Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th Street, Suite 500
Sacramento, CA 95814
Phone: 916-324-8176 | Fax: 916-255-5241
www.DMHC.ca.gov

ALL PLAN LETTER

DATE: December 12, 2025

TO: All Health Care Service Plans

FROM: Nathan Nau
Deputy Director, Office of Plan Monitoring

SUBJECT: APL 25-019 – Notice of Amendments to Rules 1300.51, 1300.67.1.3, and 1300.67.2 and Incorporated Documents – Network Adequacy Standards and Methodology for RY 2026

The Department of Managed Health Care (DMHC) issues this All-Plan Letter (APL) to notice network adequacy amendments to 28 CCR § 1300.51, 1300.67.1.3, and 1300.67.2, and documents incorporated by reference.[1] The amendments are noticed pursuant to Health & Safety Code section 1367.03(f)(5).[2]

I. Application to Health Care Service Plans

The amendments noticed in this APL apply as follows:

- Amendments Applicable to All Network Reviews: Amendments described in Section IV of this APL apply to all health care service plans (plans) that are subject to network reviews as part of new and ongoing licensure filings made pursuant to Sections 1351 and 1352 and the regulations promulgated thereunder.[3]

[1] References to "Rule" refer to the California Code of Regulations (CCR), title 28.
[2] The Knox-Keene Act is set forth in California Health and Safety Code sections 1340 et seq. References to "Section" are to sections of the Act.
[3] See Rules 1300.51, 1300.52, 1300.52.4, and 1300.67.2.1. This APL does not apply to plans licensed only to offer Medicare Advantage product lines or Employee Assistance Program (EAP) products.

- Block Transfer Filing Amendments: Amendments described in Section V of this APL apply to all plans that are subject to block transfer filing requirements under Section 1373.65 and Rule 1300.67.1.3.
- Annual Network Review Amendments: Section VI of this APL describes additional network adequacy standards and methodology applicable to plans that are required to file an Annual Network Report submission for the Annual Network Review.[4]

Amendments are effective January 1, 2026. For those plans required to submit an Annual Network Report, the DMHC will apply network requirements to the reporting year (RY) 2026 Annual Network Review.

II. Overview: New and Amended Network Adequacy Standards

This APL provides notice of new and amended network adequacy requirements, standards, and methodologies. This includes updates to network adequacy standards that were previously released in APL 24-021 (December 12, 2024) and APL 23-023 (December 14, 2023), as well as new network standards addressing the availability of mental health networks, requirements for arranging out-of-network care, and the accuracy of network data reported to the DMHC. The amendments also include updates to block transfer filing requirements. Amendments are set forth in Rules 1300.67.2 and 1300.67.1.3. Additionally, Rule 1300.51 is updated to revise citations relevant to the recent re-lettering in sections of Rule 1300.67.2.

In 2022, the Governor signed Senate Bill (SB) 225 into law.[5] Among other changes, SB 225 revised Section 1367.03(f)(5) to authorize the DMHC to adopt standards that address the availability of network providers and services, including the availability of primary care physicians, specialty physicians, hospital care, and other network providers, as a means to ensure enrollees have timely access to care. The development and adoption of these standards are exempt from formal rulemaking under the Administrative Procedure Act (APA) until December 31, 2028.[6] Under this APA exemption to formal rulemaking, the DMHC has promulgated new and revised network adequacy requirements on an annual basis, after stakeholder circulation and feedback.

The updates to Rules 1300.51, 1300.67.1.3, 1300.67.2, and incorporated documents apply to network adequacy review in the manner described in this APL and the attached documents. The DMHC will also continue to evaluate plans for compliance with existing

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[4] Full-service and mental health plans are required to submit an Annual Network Report to the DMHC, and the DMHC is required to review the Annual Network Report submissions for compliance with the Knox-Keene Act (the “Annual Network Review”). See sections 1367.03(f) and 1367.035; Rule 1300.67.2.2(h).
[5] SB 225 (Wiener, Chapter 601, Statutes of 2022).
[6] See Sections 1367.03(f)(5).

network adequacy requirements in all areas of review.[7] During the APA exemption period, the standards and methodologies incorporated in Rule 1300.67.2 and other Rules may be further tested and updated as needed.

III. Stakeholder Feedback and FAQ

The DMHC circulated draft amendments to network adequacy regulations to stakeholders for feedback on July 8, 2025, pursuant to Section 1367.03(f)(5). The documents and amendments noticed in this APL incorporate, where possible, the feedback received at that time. The DMHC thanks those stakeholders who provided input. Please note that the DMHC is no longer taking comments on the amended regulations noticed in this APL. Stakeholders will have an opportunity to provide further feedback to the DMHC in advance of any future amendments to the standards and methodologies.

The DMHC has prepared responses to frequently asked questions (FAQ) by stakeholders pertinent to the amendments noticed in this APL. FAQ responses are attached to this APL.

IV. Amendments Applicable to all Plans Subject to Network Review

The amendments noticed in this APL include updates to Rule 1300.67.2 that clarify new and existing network adequacy requirements. Additionally, citations to Rule 1300.67.2 were updated in Rule 1300.51 to reflect re-lettering organizational changes. The amendments described below apply when the Department evaluates a plan's network adequacy for the purposes of initial and ongoing licensure, and as part of the Annual Network Review.[8] Amendments to Rule 1300.67.2 include the following key updates:

A. Network Adequacy Definitions

The noticed amendments include updates to definitions set forth in Rule 1300.67.2.2(b) that are incorporated by reference in Rule 1300.67.2(a). Rule 1300.67.2(a) was previously amended to incorporate by reference the definitions set forth in Rule

[7] This includes network adequacy reviews conducted for the purposes of licensure pursuant to Rules 1300.52 and 1300.52.4, as part of the Annual Network Review pursuant to Sections 1367.03, 1367.035 and Rule 1300.67.2.2, and review of Block Transfer filings pursuant to Section 1373.65 and Rule 1300.67.1.3.
[8] As part of new and ongoing licensure filings, health plans are required to submit all networks to the DMHC for approval and subsequent reviews pursuant to sections 1351 and 1352 and the regulations promulgated thereunder.

1300.67.2.2.[9] Recently the Department published APL 25-013 (September 4, 2025), which included updates and additions to the definitions incorporated by reference.

Please see APL 25-013 (September 4, 2025) for details regarding changes to definitions that impact the network standards and requirements set forth in Rule 1300.67.2.

B. Network Provider Availability Requirements

Amendments to Rule 1300.67.2(b)(4) clarify the plan's obligation to ensure that sufficient numbers of network providers are readily available to provide health care services to enrollees in the network. The amendments specify that if a provider has not seen any patients in the network during a calendar year, it may indicate the provider is not readily available to enrollees in the network, absent circumstances that justify a lack of clinical encounters, as described in the Rule. In such cases, the plan must monitor whether the network provider is truly readily available to enrollees in the network.

C. Network Provider Practice Address Accuracy Requirements

Amendments to Rule 1300.67.2(b)(5) clarify a plan's obligation to report accurate practice addresses to the DMHC according to the definition of practice address. A plan's reporting of network provider practice locations is critical for both plans and the DMHC to monitor network adequacy. The practice address definition differentiates the provider's "primary practice address," which is based on the in-person location where the provider most frequently practices; from all other in-person locations where the provider actively practices, which are "secondary practice addresses."[10]

The amendments include a methodology the DMHC may use to review reported practice addresses for accuracy when a plan reports multiple practice addresses for a single provider. This is set forth in the "Identifying Provider Location" section of the Geographic Access Measurement Methodology document.[11] The methodology identifies likely practice address inaccuracies based on the number of practice addresses reported for the provider and the locations of the reported addresses. Plans will have an opportunity to respond to identified potential address inaccuracies.

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[9] See APL 23-023 (December 14, 2023), noticing the incorporation of network adequacy terms into Rule 1300.67.2.

[10] Practice address definitions in Rule 1300.67.2.2(b) are incorporated in Rule 1300.67.2(a).

[11] Please see the amended Geographic Access Measurement Methodology, attached. This document was originally noticed via DMHC APL 23-023 (12/14/2023), available at https://www.dmhc.ca.gov/LicensingReporting/HealthPlanLicensing/AllPlanLetters.aspx.

D. Network Service Area Requirements

Amendments to Rule 1300.67.2(c)(5) and the Geographic Access Measurement Methodology incorporated in Rule 1300.67.2 reiterate a plan's requirement to ensure geographic accessibility to all population points throughout the licensed and approved network service area. The plan's current network service area must be approved and on file with the DMHC and must be reported accurately in subsequent filings with the DMHC. The DMHC will review network adequacy based on the approved network service area on file with the DMHC.[12] For further details, refer to the amended Geographic Access Measurement Methodology, incorporated in Rule 1300.67.2 and attached to this APL.

The amendments to Rule 1300.67.2(c)(5) also clarify that enrollment is limited to the network service area, based on the enrollee's residence or workplace. When a plan reports significant enrollment outside the network service area, the DMHC may require the plan to file a notice of material modification to expand the network service area, consistent with Health and Safety Code section 1352 and supporting regulations. The Rule also defines "significant enrollment."

E. Out-of-Network Referral Requirements

Amendments to Rule 1300.67.2(i) further describe a plan's requirements to arrange for covered services from non-network providers if the services are unavailable from a network provider. This includes written notice, selection and contact with out-of-network providers, scheduling appointments in coordination with the enrollee, documenting the plan's efforts, and limiting financial obligations for the enrollee. For further information, refer to requirements in Rule 1300.67.2(i).

F. Requirements for Review of Network Adequacy through the Primary Plan

Amendments to Rule 1300.67.2(b)(6) clarify that network adequacy is typically measured based on the total set of providers available to all enrollees in the network through the primary plan, including those providers available through plan-to-plan contracts. Plans with standalone networks will be subject to network adequacy review. For further information, refer to the requirements in Rule 1300.67.2(b)(6).

G. Requirement to Permit Enrollees to Select a Distant Network Provider

In each network, a plan is required to make available primary care providers and other network providers within applicable geographic access standards or approved alternative access standards. Rule 1300.67.2(c)(4)(B) is added to clarify that, in those situations where an enrollee is able to exercise a choice when selecting a network provider or provider group, the enrollee may choose a network provider that is outside of the county or further than the geographic access standard or approved alternative

[12] See APL 23-005 (February 13, 2023).

access standard. This is in line with the network requirement that all enrollees in all product lines using the network have access to the complete list of providers available within a network.[13]

H. Individual Enrollee Right to Access Providers and Services

Rule 1300.67.2(k) clarifies the requirement that a plan must provide covered services within reasonable proximity to enrollees in the network, and in some cases, this requires plans to allow the enrollee to access a provider at a shorter distance than the distance standards set forth in the Specialty or Mental Health Geographic Access Standards and Methodology documents. The standards and methodology documents are used to determine if a plan's network meets a minimum threshold for network adequacy for the network as a whole. However, the standards are not always tailored to specific enrollee circumstances or county demographics, due to the wide variation in county types, population density, and provider availability throughout the state. This can result in lengthy distance standards for certain provider types, especially within counties that do not have large metro centers. Amendments to Rule 1300.67.2(k) clarify that if the specialist distance standard is further than 30 miles, an individual enrollee is still entitled to access a specialty provider within 30 miles, when providers of that type are available to the enrollee within shorter distances.

V. Block Transfer Amendments

The amendments noticed in this APL include revisions to the definitions applicable to Block Transfer filings contained in Rule 1300.67.1.3(a) and other technical changes, as described below.

A. Block Transfer Filings Required for Specified Subcontractors' Terminations with Providers

Amendments to the definitions in Rule 1300.67.1.3 have expanded the scope of contract terminations that will trigger a Block Transfer filing to now include contract terminations occurring between medical groups/hospitals and health plans' contracted entity, including restricted licensees, medical groups, and similar entities. The amendments further make it clear that the primary plan, as defined in Rule 1300.67.2.2(b)(13)(A), is the entity responsible for submitting a Block Transfer filing when a termination is pending.

Additionally, the definition of "contract termination" in Rule 1300.67.1.3(a)(4) has been amended to include partial terminations, constructive terminations, and other termination types. A "Partial Termination" is now defined in Rule 1300.67.1.3(a)(6).

[13] See the definition of "network" in Rule 1300.67.2.2(b), incorporated in Rule 1300.67.2(a).

B. Block Transfer Filings Required for All Hospital Terminations

The amendments to Rule 1300.67.1.3 remove the 2,000-redirected-enrollees threshold for hospital terminations. Under the revised Rule, a pending termination between a health plan and a hospital must be filed as a Block Transfer, regardless of impact to existing enrollees. This requirement also applies to a pending termination between a Plan-Contracted Entity and a hospital that is contracted with that entity.

C. Identifying Block Transferred PPO/EPO Enrollees in Provider Group Terminations

Because preferred provider organization (PPO) and exclusive provider organization (EPO) products generally do not "assign" patients to a primary care physician (PCP), health plans had previously expressed confusion regarding whether PPO and EPO enrollees should be included when calculating whether the termination would result in 2,000 or more transferred enrollees.

Language has been added to Rule 1300.67.1.3(a)(3)(A) to account for PPO/EPO enrollees who are "matched" to a PCP or group to help with referrals to physicians in that group or network. In a termination where a PPO/EPO enrollee would lose their matched PCP, they are now required to be counted towards the 2,000-enrollee transferred criteria.

D. Block Transfer Timing, Enrollee Transfer Notice Formatting Updates, and Technical Updates

Rules 1300.67.1.3(b) and (f) have been clarified and added, respectively, to require that Block Transfer filings be submitted 75 business days prior to the contract termination date. Further, language that is required to be included in enrollee transfer notices is now required to be presented in 12-point font, to ensure reading accessibility for visually impaired consumers. The amendments also make several technical updates for consistency.

VI. Annual Network Review Amendments

New and amended network adequacy standards and methodologies are set forth in the amendments to Rule 1300.67.2 and incorporated documents and are effective for the RY 2026 Annual Network Review. The DMHC is also permitted to evaluate health plans using these standards when reviewing network adequacy for the purposes of new and ongoing licensure filings.[14] Further information regarding each of these standards is set forth below.

[14] See Rules 1300.67.2(c)(2), (f)(3), and (h)(2).

A. Geographic Access Standards and Methodology *(Amended for RY 2026)*

DMHC evaluates the ability of plan networks to demonstrate sufficient geographic access to the identified provider types to ensure compliance with network adequacy standards referenced in the Act, including Sections 1367.03, 1367.035, and Rules 1300.67.2, 1300.67.2.1, and 1300.67.2.2.[15] Compliance is evaluated based on the DMHC's measurement of geographic access conducted in accordance with the Geographic Access Measurement Methodology, incorporated by reference in Rule 1300.67.2(c)(4). The Geographic Access Measurement Methodology was previously included in DMHC's APL 23-023 (December 14, 2023). Updates to this methodology are noticed in this APL as described in Section IV above.

1. Specialty Geographic Access

The Geographic Access Standards and Methodology for Specialists, Ancillary, and Facility Providers document, and accompanying Schedule E, is incorporated by reference in Rule 1300.67.2(c)(1)(A), as amended for RY 2026.[16] The enclosed document replaces the previous version of this document, issued on December 12, 2024, via DMHC's APL 24-021. For RY 2026, DMHC has added several provider types to the standards and methodology including several specialist physician, ancillary, and facility provider types.

2. Mental Health Geographic Access

The Mental Health Geographic Access Standards and Methodology document, and accompanying Schedule B, is incorporated by reference in Rule 1300.67.2(c)(1)(A), as amended for RY 2026.[17] The enclosed document replaces the previous version of the Mental Health Geographic Access Standards and Methodology issued on December 12, 2024, via DMHC's APL 24-021. For RY 2026, DMHC made minor amendments to the Mental Health Geographic Access Standards and Methodology.

Notably, for RY 2026, the distance standard for mental health facilities in Metro Counties has decreased from 45 driving miles to 35 driving miles, and the alternative distance standard for mental health facilities in identified low-density ZIP Codes in Metro

[15] For provider types not listed in any of the Geographic Access Standards and Methodology documents, health plans must continue to ensure that networks have a comprehensive range of providers that are readily available at reasonable times to all enrollees and readily accessible within reasonable proximity of all enrollees under the Knox-Keene Act, including Section 1367, 1367.03, and Rules 1300.51(d)(H) and 1300.67.2.

[16] The Department is providing notice of changes to this document prior to the reporting year, in accordance with Rule 1300.67.2(c)(1)(A).

[17] Geographic Access standards for mental health providers and facilities were first noticed on December 14, 2023 via APL 23-023, effective for RY 2024.

Counties has similarly decreased from 75 driving miles to 55 driving miles. For further information regarding this change, please refer to the Frequently Asked Questions document accompanying this APL.

B. Ratio Standards and Methodology *(New and Updated for RY 2026)*

To assess the capacity of plan networks to deliver medically necessary services, the DMHC evaluates the ratio of the identified provider-to-enrollees against a set ratio standard for each specialty type.[18] The ratio standard identifies the minimum number of full-time equivalent (FTE) physicians of the provider type per enrollees needed to demonstrate a plan network has adequate capacity and availability of licensed health care providers to reasonably assure that covered services will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollee, as required by Rule 1300.67.2(f).

1. Primary Care Physician Ratio

Effective for RY 2026, the Primary Care Physician (PCP) Ratio Standards and Methodology document, and accompanying Schedules G through G-5, is incorporated by reference in Rule 1300.67.2(f)(2)(A).

The PCP Ratio Standards and Methodology documents reiterate the longstanding ratio requirement of 1:2000 primary care physicians in the geographic areas where the network operates.[19] As with previously released ratio standards and methodology, these documents provide detail regarding how the DMHC calculates both the ratio standard and the number of full-time equivalent (FTE) providers in a particular network and county. The document also describes alternative standards and methodologies that may be applicable when a plan does not meet the ratio standard for a particular county or network.

2. Specialist Physician Ratios

The Specialist Physician Ratio Standards and Methodology document, and accompanying Schedules D through D-6, is incorporated by reference in Rule 1300.67.2(f)(2)(A), as amended for RY 2026. The enclosed document replaces the previous version of this document, issued on December 12, 2024, via DMHC's APL 24-021. For RY 2026, the DMHC made minor amendments to the Specialist Ratio Standards and Methodology and accompanying schedules to clarify potential

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[18] For specialist physician types not listed in the Specialist Physician Ratio Standards and Methodology document, the DMHC will continue to review plans to ensure that networks have a comprehensive range of specialist physician providers that are readily available at reasonable times to all enrollees and readily accessible within reasonable proximity of all enrollees under the Knox-Keene Act, including Section 1367, 1367.03, and Rules 1300.51(d)(H) and1300.67.2.

[19] See Health & Safety Code section 1375.9(a), Rule 1300.51(H).

ambiguities in the methodology language. This includes minor updates to certain provider type definitions and clarifications concerning how some of the alternative standards are calculated.

3. Mental Health Ratio

The Counseling Non-Physician Mental Health Professional Ratio Standards and Methodology document, and accompanying Schedules A through A-6, is incorporated by reference in Rule 1300.67.2(f)(2)(A), as amended for RY 2026.[20] The enclosed document replaces the previous version of the Counseling Non-Physician Mental Health Professional Ratio Standards and Methodology issued on issued on December 12, 2024, via DMHC's APL 24-021.

For RY 2026, the DMHC made minor amendments to the Counseling Non-Physician Mental Health Ratio Standards and Methodology and accompanying schedules, to clarify potential ambiguities in the methodology language. This includes minor updates to certain provider type definitions, and clarifications concerning how some of the alternative standards are calculated.

C. Accepting New Patients Standards and Methodology
(Amended for RY 2026)

The DMHC evaluates the ability of plan networks to demonstrate sufficient availability of providers, including PCPs and Counseling MHPs, to ensure compliance with network adequacy standards referenced in the Act, including Sections 1367.03, 1367.035, and Rules 1300.67.2.2 and 1300.67.2. The DMHC uses compliance thresholds to evaluate providers accepting new patients based on a plan's reported network data. The compliance thresholds reflect a minimum level of compliance for the provider or the provider locations that are accepting new patients, within a county and within the network service area.

1. Primary Care Physicians - Accepting New Patients

The Primary Care Physician Accepting New Patients Standards and Methodology document, and accompanying Schedule F, is incorporated by reference into Rule 1300.67.2(h)(1)(A), as amended for RY 2026. The enclosed document replaces the previous version of this document, issued on December 12, 2024, via DMHC's APL 24-021. For RY 2026, the DMHC made minor amendments to the PCP Accepting New Patients Standards and Methodology and accompanying schedule to clarify potential ambiguities in the methodology language.

[20] Ratio standards for mental health providers were first noticed December 14, 2023 via APL 23-023, effective for RY 2024.

2. Counseling Mental Health Professionals - Accepting New Patients

The Counseling Non-Physician Mental Health Professionals (Counseling MHP) Accepting New Patients Standards and Methodology document, and accompanying Schedule C, is incorporated by reference into Rule 1300.67.2(h)(1)(A), as amended for RY 2026.[21] The enclosed document replaces the previous version of the Counseling Non-Physician Mental Health Professionals Accepting New Patients Standards and Methodology, issued on December 12, 2024, via DMHC's APL 24-021. For RY 2026, the DMHC made minor amendments to the Counseling MHP Accepting New Patients Standards and Methodology and accompanying schedule to clarify potential ambiguities in the methodology language

D. Required Network Provider Types *(Amended for RY 2026)*

To ensure plan networks are required to have network providers of the appropriate specialty and type necessary to deliver all covered services, the DMHC evaluates reported networks for the presence of some, or all the provider types set forth in the Required Network Provider Types document. This document identifies the most essential provider types necessary for a plan to demonstrate to the DMHC that a network is able to deliver health care services required to be covered under the Knox-Keene Act; however, it is not an exhaustive list of the provider types necessary to deliver all covered services in a network.

The Required Network Provider Types document is incorporated by reference in Rule 1300.67.2(g)(2), as amended or RY 2026. The enclosed document replaces the previous version of this document, issued on December 12, 2024, via DMHC's APL 24-021. For RY 2026, DMHC added several provider types, including reproductive endocrinology/infertility, neurological surgery, IVF Clinic, and several hospital services. The DMHC also amended the provider type names for certain provider types for clarity and consistency.

E. Mental Health Utilization Standards and Methodology *(New for RY 2026)*

Effective for RY 2026, the Mental Health Utilization Standards and Methodology is incorporated by reference in Rule 1300.67.2(b)(4)(A). The DMHC has reviewed health plans for sufficiency of available mental health providers for several years, starting with the RY 2023 Annual Network Review. After years of review and testing, these standards are now incorporated into the network adequacy rules.

The DMHC will evaluate the ability of health plan networks to demonstrate there are sufficient numbers of available counseling non-physician mental health professionals (Counseling MHPs) to ensure covered services are readily available and accessible to enrollees, as described in Rule 1300.67.2(b). The Mental Health Utilization Standards

[21] These standards and methodology were first noticed December 14, 2023, via APL 23-023, effective for RY 2024.

and Methodology is intended to identify networks with a large percentage of providers who do not appear to be providing health care services to enrollees in the network, despite expected patient need for the services. The compliance threshold is a network-level standard to identify networks where the number of network providers with no clinical encounters with enrollees is so great as to suggest the services are not readily available and accessible to enrollees.

For further information regarding this Standard and Methodology, please refer to the FAQ document enclosed in this APL.

VII. Summary Tables

As a courtesy to stakeholders, attached to this APL are summary tables for some of the new and amended standards incorporated in Rule 1300.67.2, for use in RY 2026:

- **Mental Health Standards – Summary Tables for RY 2026** contains an overview of the standards set forth in the Mental Health Geographic Access Standards and Methodology, and the Counseling Non-Physician Mental Health Professionals Ratio Standards and Methodology for RY 2026.

- **Specialist Physician, Ancillary, and Facility Standards – Summary Tables for RY 2026** contains an overview of the standards set forth in the Geographic Access Standards and Methodology for Specialist, Ancillary, and Facility Providers, and the Specialist Physician Ratio Standards and Methodology for RY 2026.

The Summary Tables have been updated for RY 2026 and replace the Summary Tables for RY 2025, released in APL 24-021 (December 12, 2024). These tables provide a summary of some of the information that is contained in the incorporated standards and methodology documents. These summary tables are provided as a courtesy and are not part of the regulation.

VIII. Enforcement of Network Adequacy Standards

The DMHC may review plan networks for compliance with the network adequacy standards and methodologies included in this APL as part of the Annual Network Review.[22] For RY 2026, Medi-Cal networks will be reviewed for compliance with all standards and requirements set forth in this APL and attachments, with the exception of the mental health facility distance standards included in the Mental Health Geographic

[22] The DMHC will also continue to review Annual Network Report submissions for compliance with network adequacy requirements through its Benchmark Review, as posted on the DMHC's Timely Access and Annual Network Reporting Web Portal.

Access Standards and Methodology document, and certain provider types included in the Required Network Provider Types document.

The DMHC's enforcement of the network adequacy standards will differ depending on whether the standard is new or previously released. The PCP Ratio Standards and Methodology and the Mental Health Utilization Standards and Methodology contain new standards and methodology for RY 2026. Similarly, new provider types have been released in the Geographic Access Standards and Methodology for Specialists, Ancillary, and Facility Providers document and the Required Network Provider Types document. For new provider types or new standards and methodology, if the DMHC's review indicates a plan's network does not meet these standards within the plan's network service area, the plan will be informed of the findings and the DMHC may require the Plan to submit a corrective action plan.[23] In subsequent reporting years, the DMHC may also rely upon these standards as a basis for carrying out and completing enforcement action.

For standards and methodology that were released in previous years and are issued with amendments for RY 2026, in addition to requiring a corrective action plan, the DMHC may rely on these standards as a basis for carrying out and completing enforcement action arising from the Annual Network Review, pursuant to the APA exemptions established in Section 1367.03(f).

IX. Implementation of Noticed Amendments

A. Amendments to Rule 1300.67.2

As of the date of this APL, all plan operations must incorporate the amendments to the law and referenced documents described in **Section IV** of this APL. Plans must review all documents on file with the DMHC to ensure they are consistent with the new regulatory language in Rule 1300.67.2 and the incorporated Geographic Access Measurement Methodology, as described in Section IV. and noticed in this APL.

It is the plan's responsibility to evaluate its existing documents and determine if any documents need to be revised to address requirements outlined in this APL. To the extent a plan must amend documents on file with the DMHC to come into compliance with the regulatory changes described in Section IV. of this APL, the plan must file those documents with the DMHC pursuant to Section 1352 and Rules 1300.52 and 1300.52.4. within the timeframes prescribed by law, but no later than July 1, 2026.

If a plan has documents currently pending regulatory review in the e-Filing web portal that must be further updated to address the changes to the amended regulations described in Section IV. of this APL, the plan should communicate to the DMHC through

[23] See Rule 1300.67.2.2(i).

the e-Filing web portal for that individual filing to determine the best way to incorporate new changes.

B. Amendments to Rule 1300.67.1.3

As of the date of this APL, all plan operations must incorporate the amendments to the law described in **Section V** of this APL. Plans must review all documents on file with the DMHC to ensure they are consistent with the new regulatory language in Rules 1300.67.1.3, as described in Section V. and noticed in this APL.

It is the plan's responsibility to evaluate its existing documents and determine if any documents need to be revised to address requirements outlined in this APL. In order to evaluate compliance with the updates to Rule 1300.67.1.3 as described in Section V, and to ensure all plans have up-to-date enrollee transfer notices (ETNs) on file with the DMHC, the Department requests that all full-service health plans submit via the e-Filing web portal an amendment filing containing the following:

1. An affirmation that the Plan will be submitting all future Block Transfer filings consistent with the updates to Rule 1300.67.1.3 as described in Section V;
2. The current version of all ETNs and "Good News Letters" currently used by the Plan as Exhibits I-13: Enrollee Transfer Notices for Block Transfers. The filing type should be submitted as an Amendment and titled "Template ETNs;"
3. Updated continuity of care policies that address the new Block Transfer filing requirements pursuant to Section 1373.95(a)(2)(A). The Plan shall file these Amendments as CC001 – Continuity of Care Policy.

Please file the information specified in paragraphs 1, 2, and 3 above through the DMHC's e-Filing portal no later than July 1, 2026.

C. Implementation of Network Adequacy Standards

At this time, the network adequacy standards and methodology documents referenced in **Section VI** of this APL are reviewed as part of the Annual Network Review, and health plans that are required to make an Annual Network Report submission must be in compliance with these standards. As stated in DMHC APL 24-021 (December 12, 2024) after expiration of the exemption from the APA set forth in Section 1367.03(f)(5), plans will be required to submit any required policies and procedure updates not previously submitted, pertaining to the final network adequacy standards filed with the Secretary of State prior to December 31, 2028.

Plans are reminded that to the extent a plan's internal policy and procedure documents conflict with the amended regulatory standards and methodology set forth in this APL, the amended Regulation and incorporated documents are controlling law, as described

in this APL and the noticed amendments. When a plan amends a document currently on file with the DMHC to conform with the DMHC's network adequacy standards and methodologies, the plan should file revisions to that document in accordance with Section 1352 and Rules 1300.52 and 1300.52.4.

If a plan has documents currently pending regulatory review in the e-Filing portal, such as documents submitted pursuant to the implementation of regulatory changes outlined in APL 24-021 (December 12, 2024), and these documents must be further updated to address the changes to the amended regulations described in this APL, the plan should communicate to the DMHC through the e-Filing web portal for that individual filing to determine the best way to incorporate new changes.

X. Attachments:

Amendments are noticed in underline and strikethrough format:

- Amendments to 28 CCR § 1300.67.2
- New and amended documents incorporated by reference in 28 CCR § 1300.67.2:
  - New: Primary Care Physician Ratio Standards and Methodology
    - Attached: Scheduled G - G5
  - New: Mental Health Utilization Standards and Methodology
  - Amended: Geographic Access Measurement Methodology
  - Amended: Counseling Non-Physician Mental Health Professional Ratio Standards and Methodology
    - Attached: Schedules A - A6
  - Amended: Mental Health Geographic Access Standards and Methodology
    - Attached: Schedule B
  - Amended: Counseling Non-Physician Mental Health Professionals Accepting New Patients Standards and Methodology
    - Attached: Schedule C
  - Amended: Specialist Physician Ratio Standards and Methodology
    - Attached: Schedules D - D6
    - RY 2026 Combined County Modifier - Thresholds for Eligibility
  - Amended: Geographic Access Standards and Methodology for Specialists, Ancillary, and Facility Providers
    - Attached: Schedule E
  - Amended: Primary Care Physician Accepting New Patients Standards and Methodology
    - Attached: Schedule F
  - Amended: Required Network Provider Types

    - Amended: Adjacent Counties and Exceptions for Application of Standards and Methodology (Attached to Ratio and Accepting New Patients Standards and Methodology documents)

- Amendments to 28 CCR § 1300.51
- Amendments to 28 CCR § 1300.67.1.3
- Frequently Asked Questions (FAQ)
- Specialist Physician, Ancillary and Facility Standards - Summary Tables
- Mental Health Standards - Summary Tables

If you have any questions about this APL, please contact the Office of Plan Monitoring at ANRTeam@dmhc.ca.gov.