The following amendments to 28 CCR § 1300.67.2.2 are noticed pursuant to the exemption to the Administrative Procedures Act (APA) set forth in Health and Safety Code section 1367.03(f).[[1]](#footnote-2)

# Amendments to 28 CCR § 1300.67.2.2

## § 1300.67.2.2. Timely Access to Non-Emergency Health Care Services and Annual Timely Access and Network Reporting Requirements.

[…]

(b) Definitions.

For purposes of this section, the following definitions apply.

[…]

(4) “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.

(A) The Timely Access Compliance Report measurement year is January 1 to December 31 of the year immediately preceding the year in which the information set forth in subsection (h)(6)~~(h)(7)(A)(iv), and (h)(7)(C)~~ of this Rule is required to be submitted to the Department, pursuant to subsection (h)(1) of this Rule. Specified information set forth in subsection (h)(7) is also required to be submitted pursuant to the Timely Access Compliance Report measurement year, as described in that subsection.

(B) The Annual Network Report measurement year is the year in which the information set forth in subsection (h)(7) of this Rule is required to be submitted to the Department, pursuant to subsection (h)(1) of this Rule, except as otherwise indicated in subsections (h)(7)~~(A)(iv) and (h)(7)(C)~~ of this Rule.

(5) “Network” means a discrete set of network providers, as defined in subsection (b)(10) of this Rule, the plan has designated to deliver all covered services for a specific network service area, as defined in subsection (b)(11) of this Rule. A plan shall ensure that all networks are submitted to the Department for approval and subsequent reviews pursuant to sections 1351 and 1352, and the regulations promulgated thereunder.

(6) “Network adequacy” means the sufficiency of a plan's network to ensure the delivery of all covered services, on an ongoing basis, in a manner that meets the network accessibility, availability, and capacity requirements set forth in the Knox-Keene Act and Title 28, including subsection (a) of section 1367.03, subsection (a)(5) of section 1371.31, subsections (d) and (e) of section 1367 and section 1375.9, and Rules 1300.51, 1300.67.2, subsection (c)~~(7)~~ of this Rule, and 1300.67.2.1.

(7) “Network capture date” means the date the plan shall capture the network provider and enrollment ~~all~~ data ~~for each network~~ required to be reported pursuant to subsections (h)(6)(B)(i)a.-e. and (h)(7)~~(A)(i)-(iii)~~ of this Rule, for the Timely Access Compliance Report and the Annual Network Report. The following network capture dates apply:

(A) For the Annual Network Report, the network capture date is January 15 of the Annual Network Report measurement year, as set forth in subsection (b)(4)(B) of this Rule, except as otherwise indicated in subsection (h)(7) of this Rule, and in the Annual Network Submission Instruction Manual.

(B) For the Timely Access Compliance Report, the network capture date is a date selected by the plan that occurs on or after January 15 of the Timely Access Compliance Report measurement year as set forth in subsection (b)(4)(A) of this Rule, but no later than the date the plan begins conducting the Provider Appointment Availability Survey, set forth in subsection (f) of this Rule. The network capture date selected by the plan shall:

(i) Allow the plan to adhere to all requirements in the PAAS Manual;

(ii) Be a date as close to administration of the survey as practicable; and

(iii) Ensure the information in the plan's Provider Appointment Availability Survey Contact List is accurate and representative of the network at the time the survey is administered.

[…]

(22) "Lowest cost-sharing tier" means a network tier or tiers that comprise the lowest cost-sharing available to all enrollees in the network for each provider type or covered service within a tiered network.

(A) "Network tier" means a discrete set of network providers within a tiered network that are available at a distinct cost-sharing level to all enrollees who use the network. Pursuant to subsection (b)(10)(D) of this Rule, a network tier does not include providers accessible to enrollees through an out-of-network benefit.

(B) A "tiered network" means a network in which enrollees have access to network providers of the same provider types, delivering the same category of services, at different copayment, coinsurance, deductible, or any other form of cost-sharing levels.

(C) The lowest cost-sharing tier shall meet the following criteria:

(i) The lowest cost-sharing tier shall be comprised of network providers of such types, numbers, and locations that comply with timely access and network adequacy standards set forth in the Knox-Keene Act and this Title, without relying on any network providers offered at higher cost-sharing levels or a different network tier of providers within the network;

(ii) The lowest cost-sharing tier shall be comprised of the same discrete set of providers available to all enrollees using the network; and

(iii) The lowest cost-sharing tier shall comprise the discrete set of providers considered when a plan is determining whether it must submit a network filing pursuant to Health and Safety Code sections 1352 and 1367.27(r), and Rules 1300.52(f), and 1300.67.2.1. For purposes of calculating the change in the number of providers under Health and Safety Code section 1367.27(r), and Rule 1300.52(f), for a tiered network, the plan shall calculate the change using only the network providers included in the lowest cost-sharing tier.

(D) A plan may offer a subset of network providers or covered services at a cost-sharing rate reduced below the lowest cost-sharing tier to some or all enrollees that use the designated network. Reduced cost-sharing shall be subject to the following requirements:

(i) The reduced cost-sharing rate shall be separately identified from the lowest cost-sharing rate in all enrollee-facing and marketing materials, including the schedule of benefits;

(ii) Enrollee-facing and marketing materials shall clearly indicate that a complete network is not available at the reduced cost-sharing rate;

(iii) Network providers available at a reduced cost-sharing rate may be included in a plan's lowest cost-sharing tier for the purposes of assessing compliance with timely access and network adequacy standards only if all enrollees have access to these providers either within the lowest cost-sharing tier, or at the reduced cost-sharing rate described in this subsection; and

(iv) A plan offering a reduced ~~a~~ cost-sharing rate shall ensure it complies with all requirements set forth in Health and Safety Code section 1374.72.

(E) Pursuant to Health and Safety Code section 1367.03(a)(1), a plan's compliance with timely access and network adequacy standards shall be determined at the lowest cost-sharing tier, as described in subsections (b)(22)(C) and (b)(22)(D) of this Rule. A plan shall ensure that all plan operations, including internal monitoring processes, comply with this requirement. If an enrollee is unable to obtain a covered service in the lowest cost-sharing tier of a network within geographic and timely access standards set by law or regulation, a plan shall arrange for that service to be provided by a network provider in another tier or an out-of-network provider and ensure the enrollee is responsible for paying no more than the cost-sharing established for the lowest cost-sharing tier.

(F) Pursuant to Health and Safety Code section 1367.27(h)(12), a plan shall include information in the provider directory identifying the network tier to which the network provider is assigned, and whether a reduced cost-sharing rate is available.

(G) A plan shall not place restrictions on an enrollee's access to network providers or covered services within a tiered network, other than the established processes identified within subsection (b)(10)(C) of this Rule.

(H) A plan that is unable to meet network adequacy at the lowest cost-sharing tier under the definition set forth in this subsection may propose an alternative approach to determining which providers comprise the lowest cost-sharing tier. A plan shall justify any request for an alternative approach in accordance with the facts and circumstances set forth in subsection (c) of Rule 1300.67.2.1 and shall make the request via an initial application for licensure or a notice of material modification to the Department.

(23) “Accepting new patients” means the network provider has an open practice as set forth in section 1367.035(a)(4) at the reported practice address and is available to deliver care to enrollees in the network who are not currently patients or are not assigned to the network provider, and all of the following criteria apply:

(A) The network provider is open to enrollees in all product lines using the network, without limitations other than the established processes described in Rule 1300.67.2.2(b)(10)(C).

(B) The network provider has notified the plan that the provider is open to new patients, and as applicable, the network provider is listed as accepting new patients in the plan provider directory maintained pursuant to section 1367.27, for the reported practice address.

(C) The network provider does not limit an enrollee’s ability to establish patient care through a waitlist, or through appointment wait times that do not comply with Section 1367.03, sub. (a) and Rule 1300.67.2.2(c).

(D) Notwithstanding subsection (C), the network provider is open to new patients within the same appointment timeframes available to existing patients, when taking into consideration the scope of services to be delivered at the appointment, consistent with Rule 1300.67.

(24) “Full-time” means the network provider is available 32 hours per week or more to deliver direct patient care.

(25) “In-person appointments on an outpatient basis” means the network provider, at the reported practice address, offers either:

(A) In-person appointments in an outpatient setting; or

(B) In-person services on a same-day, “walk-in” basis in an outpatient setting.

(26) "Limited plan provider" means any provider as defined in subsection (i) of section 1345 of the Knox-Keene Act, located inside or outside of the network service area of a designated network, who would otherwise meet the criteria for "network provider" defined in subsection (b)(10) of this Rule, except the provider is not accessible to some or all enrollees in the network under the criteria defined in subsection (b)(10)(C) of this Rule. When a plan uses limited plan providers to deliver covered services, the limited plan provider must be available at the lowest-cost sharing tier, and meet the timely access and network adequacy standards, including those set forth in Sections 1367 and 1367.03(a), Rules 1300.67.2.2 (c), 1300.51, and 1300.67.2.

(27) “Part-time” means the network provider is available less than 32 hours per week to deliver direct patient care.

(28) “Practice address” and “practice location or locations” means the location(s) where the provider is physically present during the provider’s work hours to deliver health care services, as of the network capture date.

(29) “Primary care physician” shall have the definition set forth in Rule 1300.45(m).

(30) “Profile-only plan” means a plan required to submit only the network access profile on an annual basis, pursuant to Rule 1300.67.2.2(h)(1)(B).

(31) “Specialty” or “subspecialty” means the primary specialty or subspecialty type(s) the provider currently practices in the network, and for which the provider has been credentialed by or on behalf of the plan. Specialty or subspeciality shall be consistent with licensure and board certification when applicable; when not applicable, specialty or subspecialty shall be consistent with required education, experience, and training, and subject to the Plan’s quality assurance program.

(32) “Telehealth” shall have the definition set forth in Business and Professions Code section 2290.5(a)(6).

(33) “Unavailable” when referring to a network provider, provider type, or health care service means the provider, provider type, or service is not available to one or more enrollees in the network within time-elapsed standards or network adequacy standards, including geographic access standards, provider ratio requirements, and requirements for providers who are accepting new patients, as set forth in the Knox-Keene Act and supporting regulations, including this subsection, and Rule 1300.67.2.

(34) “Unscheduled urgent services” means services to diagnose and treat a condition resulting from unforeseen illness, injury, or a complication of an existing condition, including pregnancy, for which prompt medical attention is necessary to prevent a potential risk of a serious deterioration of the health of the enrollee or to alleviate excessive pain. Unscheduled urgent services are services that are made available to enrollees without an appointment on a same-day, in-person, walk-in basis at a location other than a hospital emergency room. Since such services are not scheduled, access is not subject to the standards for appointments pursuant to Rule 1300.67.2.2(c)(5)(A) and (B). Unscheduled urgent services within a network shall at a minimum, include the following:

(A) In-person urgent diagnostic and treatment services which can reasonably be performed on an outpatient basis in a provider’s office, urgent care center, clinic or facility, or otherwise outside of the emergency room setting, in accordance with Rule 1300.67(c).

(B) Basic diagnostic services available onsite; and

(C) Availability after-hours, or at a location with hours of operation outside of the traditional business hours of 8:00 a.m. to 5:00 p.m., Monday through Friday.

[…]

(h) Filing, Implementation and Reporting Requirements.

[…]

(7) Annual Network Report. The Annual Network Report shall confirm the status of each of the plan's networks and enrollment, including the data categories set forth in subsections (a) and (g) of section 1367.035 of the Knox-Keene Act. The Annual Network Report shall consist of the items set forth in subsection (h)(7) and subsection (h)(8) of this Rule, for the applicable measurement year. The plan shall submit the items described in subsection (h)(7) within the Department's report forms in the manner described in subsection (h)(7)(B) of this Rule and in the Annual Network Submission Instruction Manual, which is hereby incorporated by reference. A plan shall use the version of the Annual Network Submission Instruction Manual noticed on the Department's website at [www.dmhc.ca.gov](http://www.dmhc.ca.gov), on or before November 1 of the calendar year prior to the reporting year.

(A) The Annual Network Report shall include the following information and data, in the format approved by the Department set forth in subsection (h)(7)(B) of this Rule and incorporated documents:

(i) The plan's enrollment in each network and product line, on a ZIP Code and county basis.

(ii) The network service area of each network, on a ZIP Code and county basis.

(iii) A complete list of all network providers within each network.

(iv) All grievances regarding network adequacy and timely access compliance received for each network during the measurement year described in subsection (b)(4)(A) of this Rule.

(v) Clinical encounter data for non-physician mental health professionals for each network during the measurement year described in subsection (b)(4)(A) of this Rule.

(vi) All non-network provider requests and determinations for each network during the measurement year described in subsection (b)(4)(A) of this Rule.

(vii) A complete list of limited plan providers the plan makes available to each network if the plan uses the limited plan provider to deliver access to care when a network provider is unavailable.

(B) Annual Network Report Forms. A plan shall submit the network information and data set forth in subsection (h)(7) of this Rule in accordance with the Annual Network Submission Instruction Manual. A plan shall use and submit only the following report forms issued by the Department, form numbers 40-265 through 40-272, and 40-287, which are incorporated by reference and referred to collectively as “Annual Network Report Forms”. A plan shall use the version of each report form listed below noticed on the Department's website at [www.dmhc.ca.gov](http://www.dmhc.ca.gov), on or before November 1 of the calendar year prior to the reporting year.

(i) Network Service Area and Enrollment Report Form (Form No. 40-265).

(ii) PCP and PCP Non-Physician Medical Practitioner Report Form (Form No. 40-266).

(iii) Specialist and Specialist Non-Physician Medical Practitioner Report Form (Form No. 40-267).

(iv) Mental Health Professional and Mental Health Facility Report Form (Form No. 40-268).

(v) Other Outpatient Provider Report Form (Form No. 40-269).

(vi) Hospital and Clinic Report Form (Form No. 40-270).

(vii) Telehealth Report Form (Form No. 40-271).

(viii) Timely Access and Network Adequacy Grievance Report Form (Form No. 40-272).

(ix) Non-Network Provider Arrangements Report Form (Form No. 40-287).

[…]

(8) Network Access Profile. Before submission of the report forms set forth in section (h)(6) and (h)(7) of this Rule, the plan shall identify a ~~health~~ plan contact, complete or update the network access profile in the Department's web portal, so that it contains current information and data as of the network capture date for each applicable measurement year, as defined in subsection (b)(4)(A)-(B) of this Rule. The plan shall identify each network by its network name and network identifier, and describe each network identified pursuant to the requirements in this subsection and in the Annual Network Submission Instruction Manual. Prior to submission, the plan shall affirm the accuracy of the information and data, as described in subsection (h)(2) of this Rule. The plan shall submit the network access profile data as follows:

[...]

(D) Within the Annual Network Submission Instruction Manual and the Department's web portal, the Department shall set forth standardized terminology the plan shall use to submit data in the report forms. The plan shall report the required data within the report forms either by using the standardized terminology when reporting the information listed in subsections (h)(8)(D)(i)-(x) of this Rule, or by connecting the plan's own terminology to the standardized terminology, as available, via the crosswalk tables provided by the Department within the Department's web portal. Such areas of standardized terminology shall include the following:

(i) Hospital and other inpatient facility names. The plan shall report hospital and other inpatient facility names using the name on record with the California Department of Health Care Access and Information (HCAI), available at [hcai.ca.gov](http://www.hcai.ca.gov/), as of the network capture date. The Department shall make available annually a standardized list of hospital names within its web portal, based on the most recent data obtained from HCAI.

(ii) Product line categories.

(iii) Provider types. The plan shall report physician specialty type, non-physician medical practitioner specialty type, mental health professional specialty type, other outpatient provider type, hospital and other inpatient facility type, clinic type, and mental health facility type, according to the standardized terminology. Plans shall report physician specialties according to the network provider's primary specialty practice areas and plan credentialing. The plan shall identify the physician using the Department's standardized terminology, consistent with the physician specialty and subspecialty designations recognized by the American Board of Medical Specialties and the Knox-Keene Act. Non-physician medical practitioner specialty designations shall be based on the areas of specialization available through the appropriate licensing boards, as applicable.

(iv) Provider languages spoken.

(v) Provider group names. The plan shall report provider group names using the business name registered with the Secretary of State, the name on file with the Department for capitated provider groups, or the name on file with the Department for risk-bearing organizations that file information with the Department pursuant to Rule 1300.75.4.2, as applicable. The Department shall make available annually a standardized list of provider group names within the Department's web portal, based on filings with the Department and the Secretary of State. Each provider group reported by the plan shall match the most recent list on the Department's web portal. If the provider group is not listed on the Department's standardized list, the plan shall report the provider group using a name that is reported consistent within this subsection.

(vi) Type of license or certificate. The standardized terminology shall be consistent with one or more of the following sources: the Department of Consumer Affairs, the California Board of Registered Nursing, the Medical Board of California, the Osteopathic Medical Board of California, the National Plan and Provider Enumeration System taxonomy, or departments within California Health and Human Services Agency, including the Department of Health Care Services.

(vii) ZIP Code and county and population points. The Department shall make available annually in its web portal a list of ZIP Codes and counties for the State of California, issued by the USPS. Each ZIP Code and county combination reported by the plan within California shall match the USPS list of ZIP Codes posted on the Department's web portal. The Department shall also make available annually in its web portal the corresponding population points, as defined.

[…]

NOTE: Authority cited: Sections 1344, 1346, 1367.03, 1386 and 1394, Health and Safety Code.

Reference: Sections 1342, 1367, 1367.01, 1367.03, 1367.035, 1367.04, 1370, 1371.31, 1375.7 and 1380, Health and Safety Code.

1. *See* Senate Bill (SB) 221 (Wiener, Chap. 724, Stats 2021), and SB 225 (Wiener, Chap. 601, Stats 2022). [↑](#footnote-ref-2)