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DEPARTMENT OF MANAGED HEALTH CARE
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DATE: June 12, 2020

ACTION: Notice of Rulemaking Action
Title 28, California Code of Regulations

SUBJECT: Timely Access to Non-Emergency Health Care Services and Annual Timely Access and Network Reporting Requirements Proposed Amendment of Section 1300.67.2.2 and Proposed Adoption of Section 1300.67.2.3, in Title 28 of the California Code of Regulations. Control No. 2019-5239.

PUBLIC PROCEEDINGS:

Notice is hereby given that the Director of the Department of Managed Health Care (DMHC) proposes to adopt the proposed regulations under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) to ensure timely access to necessary health care by standardizing and codifying reporting methodologies for the timely access report and the annual network report. Changes to the text of the regulation during the first comment period are noted by underline and strikeout. Changes to the Manuals during the first comment period are noted by underline. Changes to the forms in the first comment period are noted by underline.

This rulemaking action proposes to amend existing section 1300.67.2.2 and adopt section 1300.67.2.3, in title 28, California Code of Regulations (the Regulations). Before undertaking this action, the Director of the DMHC (Director) will conduct written public proceedings, during which time any interested person, or such person's duly authorized representative, may present statements, arguments, or contentions relevant to the action described in this notice.

PUBLIC HEARING:

No public hearing is scheduled. Any interested, person, or his or her duly authorized representative, may submit a written request for a public hearing pursuant to Government Code section 11346.8(a). The written request for a hearing must be received by the DMHC's contact person, designated below, no later than 15 days before the close of the written comment period.

WRITTEN COMMENT PERIOD:

Any interested person, or his or her authorized representative, may submit written statements, arguments or contentions (hereafter referred to as comments) relating to the proposed regulatory action by the DMHC. Comments must be received no later than the close of business on **July 27, 2020**, which is hereby designated as the close of the written comment period.

Please address all comments to the DMHC’s, Office of Legal Services, Attention: Jennifer Willis, Senior Counsel. Comments may be transmitted by regular mail, fax, email or via the Department’s website:

Website <http://www.dmhc.ca.gov/LawsRegulations.aspx#open>
Email: regulations@dmhc.ca.gov
Mail: Department of Managed Health Care
 Office of Legal Services
 Attn: Regulations Coordinator
 980 9th Street, Suite 500
 Sacramento, CA 95814
Fax: (916) 322-3968

Please note: if comments are sent via the website, email or fax, there is no need to send the same comments by mail delivery. All comments, including via the website, email, fax, or mail, should include the author’s name and a U.S. Postal Service mailing address so the Department may provide commenters with notice of any additional proposed changes to the regulation text.

Please identify the action by using the DMHC’s rulemaking title and control number, **Timely Access to Non-Emergency Health Care Services and Annual Timely Access and Network Reporting Requirements, Control No. 2019-5239** in any of the above inquiries.

CONTACTS: Inquiries concerning the proposed adoption of these regulations may be directed to:

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AVAILABILITY OF DOCUMENTS:

The DMHC has prepared and has available for public review the Initial Statement of Reasons, text of the proposed regulation and all information upon which the proposed regulation is based (rulemaking file). This information is available by request to the Department of Managed Health Care, Office of Legal Services, 980 9th Street, Sacramento, CA 95814, Attention: Regulations Coordinator.

The Notice of Proposed Rulemaking Action, the proposed text of the regulation, and the Initial Statement of Reasons are also available on the Department's website at <http://www.dmhc.ca.gov/LawsRegulations.aspx#open>.

You may obtain a copy of the Final Statement of Reasons once it has been prepared by making a written request to the Regulation Coordinator named above.

AVAILABILITY OF MODIFIED TEXT:

The full text of any modified regulation, unless the modification is only non-substantial or solely grammatical in nature, will be made available to the public at least 15 days before the date the DMHC adopts the regulation. A request for a copy of any modified regulation(s) should be addressed to the Regulations Coordinator. The Director will accept comments via the DMHC's website, mail, fax, or email on the modified regulation(s) for 15 days after the date on which the modified text is made available. The DMHC may thereafter adopt, amend or repeal the foregoing proposal substantially as set forth without further notice.

AUTHORITY AND REFERENCE:

Pursuant to Health and Safety Code section 1341.9, the DMHC is vested with all duties, powers, purposes, responsibilities, and jurisdiction as they pertain to health care service plans (health plans) and health plan business.

Health and Safety Code section 1341, subdivision (a), authorizes the DMHC to regulate health plans. Health and Safety Code section 1345, subdivision (f)(1), defines a "health care service plan" (health plan) as "any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost of those services in return for a prepaid or periodic charge paid by or on behalf of subscribers or enrollees."

Health and Safety Code section 1342, subdivision (g), states the Legislature's intent to ensure that health plan subscribers and enrollees receive available and accessible health and medical services rendered in a manner providing continuity of care.

Health and Safety Code section 1344 grants the Director authority to adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of the Knox-Keene Act .

Health and Safety Code section 1367 states requirements that each health plan must meet for compliance with the Knox-Keene Act. This section requires a health plan to furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice and to ensure it has the organizational and administrative capacity to fulfill its duties to enrollees. Health and Safety Code section 1367 also requires health plans to make all services readily available at reasonable times to each enrollee consistent with good professional practice and, to the extent feasible, to make all services readily accessible to all enrollees consistent with Health and Safety Code section 1367.03 (regarding timely access to needed health care services). This section also requires the health plan to make all services accessible and appropriate consistent with Health and Safety Code section 1367.04 (requiring access to language assistance).

Health and Safety Code section 1367.03(f), requires health plans to report annually to the DMHC on compliance with timely access standards, in a manner specified by the DMHC. Health and Safety Code section 1367.03 authorizes the DMHC to develop standardized methodologies for reporting that shall be used by health plans to demonstrate compliance with this section and any regulations adopted pursuant to it. The DMHC shall consult with stakeholders in developing standardized methodologies for reporting pursuant to Health and Safety Code section 1367.03.

As part of the annual timely access report required by Health and Safety Code section 1367.03, Health and Safety Code section 1367.035 requires a health plan to also report data regarding the adequacy of the health plan's networks, in a manner specified by the DMHC.

Health and Safety Code section 1371.31(a)(4), requires a health plan to include in its annual report to the DMHC pursuant to section 1367.035, the number of payments made to noncontracting individual health professionals for services under specified circumstances, as well as other data sufficient to determine the proportion of noncontracting to contracting individual health professionals at contracting health facilities, as defined. Further, Health and Safety Code section 1371.31 (a)(5), references existing network adequacy laws and authorizes the DMHC to adopt additional necessary regulations to ensure health plans meet these network requirements.

Health and Safety Code section 1375.9 specifies minimum primary care physician-to-enrollee ratios.

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW:

Existing law, under the Knox-Keene Act, provides for the licensure and regulation of health plans by the DMHC. The Knox-Keene Act also requires a health plan's provider network to be adequate enough to provide necessary care in a reasonable and timely manner to the health plan's enrollees. Health plans must ensure health care services are provided in a readily accessible manner in accordance with good professional practice. Further, a health plan is responsible for providing health care services in a manner that provides and ensures continuity of care for enrollees and provides referrals of patients to other providers as necessary in accordance with good professional practice.

A health care service plan must employ and utilize allied manpower for the furnishing of health care services to the extent permitted by law and consistent with good professional practice. Existing law also requires a health plan to have sufficient organization and administrative capacity to assure the delivery of health care services to its enrollees.

Health plans report to the DMHC, on an annual basis, compliance with timely access to care standards and report to the DMHC the adequacy of the health plan's provider network. In 2010, the DMHC adopted clarifying regulations for timely access to care compliance. Rule 1300.67.2.2¹ specified requirements for timely access (including maximum wait time for appointments), and the deadline of when health plans are required to submit annual compliance reports to the DMHC. In the years following implementation of the regulation, health plan timely access reports received by the DMHC were filled with errors and reflected inaccurate information that was often incomplete and unhelpful during the DMHC's review. The disparate, incomplete, and poor quality information contained within the health plan reports made it impossible for the DMHC to determine timely access to care compliance.

Through Senate Bill (SB) 964², the legislature empowered the DMHC to develop standardized reporting methodologies for the health plans' annual timely access reporting and annual network adequacy reporting. The authority for the DMHC to develop a standardized methodology for the annual timely access report and the annual network adequacy report is pursuant to an exemption from the Administrative Procedures Act (APA). The exemption expires on January 1, 2020.

This rulemaking action proposes to codify and implement the processes and methodologies developed during the APA exemption period. Pursuant to the statutory requirement contained in Health and Safety Code section 1367.03(f)(3), the DMHC has

¹ Title 28, CCR section 1300.67.2.2, regarding Timely Access to Non-Emergency Health Care Services. Unless otherwise stated, references to "Rule" refer to the sections of the CCR.

² Senate Bill (SB) 964 (Hernandez, Chapter 573, Stats of 2014).

met extensively with stakeholders, including health plans and consumer advocates, over the past four years to ensure these proposed regulations address any concerns and issues regarding enrollee access to health care services in a timely manner. This includes the development of a uniform and comprehensive reporting criteria that enables health plans to report timely access to care compliance to the DMHC in a manner that allows for comparison and enables the DMHC to determine whether health plans are meeting the statutory and regulatory requirements under the Knox-Keene Act. The processes and methodologies involve the methods by which a health plan is required to gather and interpret provider network data and report the information back to the DMHC to allow the DMHC to determine health plan timely access to care compliance in a meaningful way.

During the APA exemption period described above, the DMHC published mandatory methodologies for health plans to use when annually reporting timely access to care and network adequacy data. In most respects, the amendments proposed in Rule 1300.67.2.2 codify the process set forth in the published 2019 methodology that health plans have already implemented.

This rulemaking action also proposes to preserve the current timely access to care reporting requirements that exist in Rule 1300.67.2.2 until the new proposed requirements become law.

BROAD OBJECTIVES AND SPECIFIC BENEFITS OF THE REGULATION:

Introduction

Pursuant to Government Code section 11346.5(a)(3)(C), the broad objectives and benefits of this regulation are to clarify and make specific the timely access to care and annual network reporting requirements for health plans. This will benefit health plans because the proposed amendments to Rule 1300.67.2.2 include specifying the specific standards and methodologies health plans must use to assess their network compliance and report the gathered and analyzed information back to the DMHC in a streamlined and standardized manner. The DMHC is proposing to amend Rule 1300.67.2.2 to clarify and incorporate health plan reporting requirements for timely access to care by codifying the process health plans use to report data to the DMHC in a manner that enables the DMHC to evaluate health plan compliance with time-elapsed standards addressed in current law. This will benefit reporting health plans because it will clarify and make specific the reporting methods the health plan is required to use in submitting timely access data to the DMHC. Alternately, the DMHC will be able to receive meaningful data for comparison purposes, across its regulated health plans, and ensure health care compliance with timely access to care requirements.

The proposed regulatory action will benefit California residents and protect public health by ensuring California residents seeking needed health care services are able to access appropriate health care providers in a timely manner.

Broad Objectives and Specific Benefits Addressed

Proposed amendments to Rule 1300.67.2.2(a)(1) change current terms from singular to plural to improve the readability of the section for health plans, stakeholders, and enrollees. This amendment also ensures consistency within the subdivision.

Amendments to Rule 1300.67.2.2(a)(2)-(4) add a modifier “specialized” to the terms dental, vision, chiropractic, and acupuncture to align with current terminology in Health and Safety Code section 1345. This is beneficial to the reader by providing clarity and consistency in the way dental, vision, chiropractic, and acupuncture are referred to in both the health care industry and other parts of the Knox-Keene Act. Other non-substantive changes are made to this subsection to conform with updated and proposed subsections appearing later in the text.

Proposed adoption of Rule 1300.67.2.2(a)(5) requires the health plan to ensure it is submitting its network reports on time and it reminds the health plan to ensure it is submitting accurate information to the DMHC. This addition benefits the health plans and the DMHC because it attempts to address the past history of erroneous and inaccurate health plan timely access reporting. Further, it reminds the health plan that data must be submitted by the timelines requested by the DMHC to allow the DMHC to assess compliance in a timely and efficient manner.

Proposed amendments to Rule 1300.67.2.2(b) benefit health plans and stakeholders by defining key terms that encapsulate the entirety of timely access and annual network reporting. The terms have been developed over the years during the APA exemption period and appear throughout the proposed text and incorporated documents. The terms assist health plans and stakeholders in understanding all the different definitional elements related to network reporting and ensure all parties subject to the regulation and benefiting from the regulation refer to timely access reporting concepts consistently. This will provide clarity for health plans and ensure reporting is consistent across all health plans when all parties use the same terms.

Proposed amendments to Rule 1300.67.2.2(b)(3) define “measurement year” which refers to the period of time that must be reflected in the timely access report and the annual network report. This definition is beneficial to health plans and stakeholders because it describes what time period the data submission must be based on. The description ensures all the health plans are measuring the same time period for accurate data reporting.

Proposed amendments to Rule 1300.67.2.2(b)(11) define “patterns of non-compliance” by introducing a standardized methodology that allows health plans to measure compliance with timely access to care standards for urgent appointments and non-urgent appointments. The standardized methodology is beneficial for health plans because it provides a clear threshold standard for data resulting from conducting the Provider Appointment Availability Survey. The standard enables the health plan to measure compliance.

Proposed amendments to Rule 1300.67.2.2(c) benefit health plans and stakeholders by addressing minor edits and updating outdated information to make the regulation consistent with other changes occurring throughout the text. This is beneficial in making the regulatory language clearer to the reader.

Proposed amendments to Rule 1300.67.2.2(d) benefit health plans and stakeholders by addressing the date by when a health plan must comply with the new requirements in the subsection. The subsection also incorporates by reference the Provider Appointment Availability Survey, used by the DMHC and health plans during the APA exemption period, into the existing methods of measuring timely access to care. Existing language references the enrollee experience survey and the provider survey. Proposed amendments incorporate the Provider Appointment Availability Survey as an additional means of measuring timely access to care in accordance with the DMHC's methodology and provides additional requirements in administering the existing requirements. The incorporation of the Provider Appointment Availability Survey is beneficial to health plans and stakeholders because it is another means of accurately assessing health plan compliance with timely access to care and annual network reporting standards.

Proposed adoption of Rule 1300.67.2.2(f) is beneficial to health plans and stakeholders because it describes in detail, when and how health plans are to conduct the Provider Appointment Availability Survey in order to determine timely access to care compliance. This proposed rule incorporates by reference the Provider Appointment Availability Survey Manual and the Timely Access and Annual Network Submission Instruction Manual. Both manuals consist of detailed and comprehensive instructions explaining exactly how a health plan is to report its compliance to the DMHC. The adoption of this proposed rule is necessary to provide as much detail as possible to health plans in order to assist them in reporting compliance to the DMHC and to assist the health plan in conducting the required provider surveys. The adoption of these manuals and other specific requirements a health plan must follow in conducting the Provider Appointment Availability Survey described in subsection (f) are beneficial to all parties by providing comprehensive instructions and are necessary to achieve consistency and accuracy of data reported by the health plans to the DMHC. A more detailed discussion regarding the benefit of the incorporated manuals is discussed below.

Proposed amendments to Rule 1300.67.2.2(g) benefit health plans and stakeholders by clarifying that a health plan may submit a request to the DMHC for an alternative access standard to the threshold rate of compliance, established in proposed Rule 1300.67.2.2(b), if the health plan is unable to meet the proposed established threshold. Current law allows for a health plan to request alternative timely access standards as long as its request includes the elements described in existing Rule 1300.67.2.2(f).

Proposed amendments clarify that the alternative access standard request extends to the proposed rate of compliance as long as the request includes the elements described in the law.

Proposed amendments to Rule 1300.67.2.2(h), benefit health plans and stakeholders because the amendments clarify that the timely access reporting requirements implemented by the proposed regulation are effective in the year 2022. Meaning, health plan reporting under the new proposed amendments in Rule 1300.67.2.2 will not begin until January 1, 2022. (This effective date is different than the timely access and annual network reporting requirements proposed in the adoption of Rule 1300.67.2.3. Proposed adoption of Rule 1300.67.2.3 requires submission of data during the year 2021 in accordance with existing Rule 1300.67.2.2). The delayed implementation of the reporting requirements in proposed Rule 1300.67.2.2 will benefit health plans and stakeholders by allowing ample time to update and prepare data collection and reporting procedures pursuant to the new requirements.

Other proposed changes in Rule 1300.67.2.2(h) benefit health plans and stakeholders by addressing all of the different necessary components that make up the Timely Access Compliance Report and the Annual Network Report, including but not limited to, the forms the health must use to submit data, the policies and procedures the health plan uses to adhere to compliance, the different provider networks the health plan is reporting, and clarifying the exact dates the health plan must report the information to the DMHC. Health plans and stakeholders will know what exact information the health plan must submit as part of its annual filing with the DMHC. Further, since all health plans are required to submit the same standardized information articulated in the new proposed language, the DMHC, stakeholders, and enrollees will be able to compare and evaluate timely access to care information across health plans. The benefit of each specific form incorporated by reference in this subsection is discussed below.

Proposed amendments to Rule 1300.67.2.2(i) benefit health plans, stakeholders, and enrollees by articulating the different circumstances that may lead the DMHC to find a health plan's timely access and network adequacy submission to be non-compliant with the requirements of the Knox-Keene Act. The proposed amendments are beneficial in explaining to regulated health plans the circumstances that may potentially lead to enforcement action.

Proposed Rule 1300.67.2.2(j) benefits health plans, stakeholders, and enrollees by clarifying the importance of submitting the annual timely access report and annual network reports on time and ensuring the reports are accurate and complete in nature. The proposed enforcement language provides a reminder to all parties that the DMHC may seek enforcement action for the failure of a health plan to provide meaningful reports.

In addition, the DMHC is proposing to adopt Rule 1300.67.2.3 in its entirety to preserve the timely access to care reporting requirements prior to the enactment of the amendments proposed in Rule 1300.67.2.2. Rule 1300.67.2.3 is beneficial because it accounts for the time period prior to the effective date of Rule 1300.67.2.2. Since the APA exemption for the reporting data required pursuant to Rule 1300.67.2.3 expires on January 1, 2020, there will be a lapse between the APA exemption expiration date and

the new requirements proposed in 1300.67.2.2. Therefore, Rule 1300.67.2.3 requires health plans to continue reporting annual timely access and annual network reports during the interim period before the amendments to Rule 1300.67.2.2 become effective.

Specific Benefits of Manuals and Forms Incorporated by Reference

Manuals

As stated above, proposed Rule 1300.67.2.2(f)(1) incorporates by reference the Provider Appointment Availability Survey (PAAS) Manual and the Timely Access and Annual Network Submission Manual (Instruction Manual). The specific benefit of the PAAS Manual is that it provides the health plan with step-by-step instructions on how to conduct the PAAS survey for timely access reporting in accordance with the methodology the DMHC developed during the APA exemption period. The PAAS Manual is beneficial because it ensures health plans obtain consistent and non-repetitive data that accurately represents a health plan's rate of compliance with time-elapsed standards articulated in Rule 1300.67.2.2(c)(5). This manual benefits the DMHC because it allows the DMHC to assess health plan compliance with timely access to care standards in a uniform and standardized way. The incorporation of this document attempts to remedy past experiences with erroneous timely access to care reporting. Ultimately, enrollees are benefitted if a health plan is able to correctly perform the PAAS because if network deficiencies are identified by either the DMHC or the health plan, deficiencies can be addressed and corrected. The PAAS Manual ensures health plan reporting is done in an accurate way that correctly measures timely access to care.

The Instruction Manual benefits reporting health plans because it provides detailed and comprehensive step-by-step instructions on how to complete the health plan's provider network profile, required report forms, and instructs how to submit timely access data to the DMHC for both timely access to care reporting and annual network reporting. Enrollees are benefitted if a health plan is able to correctly report network adequacy deficiencies when identified by either the DMHC or the health plan because deficiencies can be addressed and corrected. The Instruction Manual ensures reporting is done in an accurate way that enables the health plan to correctly measure timely access to care. Further, consumers and enrollees are able to compare results across health plans when seeking health care coverage.

Forms

Proposed Rule 1300.67.2.2(h)(6)(B)(i)a. incorporates by reference the Primary Care Providers Contact List Report Form (Form No. 40-254). This report form is beneficial because it enables the health plan to ensure it is contacting unique Primary Care Providers when conducting the PAAS survey. Ensuring a provider is only contacted once is beneficial in maintaining the integrity of the PAAS results.

Proposed Rule 1300.67.2.2(h)(6)(B)(i)b. incorporates by reference the Non-Physician Mental Health Care Providers Contact List Report (Form No. 40-255). This report form

is beneficial because it enables the health plan to ensure it is contacting unique Non-Physician Mental Health Providers when conducting the PAAS survey. Ensuring a provider is only contacted once is beneficial in maintaining the integrity of the PAAS results.

Proposed Rule 1300.67.2.2(h)(6)(B)(i)c. incorporates by reference the Specialist Physicians Contact List Report Form (Form No. 40-256). This report form is beneficial because it enables the health plan to ensure it is contacting unique Specialist Physicians when conducting the PAAS survey. Ensuring a provider is only contacted once is beneficial in maintaining the integrity of the PAAS results.

Proposed Rule 1300.67.2.2(h)(6)(B)(i)d. incorporates by reference the Psychiatrists Contact List Report Form (Form No. 40-257). This report form is beneficial because it enables the health plan to ensure it is contacting unique Psychiatrists when conducting the PAAS survey. Ensuring a provider is only contacted once is beneficial in maintaining the integrity of the PAAS results.

Proposed Rule 1300.67.2.2(h)(6)(B)(i)e. incorporates by reference the Ancillary Service Providers Contact List Report Form (Form No. 40-258). This report form is beneficial because it enables the health plan to ensure it is contacting unique Ancillary Service Providers when conducting the PAAS survey. Ensuring a provider is only contacted once is beneficial in maintaining the integrity of the PAAS results.

Proposed Rule 1300.67.2.2(h)(6)(B)(i)f. incorporates by reference the Primary Care Providers Raw Data Report Form (Form No. 40-259). This report form is beneficial because it enables the health plan to summarize the results of the PAAS for the contacted Primary Care Providers in the health plan's network. The summarized information will assist in calculating compliance with timely access to care standards.

Proposed Rule 1300.67.2.2(h)(6)(B)(i)g. incorporates by reference the Non-Physician Mental Health Care Providers Raw Data Report Form (Form No. 40-260). This report form is beneficial because it enables the health plan to summarize the results of the PAAS for the contacted Non-Physician Mental Health Care Providers in the health plan's network. The summarized information will assist in calculating compliance with timely access to care standards.

Proposed Rule 1300.67.2.2(h)(6)(B)(i)h. incorporates by reference the Specialist Physicians Raw Data Report Form (Form No. 40-261). This report form is beneficial because it summarizes the results of the PAAS for the contacted Specialist Physicians in the health plan's network. The summarized information will assist in calculating compliance with timely access to care standards.

Proposed Rule 1300.67.2.2(h)(6)(B)(i)i. incorporates by reference the Psychiatrists Raw Data Report Form (Form No. 40-262). This report form is beneficial because it summarizes the results of the PAAS for the contacted Psychiatrists in the health plan's

network. The summarized information will assist in calculating compliance with timely access to care standards.

Proposed Rule 1300.67.2.2(h)(6)(B)(i)j. incorporates by reference the Ancillary Service Providers Raw Data Report Form (Form No. 40-263). This report form is beneficial because it summarizes the results of the PAAS for the contacted Ancillary Providers in the health plan's network. The summarized information will assist in calculating compliance with timely access to care standards.

Proposed Rule 1300.67.2.2(h)(6)(B)(i)k. incorporates by reference the Results Report Form (Form No. 40-264). This form consists of specific tabs that show the results of the auto-calculation based on the Raw Data forms described above. The tabs are as follows: Primary Care Providers Result Tab, Non-Physician Mental Health Care Providers Results Tab, Specialist Physicians Results Tab, Psychiatrists Results Tab, Ancillary Service Providers Results Tab, Summary of Rates of Compliance Tab, and Network by Provider Survey Type Tab. This Report Form and associated tabs is beneficial to health plans because it is used to auto-populate and auto-calculate the results or rate of compliance of the PAAS for each of the reported provider types in one single form. This will be beneficial to the health plan because it provides efficiency in reporting timely access to care information back to the DMHC. This allows the DMHC to determine network adequacy compliance.

Proposed Rule 1300.67.2.2(h)(7)(B) incorporates by reference the Annual Network Report Forms that are required to be submitted to the DMHC as part of the health plan's annual network reporting. These forms are beneficial because they explain to the health plan what exact information must be reported back to the DMHC to enable the DMHC to determine whether the health plan has sufficient providers and facilities to provide health care services to the health plan's enrollees. This allows the DMHC to determine network adequacy compliance.

Proposed Rule 1300.67.2.2(h)(7)(B)(i) incorporates by reference the PCP and PCP Non-Physician Medical Practitioner Report Form (Form No. 40-265). This report form is beneficial because it allows the health plan to report to the DMHC the number of PCP and PCP Non-Physician Medical providers that are available in the health plan's network and available to provide care to health plan enrollees. This allows the DMHC to determine network adequacy compliance.

Proposed Rule 1300.67.2.2(h)(7)(B)(ii) incorporates by reference the Specialist and Specialist Non-Physician Medical Practitioner Report Form (Form No. 40-266). This report form is beneficial because it allows the health plan to report to the DMHC the number of Specialist and Specialist Non-Physician Medical Practitioners that are available in the health plan's network and available to provide care to health plan enrollees. This allows the DMHC to determine network adequacy compliance.

Proposed Rule 1300.67.2.2(h)(7)(B)(iii) incorporates by reference the Hospital and Clinic Report Form (Form No. 40-267). This report form is beneficial because it allows the health plan to report to the DMHC the number of hospitals and clinics the health plan has available for health plan enrollees to utilize when needed. This allows the DMHC to determine network adequacy compliance.

Proposed Rule 1300.67.2.2(h)(7)(B)(iv) incorporates by reference the Other Outpatient Provider Report Form (Form No. 40-268). This report form is beneficial because it allows the health plan to report to the DMHC the number of Other Outpatient Providers the health plan has available for health plan enrollees to utilize when needed. This allows the DMHC to determine network adequacy compliance.

Proposed Rule 1300.67.2.2(h)(7)(B)(v) incorporates by reference the Mental Health Professional and Mental Health Facility Report Form (Form No. 40-269). This report form is beneficial because it allows the health plan to report to the DMHC the number of Mental Health Professionals and Mental Health Facilities the health plan has in its network for enrollees' use. The reporting of this information allows the DMHC to determine network adequacy compliance.

Proposed Rule 1300.67.2.2(h)(7)(B)(vi) incorporates by reference the Network Service Area and Enrollment Report Form (Form No. 40-270). This form is beneficial because it allows health plans to report to the DMHC the geographic area served by the health plan and the number of enrollees within the geographic area the health plan services. The reporting of this information allows the DMHC to determine network adequacy compliance.

Proposed Rule 1300.67.2.2(h)(7)(B)(vii) incorporates by reference the Telehealth Report Form (Form No. 40-271). This form is beneficial because it allows a health plan who provides services via telehealth to report the information to the DMHC as part of its network adequacy reporting. The reporting of this information allows the DMHC to determine network adequacy compliance.

Proposed Rule 1300.67.2.2(h)(7)(B)(viii) incorporates by reference the Timely Access and Network Adequacy Grievance Report Form (Form No. 40-272). This form is beneficial because it allows a health plan to report to the DMHC its compliance with Health and Safety Code section 1367.035 requiring the plan to submit grievances related to network adequacy. This form provides a uniform reporting method for all health plans and allows the DMHC to assess network adequacy compliance.

Proposed Rule 1300.67.2.2(h)(7)(C) incorporates by reference the Out- of- Network Payment Report Form (Form No. 40-273). This form is beneficial because it provides a uniform method of health plan reporting for compliance with Health and Safety Code section 1371.31(a)(4) which requires a health plan to include information regarding payments to out-of-network providers within its annual network report. This will assist

the DMHC in determining whether a health plan's network sufficiently contains in-network providers to service the health plan's enrollees.

ALTERNATIVES CONSIDERED:

Pursuant to Government Code section 11346.5(a)(13), a rulemaking agency must determine that no reasonable alternative considered by the agency or that has otherwise been identified and brought to the attention of the agency (1) would be more effective in carrying out the purpose for which the action is proposed, (2) would be as effective and less burdensome to affected private persons than the proposed action, or (3) would be more cost effective to affected private persons and equally effective in implementing the statutory policy or other provision of law. As described in the Initial Statement of Reasons for this rulemaking action, the Department has not determined that any known alternatives meet standards (1)-(3), described above.

As described in more detail in the Initial Statement of Reasons for this rulemaking action, the DMHC did consider two separate alternatives to the requirements of the proposed rule. The DMHC considered auditing provider records rather than conducting the Provider Appointment Availability Survey described in proposed Rule 1300.67.2.2(f), and also considered surveying providers at the provider group, rather than at the county and network level. After consulting with the health plans and stakeholders, the DMHC determined these alternatives did not meet the requirements of Government Code section 11346.5(a)(13).

The DMHC invites interested persons to present statements or arguments with respect to alternatives to the requirements of the proposed regulations during the written comment period.

PURPOSE OF THE REGULATION:

The purpose of this rulemaking action is to clarify and make specific the standardized methodology developed by the DMHC pursuant to Health and Safety Code section 1367.03(f)(3) regarding how health plans report timely access to care requirements and annual network requirements to the DMHC. Health and Safety Code section 1367.03(f)(3) allows the DMHC to develop a standardized methodology for health plan reporting of timely access to care requirements and provider network requirements.

During the APA exemption period described above, the DMHC worked extensively with health plans and stakeholders to develop a standardized method of reporting data to the DMHC. For the past four years, the health plans have submitted data to the DMHC according to the developed methodology and the DMHC has analyzed the data to ensure health plans are able to provide enrollees with timely access to care as described in the Knox-Keene Act and regulations.

The DMHC is proposing this rulemaking action to amend existing regulations to implement the current method health plans are using to report compliance with timely access to care and to clarify the methodology health plans are required to use. This rulemaking action codifies the timely access to care reporting methodology developed during the APA exemption period. Further, the DMHC is adopting a new regulation to implement, interpret, and make specific the current timely access to care and network requirements. The purpose of adopting Rule 1300.67.2.3 is to ensure health plans continue to comply with the existing requirements in Rule 1300.67.2.2 before the implementation of the proposed changes to Rule 1300.67.2.2.

A major component of the proposed regulation is the incorporation by reference of the Timely Access and Annual Network Submission Instruction Manual, the Provider Appointment Availability Survey Manual, and the accompanying reporting forms (Form Nos. 40-254 through Form Nos. 40-273) described above. The purpose of the Timely Access and Annual Network Submission Instruction Manual is to provide detailed step-by-step instructions on how a health plan is to use the required report forms to submit timely access to care and network adequacy information to the DMHC. The purpose of the detailed instructions are to guide the health plans in reporting accurate and meaningful information to the DMHC to assist the DMHC in assessing compliance with Health and Safety Code sections 1367.03(f) and 1367.035(a). The purpose of the Provider Appointment Availability Manual is to provide comprehensive instructions on the methodology a health plan is to use when conducting its provider surveys and what forms the health plan is to use when compiling data. The purpose of the manuals is to specify how a health plan is to submit the required forms to the DMHC to ensure complete and consistent reporting across health plans. The manuals and the forms work together to illustrate health plan performance with timely access to care standards.

The DMHC believes the adoption of these proposed regulations will have significant benefits for health plan enrollees in accessing appropriate health care services. The purpose of the proposed regulation and its health plan reporting requirements is to protect consumers from the potential inability to access needed health care services. The comprehensive timely access to care reporting standards ensure the health plan's provider network has the necessary providers ready to provide health care services to the health plan's enrollee population. Further, the standardized reporting requirements proposed by the regulation allow enrollees and consumers the ability to compare timely access to care data across health plans when choosing health care coverage. The reporting requirements hold health plans accountable to consumers and enrollees.

EVALUATION OF CONSISTENCY/COMPATIBILITY WITH EXISTING STATE REGULATIONS

The DMHC evaluated regulations in title 28, including existing sections 1300.67, 1300.67.2 and 1300.67.2.1, and has found that these proposed regulations are consistent and compatible with other areas of the Knox-Keene Act that address more

specific health plan responsibilities. Therefore, these regulations are neither inconsistent nor incompatible with existing state regulations the DMHC reviewed.

FORMS INCORPORATED BY REFERENCE

Pursuant to Title 1, California Code of Regulations, section 20(c)(3), and as cited to in the proposed regulations, the DMHC is incorporating by reference the following manuals and forms: Timely Access and Annual Network Review Submission Instruction Manual, and the Provider Appointment Availability Survey [PAAS] Manual.

The following types of forms are also incorporated by reference: Provider Appointment Availability Survey Report Forms, numbered 40-254 through 40-264, and the Annual Network Review Report Forms, numbered 40-265 through 40-272, as described below.

The Provider Appointment Availability Survey Report Forms consist of the following eleven report forms:

1. Primary Care Providers Contact List Report Form (Form No. 40-254);
2. Non-Physician Mental Health Care Providers Contact List Report Form (Form No. 40-255);
3. Specialist Physicians Contact List Report Form (Form No. 40-256);
4. Psychiatrists Contact List Report Form (Form No. 40-257);
5. Ancillary Service Providers Contact List Report Form (Form No. 40-258);
6. Primary Care Providers Raw Data Report Form (Form No. 40-259);
7. Non-Physician Mental Health Care Providers Raw Data Report Form (Form No. 40-260);
8. Specialist Physicians Raw Data Report Form (Form No. 40-261);
9. Psychiatrists Raw Data Report Form (Form No. 40-262);
10. Ancillary Service Providers Raw Data Report Form (Form No. 40-263); and,
11. Results Report Form (Form No. 40-264), including the following information:
 - a. Primary Care Providers Results Tab;
 - b. Non-Physician Mental Health Care Providers Results Tab;
 - c. Specialist Physicians Results Tab;
 - d. Psychiatrists Results Tab;
 - e. Ancillary Service Providers Results Tab;
 - f. Summary of Rates of Compliance Tab; and
 - g. Network by Provider Survey Type Tab.

The Annual Network Review Report Forms consist of the following nine report forms:

1. Network Service Area and Enrollment Report Form (Form No. 40-265);
2. PCP and PCP Non-Physician Medical Practitioner Report Form (Form No. 40-266);
3. Specialist and Specialist Non-Physician Medical Practitioner Report Form (Form No. 40-267);

4. Mental Health Professional and Mental Health Facility Report Form (Form No. 40-268);
5. Other Outpatient Provider Report Form (Form No. 40-269);
6. Hospital and Clinic Report Form (Form No. 40-270);
7. Telehealth Report Form (Form No. 40-271); and,
8. Timely Access and Network Adequacy Grievance Report Form (Form No. 40-272).

In addition, the Out-of-Network Payment Report Form (Form No. 40-273) is also incorporated by reference.

SUMMARY OF FISCAL IMPACT

- Mandate on local agencies and school districts: None.
- Cost or Savings to any State Agency: As described in the Economic Impact Assessment in the Initial Statement of Reasons, for this rulemaking action, there will be costs incurred by the Department of Health Care Services related to the implementation of the requirements proposed in this regulation for health plans offering Medi-Cal products without any commercial business. The DMHC estimated the fiscal impact for implementation costs to be approximately \$1.2 million dollars. The DMHC estimated the fiscal impact for ongoing costs to be approximately \$1.2 million dollars. Both of these costs are absorbable by existing budgets.
- Cost to Local Agencies and School Districts Required to be Reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code: None.
- Other non-discretionary costs or savings imposed upon local agencies: As described in the Economic Impact Assessment in the Initial Statement of Reasons, for this rulemaking action, the DMHC estimated one health care plan offering the County Organized Health System (COHS) would be fiscally impacted by the requirements of the proposed regulation. The affected COHS offers the In-home Supportive Services program with a total of 636 enrollees. The DMHC estimated the yearly costs to be between \$960.36 and \$254.40 dollars. These estimates include costs for implementation of the new requirements proposed in the rulemaking action as well as ongoing costs. Costs associated with the proposed Rule are administrative, and will be incurred by the state General Fund, when available, pursuant to Welfare and Institutions Code section 12306.16.
- Direct or Indirect Costs or Savings in Federal Funding to the State: None.
- Costs to private persons or businesses directly affected: The DMHC has determined that this proposed regulatory action will have cost impacts that a business would necessarily incur in complying with the proposed requirements. As described in the Economic Impact Assessment in the Initial Statement of Reasons, for this rulemaking action, the fiscal impact to all affected businesses for initial implementation are estimated to be between \$5 million and \$6 million

dollars. The DMHC estimated the fiscal impact for ongoing implementation to be between \$3.4 million and \$4.6 million dollars per year.

- Effect on Housing Costs: None.

DETERMINATIONS

The DMHC has made the following initial determinations:

- The DMHC has determined the regulation will not impose a mandate on local agencies or school districts, nor are there any costs requiring reimbursement by Part 7 (commencing with Section 17500) of Division 4 of the Government Code.
- The DMHC has determined the regulation will have no significant effect on housing costs.
- The DMHC has determined the regulation minimally effects small business organizations. Health care service plans are not considered a small business under Government Code Section 11342.610(b) and (c). However, some provider groups impacted by the reporting requirements of the proposed regulation do meet the small business definition. Using the DMHC's cost analysis methodology, the DMHC determined the small business costs to be 13% of total costs incurred. Please see the Economic Impact Assessment in the Initial Statement of Reasons for this rulemaking action for more specific information.
- The DMHC has determined the regulation will not have a significant statewide adverse economic impact directly affecting businesses, including the ability of California businesses to compete with businesses in other states. Please see the Economic Impact Assessment in the Initial Statement of Reasons for this rulemaking action for more specific information.
- The DMHC has determined the regulation will have costs to a local government offering health care coverage through the COHS, as described above. The DMHC identified one local health plan offering health care services through the COHS that will incur implementation costs and ongoing costs. Please see the Economic Impact Assessment in the Initial Statement of Reasons for this rulemaking action for more specific information.
- The DMHC has determined the regulation will have no cost or savings in federal funding to the state.
- The DMHC has determined the approach proposed by the DMHC for this rulemaking action balances the needs of all parties, while protecting health plan enrollees.

RESULTS OF THE ECONOMIC IMPACT ANALYSIS (Government Code section 11346.3, subdivision (b))

Creation of New Businesses or Elimination of Existing Businesses within California

The proposed amendments to Rule 1300.67.2.2 will neither create new businesses nor eliminate existing businesses. The proposed amendments affect only existing business subject to the DMHC's jurisdiction, and do not require the creation of any new businesses. During the APA exemption period, health plans implemented operational changes to accommodate the mandatory timely access to care and network adequacy reporting to the DMHC according to the methodology developed under the APA exemption. The DMHC is unaware of any existing businesses that will be created or eliminated as a result of these requirements.

Creation or Elimination of Jobs Within the State of California:

The DMHC does not believe that health plan employers will create additional positions in order to comply with the requirements of the proposed rule. During the APA exemption period, health plans implemented operational changes to accommodate the mandatory timely access to care and network adequacy reporting to the DMHC according to the methodology developed under the APA exemption; therefore, implementing the changes proposed in the proposed rule will not impact lead to the creation of new jobs within the State of California.

Additionally, the proposed Rule will not eliminate any existing jobs in California. As discussed, existing statutes and regulations require health plans to provide timely access to care for enrollees. This proposed Rule standardizes reporting requirements, and codifies the published Measurement Year 2019 methodology. Although the proposed rule affects health plan procedures for collecting and reporting data, it does not eliminate any particular job functions within a health plan.

Expansion of Businesses Currently Doing Business Within the State of California:

The proposed regulation is unlikely to cause a significant increase in workload on existing health plan personnel. The DMHC has not observed an expansion in health plan businesses as a result of the APA-exempt methodologies. The DMHC determined the indirect impact on providers that the proposed amendments impose only require a small amount of annual staff time per inquiry. The DMHC believes that this relatively minimal requirement will not result in the expansion of provider businesses.

The DMHC does not believe that vendors contracting with health plans to conduct activities required by the proposed regulation will expand as a result of implementation. The DMHC estimates a relatively low increase in contracting costs for those health plans who choose to use a vendor to conduct the required activities proposed by the regulation.

Benefits of the Regulation to the Health and Welfare of California Residents, Worker Safety, and the State's Environment:

The proposed amendments and adoption benefits the health and welfare of California residents by ensuring that enrollees and patients across the state receive needed health care services at the appropriate time. Enrollees in DMHC-regulated coverage have a right to access health care services within certain timeframes. The proposed amendments and adoption enables the DMHC to provide better oversight over health plan practices, ensuring that patients are receiving requested health care services in a timely manner.

By standardizing reporting requirements, the proposed amendments and adoption will allow the DMHC to collect data in a useful way and draw helpful conclusions about access to care. For instance, as a result of SB 964, the DMHC has been able to improve its ability to compare results among health plans and publically report more accurate data regarding timely access to health care. Codifying existing standardized methodologies will enable to the DMHC to continue to draw useful conclusions about timely access to health care, and use these conclusions to better protect enrollees' health care rights.

REPORTING REQUIREMENT

Pursuant to Government Code section 11346.3(d), the DMHC has determined that the reporting requirements contained in this regulation are necessary for the health, safety or welfare of the people of the State of California. The proposed regulation is a benefit to the health plans because it provides a standardized, cohesive reporting methodology that enables health plans to report meaningful timely access to care and network adequacy data to the DMHC. The health plans are required by existing law to provide the DMHC with timely access to care and annual network reports on an annual basis. The proposed regulation codifies the methodologies the health plans have been using for the past four years to report this data. Health plans benefit because uniform standards allow for ease of report submission. Submission of this statutorily required information allows the DMHC to ensure health plans are complying with appointment time-elapsed standards and that health plans have adequate provider networks to meet the needs of the enrollee population they serve.

BUSINESS REPORT:

This rulemaking package clarifies and updates the requirements of health plans to provide timely access to health care services and provide an adequate network of providers by clarifying definitions, timely access to care and annual network reporting requirements, and timely access to care and network adequacy standards. The amendments to this regulation are necessary for the health, safety or welfare of the people of the State of California.