub. (a)(5).

- A referral to a specialist by a primary care provider or another specialist shall be subject to the relevant time-elapsed standard, unless the requirements in Section 1367.03, sub. (a)(5)(H) or (I) are met.³²
 - A plan shall ensure it has sufficient numbers of network providers to maintain compliance with the standards established by Section 1367.03.³³
 - If medically necessary treatment of a mental health or substance use disorder is not available in network within the geographic and timely access standards set by law or regulation, a health care service plan shall arrange coverage outside the plan's contracted network in accordance with subdivision (d) of Section 1374.72.³⁴
 - A plan shall not prevent, discourage, or discipline a contracting provider or employee for informing an enrollee or subscriber about the timely access standards.³⁵
 - Commencing July 1, 2022, non-urgent follow-up appointments with a non-physician mental health care (NPMH) or substance use disorder provider must be offered within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition, except as provided in Section 1367.03(a)(5)(H).³⁶
- ✓ **Identify the Non-Physician Mental Health Care Providers who treat substance use disorders in the PAAS Contact List.**
When completing the PAAS Contact List Template for MY 2022, plans must include the NPMH providers in accordance with the MY 2019 PAAS Methodology. For the NPMH providers who are included in the Contact List Template, plans shall identify which of those providers also treat substance use disorders. To identify these providers, use the existing instructions in the PAAS NPMH Contact List Template to enter a value that is crosswalked to "Alcohol and Other Drug Counselor" in the "Type of Licensure/Certificate" field and/or "Alcohol and Other Drugs" in the "Specialty/Area of Expertise" field. A plan that operates a network that is only used with a Medi-Cal Managed Care product is not required to identify SUD providers for that network.
- ✓ **Describe how the plan monitors the 10-business day follow-up appointment standard for NPMH and substance use disorder providers.**
Commencing July 1, 2022, plans shall ensure that enrollees are able to obtain NPMH and substance use disorder provider follow-up appointments within the time-elapsed standard set forth in Section 1367.03, sub. (a)(5)(F). Plans shall submit to the DMHC in the MY 2022 Timely Access Compliance Report a summary of the following information:

³² Section 1367.03, sub. (a)(5)(J).

³³ Section 1367.03, sub. (a)(7)

³⁴ Section 1367.03, sub. (a)(7)(B).

³⁵ Section 1367.03, sub. (d).

³⁶ Section 1367.03, sub. (a)(5)(F).

- How the plan informed providers and enrollees of the follow-up appointment standard set forth in Section 1367.03, sub. (a)(5)(F).
- How the plan monitored its compliance with the follow-up appointment standard set forth in Section 1367.03, sub. (a)(5)(F). A plan that does not provide or arrange for the provision of substance use disorder services shall include in this summary a statement indicating that these services are not covered and that no NPMH providers who offer these services are identified in the PAAS Contact List for one or more networks (e.g., the plan is not delegated to provide substance use disorder services).

PAAS Follow-Up Appointment Pilot

Plans may add additional survey questions in the PAAS Survey Tool after the standardized questions to satisfy the follow-up appointment compliance monitoring requirement. If the plan chooses to include follow-up appointment questions in the PAAS as part of its monitoring activities, such modifications to the Survey Tool must comply with the survey tool modification parameters and requirements set forth in Step 6 of the MY 2019 PAAS Methodology. A plan may submit redline revisions with the additional survey questions as an exhibit J-13 within 30 days prior to the implementation of the change for DMHC review. Alternatively, a plan may add the following survey questions after Question 2 in the NPMH Survey Tools without prior approval from the DMHC:³⁷

Question 3

Do you schedule non-urgent appointments for new patients differently than follow-up appointments for ongoing care?

(If no, record the response to the next available non-urgent appointment as the response to the next available follow-up appointment. If yes, ask the next two questions.)

Question 4

When is the next available appointment date and time with [Provider Name or FQHC/RHC Name] for non-urgent services for a new patient?

Question 5

When is the next available follow-up appointment date and time for a patient being seen today by [Provider Name or FQHC/RHC Name]?

To avoid bias and ensure comparability of the data, plans may not change the provider's response (or the compliance calculation) to Question 2 regarding non-urgent appointments based on the provider's response to the questions set forth above.

³⁷ Question 2: "When is the next available appointment date and time with [Provider Name or FQHC/RHC Name] for non-urgent services?"

If the plan adopts this approach, the plan is not required to submit the results of the follow-up appointment questions to the Department; however, it shall indicate that it included additional survey questions in its PAAS to monitor the availability of follow-up appointments and indicate what specific questions the plan included to assess follow-up appointment availability. To assist the Department in developing the methodology for measuring follow-up appointments, the Department requests that the plan provide an assessment of the efficacy of its questions regarding follow-up appointments in the written summary of follow-up appointment monitoring required to be submitted in the MY 2022 Timely Access Compliance Report submission to the DMHC. The DMHC recommends that the plan note in its assessment any confusion or pertinent information obtained while administering the additional questions regarding follow-up appointments.

Plans' MY 2022 Timely Access Compliance Report shall be submitted to the DMHC by May 1, 2023.³⁸

3. RY 2024: Implement the Regulatory Amendments to the Timely Access Compliance Report with DMHC-Issued SB 221 APA Exempt Amendments.

Plans must be ready to comply with the regulatory amendments in Rule 1300.67.2.2, subs. (d) and (h)(6) for MY 2023, which shall be reported to the DMHC by May 1, 2024. (Section 1367.03, sub. (f)(3).)³⁹ Plans must also fully implement monitoring of the new SB 221 standards in RY 2024/MY 2023.

In 2022, the DMHC will develop amendments to the PAAS Methodology, consult with stakeholders and provide additional reporting instructions and information for implementation in MY 2023 of the new SB 221 standards and monitoring requirements, including standardized requirements related to measuring and reporting compliance with the follow-up appointment standard for NPMH and substance use disorder providers set forth in Section 1367.03, sub. (a)(5)(F). (Section 1367.03, sub. (f)(3).)

V. Changes to Annual Network Reporting:

1. RY 2022: Annual Network Reporting – No Changes

There are no changes to the annual network reporting data for RY 2022/MY 2021, which is due by March 31, 2022. Plans report according to Rule 1300.67.2.2 (as enacted in 2009), and the Annual Network Reporting instructions and report forms posted to the Web Portal on October 31, 2021.⁴⁰

³⁸ Rule 1300.67.2.2, sub. (h)(1) (as amended on April 1, 2022).

³⁹ The Timely Access Compliance Report requirements were originally enacted in 2009 under Rule 1300.67.2.2, subs. (g)(2)(A)-(F). The amendments to the Timely Access Compliance Report are enacted under Rule 1300.67.2.2, sub. (h)(6), effective April 1, 2022.

⁴⁰ Rule 1300.67.2.2, sub. (g)(2) (as enacted in 2009). March 31, 2022, is a holiday and MY 2021 data may be reported on April 1, 2022.

2. RY 2023: Annual Network Reporting – Overview of Changes

a. Changes Due to Amendments to Rule 1300.67.2.2:

Beginning in RY 2023, plans are required to submit annual network data and information in the network access profile, in accordance with the amended regulation, on or before May 1, 2023.⁴¹ The amendments to Rule 1300.67.2.2 make several changes to Annual Network Reporting. Changes include the following:

- ✓ **The submission date has changed:** Beginning in RY 2023, annual network data must be submitted during the same year in which the network capture date occurs, thereby aligning the reporting year and measurement year. The submission date is May 1st of the measurement year.⁴² The reporting deadline for RY/MY 2023 is **May 1, 2023**.
- ✓ **The capture date for annual network data has changed:** Beginning in RY 2023, the annual network reporting network capture date is January 15th of the Annual Network Report measurement year.⁴³ The network capture date for RY 2023/MY 2023 is **January 15, 2023**.
- ✓ **All plans must complete a profile with basic network information:** All plans identified in the amended Rule 1300.67.2.2, sub. (a) must complete a network access profile on an annual basis.⁴⁴ This obligation extends to restricted and limited full-service health care service plans, subcontracted plans, and all licensed specialized health care service plans, including vision, dental, and acupuncture/chiropractic plans. The network access profile contains basic identifying network information.
- ✓ **Plans set forth in Rule 1300.67.2.2, sub. (h)(1)(A) must report all required network data:** Reporting plans, as defined in Rule 1300.67.2.2, sub. (b)(17), must submit all required network information and annual network report forms according to the DMHC instructions.⁴⁵
- ✓ **Primary plans report all network data on behalf of the network:** When reporting a network that includes network providers made available through plan-to-plan contracts, as defined, the primary plan is required to report all network data on behalf of the plan's own network and any network providers included in the primary plan's network due to a plan-to-plan arrangement with the subcontracted plan.⁴⁶ A subcontracted plan, as defined, does not submit data to

⁴¹ Rule 1300.67.2.2, subs. (h), (h)(7), and (h)(8), as amended, and the incorporated Annual Network Report Form Instructions, and Timely Access and Annual Network Reporting Submission Instruction Manual.

⁴² Rule 1300.67.2.2, sub. (h)(1).

⁴³ Rule 1300.67.2.2, sub. (b)(7)(A).

⁴⁴ Rule 1300.67.2.2, subs. (h)(1)(A) and (h)(1)(B).

⁴⁵ Rule 1300.67.2.2, sub. (h)(1)(A).

⁴⁶ Rule 1300.67.2.2, sub. (h)(3).

the DMHC on behalf of the primary plan; the primary plan is responsible for this submission.

- ✓ **Plans must adopt defined terms as set forth in the amended regulation:** Plans must report annual network data according to defined terms set forth in Rule 1300.67.2.2, sub. (b) and within the “Definitions” section of the Timely Access and Annual Network Submission Instruction Manual (Instruction Manual), which was promulgated pursuant to the administrative procedures act (APA) and is incorporated in the amended Rule 1300.67.2.2. Defined terms in subsection (b) of the amended Rule include the following terms, among others:

- network
- network adequacy
- network provider
- network service area
- plan-to-plan contract
- product line

Defined terms in the incorporated Instruction Manual include the following terms, among others:

- practice address or location
- accepting new patients
- full-time
- part-time
- network tier
- unscheduled urgent services

Plans are advised to review all definitions in the amended regulation and incorporated instructions, to ensure proper reporting of annual network data, pursuant to the obligations in Rule 1300.67.2.2, sub. (a)(5), as amended.

- ✓ **Plans must use updated Report Forms and complete all fields required under the regulation:** All annual network report forms and the fields within each report form are required for submission, unless otherwise indicated. The amended Rule 1300.67.2.2 includes new fields and instructions pertaining to the annual network report forms, as incorporated. The field instructions also incorporate the defined terms within the amended regulation and incorporated documents. The DMHC will release the fillable annual network report forms for RY 2023 by November 1, 2022.⁴⁷

b. Annual Network Reporting Changes due to SB 221:

Section 1367.03, sub. (a)(7), as amended by SB 221, requires plans to ensure that each network contains sufficient numbers of in-network providers to maintain

⁴⁷ Section 1367.035, subs. (a) and (g).

compliance with the standards established by section 1367.03. The amended statute includes further requirements for plans when mental health and substance use disorder providers are not available in the network.⁴⁸ The statute incorporates existing provider-to-enrollee ratio standards and geographic accessibility standards established in sections 1300.51, 1300.67.2, and 1300.67.2.1 of the California Code of Regulations.⁴⁹

Plans submit the Annual Network Report as part of the annual reports submitted pursuant to Section 1367.03, sub. (f).⁵⁰ The DMHC is required to develop standardized methodologies for reporting that shall be used by health care service plans to demonstrate compliance with the standards with the section, and any regulations adopted pursuant to the section.⁵¹ Plans report compliance with the standards in a manner specified by the DMHC.⁵²

Non-Physician Mental Health Professional - Patient Encounters

In accordance with the obligations in Sections 1367.03 and 1367.035, the DMHC is developing standardized methodologies for reporting in RY 2023 and subsequent reporting years, to ensure that each network has sufficient numbers of in-network providers that are available to enrollees to maintain compliance with the standards in Section 1367.03 and supporting regulations.⁵³ As part of the annual network reporting, the DMHC will require reporting plans, as defined in Rule 1300.67.2.2, sub. (b)(17), to submit data related to patient encounters with non-physician mental health professionals (MHP), as set forth below:⁵⁴

- ✓ **MHP Patient Encounters:** For each network and each MHP reported on the Mental Health Professional and Mental Health Facility Report Form, plans will be required to submit data to the DMHC regarding the number of clinical encounters with enrollees in the network and the number of enrollees who had clinical encounters with each MHP. Clinical encounters include face-to-face or electronic patient visits or encounters, whether reported to the plan through claims data, encounter data, or otherwise provided to the plan. It does not include inpatient hospital-based or hospital emergency room-based patient visits or encounters.
- ✓ **Shortened data collection period for implementation (RY 2023):** There will be a shortened data collection period for RY 2023 to ensure plans have adequate time to collect data and implement this change. For RY 2023 (reported on or

⁴⁸ Section 1367.035, sub. (a)(7)(B).

⁴⁹ Section 1367.03, sub. (a)(7)(A).

⁵⁰ Section 1367.035, subs. (a) and (d).

⁵¹ Section 1367.03, sub. (f)(3). The development and adoption of methodologies to demonstrate compliance with standards set forth in 1367.03 and regulations adopted pursuant to that section is not subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), until July 1, 2025.

⁵² Section 1367.03, sub. (f)(2).

⁵³ Section 1367.03, subs. (a), (a)(7) and (f); Section 1367.035, sub. (a); Rule 1300.67.2.2.

⁵⁴ The term MHP is used to maintain consistency with the annual network report forms and reporting instructions incorporated in Rule 1300.67.2.2, as amended in 2022.

before May 15, 2023), please refer to the Shortened Data Capture Timeframe in the Table below:

Annual Network Reporting – Reporting MHP Patient Encounters	
Reporting Year	RY 2023
Submission Date	May 1, 2023
Network Capture Date	January 15, 2023
Shortened Data Capture Timeframe for RY 2023	Report encounters that were reported to, or received by, the plan in the six (6) calendar months prior to the network capture date, <u>regardless of the date of service of the specific encounter.</u> ⁵⁵
Required Data Capture for RY 2023	
Clinical Encounters by Network	For each MHP reported in the network, the number of clinical encounters the MHP had with enrollees in the network. Use the shortened data capture timeframe described within this table.
Number of Enrollees Utilizing each MHP by Network	For each MHP reported in the network, the number of enrollees who had at least one clinical encounter with the MHP. Use the shortened data capture timeframe described within this table.

The report form fields and instructions for the data set forth above will be disseminated for further stakeholder feedback in summer 2022. The instructions will provide further detail regarding the parameters of these fields. This APL provides plans with advance notice of the new standardized methodologies for reporting under SB 221, so plans may prepare for the changes in reporting that will occur in RY 2023.

MHPs that are Accepting New Patients – Annual Network Reporting

As part of annual network reporting, plans are required to report the non-physician mental health professionals (MHP) accepting new patients within a network in accordance with a standardized reporting methodology.⁵⁶ The reporting instructions include a definition for “accepting new patients” pertaining to the reported network.⁵⁷

⁵⁵ This includes face-to-face or electronic patient visits or encounters, whether reported to the plan through claims data, encounter data, or otherwise provided to the plan. It does not include inpatient hospital-based or hospital emergency room-based patient visits or encounters.

⁵⁶ Rule 1300.67.2.2 and incorporated documents, as amended in 2022.

⁵⁷ Rule 1300.67.2.2 and incorporated Timely Access and Annual Network Submission Instruction Manual, Introduction: A. Definitions 1. Accepting new patients.

The DMHC will review reported annual network data, including the plan's reported percentage of MHPs accepting new patients, for the sufficiency and availability of MHPs within each network to deliver timely care.⁵⁸

The DMHC is also evaluating an appropriate threshold for the minimum percentage of MHPs accepting new patients within a network, or within provider locations and geographic regions within a network, necessary to maintain compliance with the network adequacy standards referenced in Sections 1367.03, 1367.035, and Rule 1300.67.2.2. The substantive standard will be incorporated into future rulemaking.

The DMHC will use a preliminary threshold percentage of compliance when reviewing annual network data in accordance with Section 1367.035, sub. (d). During annual reporting, plans may provide input on the preliminary threshold of compliance for the minimum percentage of MHPs accepting new patients, and/or reasons the plan's reported data may not meet the preliminary standard. The DMHC will provide stakeholders with further information on the preliminary threshold in summer 2022.

c. Changes due to AB 457:

Plans are required to submit third-party corporate telehealth data and enrollee demographic data for each product type as part of required annual network reporting under Section 1367.035 and the regulations adopted pursuant to that section.⁵⁹ The annual network reporting is part of the reporting obligations under Section 1367.03, sub. (f).⁶⁰ Section 1374.141 reporting requirements do not apply to Medi-Cal managed care plans.⁶¹

For RY 2023 (due May 1, 2023), the DMHC will issue detailed instructions to report required information, along with report forms and additional required demographic information determined necessary by the DMHC, in accordance with Section 1367.035. The report forms and instructions to capture required data under Section 1374.141 will be disseminated for further stakeholder feedback in summer 2022.

✓ **Third Party Corporate Telehealth Providers – Required Reporting:**

Third-party corporate telehealth provider is defined in Section 1374.141, sub. (b)(4).

The DMHC will include the following reporting requirements as part of the annual network reporting, beginning in RY 2023, for each product type by network:

- (1) By specialty, the total number of services delivered via telehealth by third-party corporate telehealth providers.

⁵⁸ Section 1367.03, subs. (a)(1) and (a)(7); Section 1367.035, subs. (a) and (d).

⁵⁹ Section 1374.141, sub. (d).

⁶⁰ Section 1367.035, sub. (a).

⁶¹ Section 1374.141, sub. (h).

(2) The names of each third-party corporate telehealth provider contracted with the plan and, for each, the number of services provided by specialty.

(3) For each third-party corporate telehealth provider with which it contracts, the percentage of the third-party corporate telehealth provider's contracted providers available to the plan's enrollees that are also contracting individual health professionals.

(4) For each third-party corporate telehealth provider with which it contracts, the types of telehealth services utilized by enrollees, including frequency of use, gender, age, and any other information as determined by the DMHC.

(5) For each enrollee that has accessed services for a third-party corporate telehealth provider, enrollee demographic data, including gender and age and any other information as determined by the DMHC.

Enrollee demographic data set forth in Section 1374.141, sub. (d)(5) will further be collected by county, for RY 2023.⁶² The DMHC may require additional information, as set forth in subsections (d)(4) or (d)(5) of Section 1374.141, in subsequent reporting years, if necessary.

VI. Implementation Filings for the Amendments to Rule 1300.67.2.2

By the fall of 2022, the DMHC will issue a checklist for updates to plan policies and procedures filed with the DMHC as part of its license and any affirmations related to implementation of the amendments to Rule 1300.67.2.2. The checklist will include a submission schedule indicating that submission of the updated policies and procedures and affirmations shall begin January 1, 2023, will be due on a rolling basis, and will include changes to timely access and network adequacy monitoring beginning January 1, 2023, in accordance with the amended Rule 1300.67.2.2, sub. (d).⁶³

If you have any questions about this APL, please contact the Office of Plan Monitoring. Questions related to Timely Access Compliance may be sent to TimelyAccess@dmhc.ca.gov. Questions related to Annual Network Reporting may be sent to ANRTeam@dmhc.ca.gov.

⁶² Section 1374.141, sub. (d)(5). This is consistent with enrollee reporting requirements set forth in Rule 1300.67.2.2, sub. (h)(7)(A).

⁶³ As a reminder, all plans, except those set forth in Rule 1300.67.2.2, sub. (a)(2), are required to monitor networks for network adequacy on a quarterly basis, regardless of the product type(s) within the network, in accordance with the amended Rule 1300.67.2.2, sub. (d)(2)(F). Plans must conduct required monitoring according to defined terms set forth in Rule 1300.67.2.2, sub. (b). Defined terms include "network," "network provider," and "network service area" among others.