

**STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE
TITLE 28, CALIFORNIA CODE OF REGULATIONS
SECTIONS 1300.67.2.2 and 1300.67.2.3**

INITIAL STATEMENT OF REASONS (ISOR)

**TIMELY ACCESS TO NON-EMERGENCY HEALTH CARE SERVICES AND
ANNUAL TIMELY ACCESS AND NETWORK
REPORTING REQUIREMENTS**

Pursuant to Government Code section 11346.2, the Director of the Department of Managed Health Care (DMHC) submits this Initial Statement of Reasons in support of the 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 (CCR).

I. AUTHORITY

Pursuant to California Health and Safety Code (HSC) 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 the health care service 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 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 of the DMHC (Director) authority to adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act).

Health and Safety Code section 1367 states requirements that each health plan must meet. 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. 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 care service plan to make all services accessible and appropriate consistent with section 1367.04 (requiring access to language assistance). Health and Safety Code section 1367 also requires a health care service plan to employ and utilize allied health manpower for the furnishing of services to the extent permitted by law and consistent with good medical practice.

Health and Safety Code section 1367.03, subdivision (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 must be used by health plans to demonstrate compliance with this section and any regulations adopted pursuant to it. The DMHC is required to 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 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, subdivision (a)(4), requires a health plan to include in its annual report to the DMHC pursuant to Health and Safety Code 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, subdivision (a)(5), ratifies existing network adequacy laws and authorizes the DMHC to adopt additional necessary regulations.

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

II. Specific Problems Addressed, and Necessity of Regulation

The following sections provide a broad overview of: (A) the statutory and regulatory background underlying this regulatory action; (B) the general processes used by health plans for annual reports; (C) the contents of the proposed regulation; (D) the staggered implementation dates for the proposed regulation; and (E) the specific purpose and necessity for each proposed adoption, amendment, and repeal (including specific problems addressed and anticipated benefits).

A. Background: timely access and annual network review statutes and regulation

Providing timely access to necessary health care is among a health plan's fundamental duties to its enrollees.¹ California law requires health plans to ensure all services are

¹ Health and Safety Code section 1342.

readily available at reasonable times, and to furnish necessary health care in accordance with good professional practice.² To accomplish this requirement, health plans contract with doctors, hospitals, and other health care service providers (providers) to form a “network” of providers who care for the health plan’s enrollees. Existing law requires the health plan’s network to be adequate to provide necessary care in a reasonable and timely manner to the health plan’s enrollees. Network adequacy is a multifaceted requirement for sufficient numbers and types of providers, located within reasonable geographic distance to provide care for a health plan’s service area.

California law has long required health plans to ensure access to care, but the law prior to 2002 did not mandate specific standards for timely access. Then, in response to high volumes of consumer complaints about lack of timely access to health care, the California legislature declared:

...timely access to health care is essential to safe and appropriate health care and that lack of timely access to health care may be an indicator of other systemic problems such as lack of adequate provider panels, fiscal distress of a health care service plan or a health care provider, or shifts in the health needs of a covered population...³

The Legislature further declared its intent to incorporate timely access standards into myriad aspects of health plan regulation, including licensing, surveys (a type of audit), enforcement, and other processes intended to protect consumers.⁴ To that end, the Legislature enacted Health and Safety Code section 1367.03, directing the DMHC to adopt a regulation to ensure timely access to necessary health care, including indicators of timeliness of access. Health and Safety Code section 1367.03 required the DMHC’s regulation to consider various factors, such as waiting times for appointments, timeliness of care in an episode of illness (including necessary referrals), waiting times to speak to a qualified provider, clinical appropriateness of care, the nature of the specialty, the urgency of care, and the requirements of other provisions of law that may affect timeliness of access.⁵ Health and Safety Code section 1367.03 also required health plans to annually report to the DMHC compliance with timely access standards.

In 2010, the DMHC adopted the required timely access regulation in Rule 1300.67.2.2.⁶ Rule 1300.67.2.2 specifies requirements for timely access (including maximum wait-times for various types of appointments), the deadline for a health plan to submit its annual timely access compliance report to the DMHC, as well as general parameters for the annual report. For example, the existing Rule 1300.67.2.2 requires the health plan’s annual report to document the health plan’s rate of compliance (ROC), which may be

² Health and Safety Code section 1367(d).

³ Assembly Bill (AB) 2179 (Cohn, Chapter 797, Stats of 2002), Sec. 1.

⁴ Assembly Bill (AB) 2179 (Cohn, Chapter 797, Stats of 2002), Sec. 1.

⁵ Health and Safety Code section 1367.03, subsection (a)-(b).

⁶ 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 sections of the CCR.

developed using “statistically reliable sampling methodology [...]”⁷

However, in the years following promulgation of Rule 1300.67.2.2, the annual reports from health plans contained numerous errors. The disparate, incomplete, and poor-quality timely access data in the health plan reports made the DMHC’s review of timely access compliance difficult, and made comparison of compliance between different health plans nearly impossible.

Subsequently, in 2014, through Senate Bill (SB) 964,⁸ the Legislature revisited the subject of “timely access to care.” The Legislature added two important elements to the existing law: (1) the Legislature empowered the DMHC to develop standardized reporting methodologies for the annual report, pursuant to a five-year exemption from the Administrative Procedures Act (APA),⁹ and (2) the Legislature required health plans to include network adequacy data in the existing annual report required by Health and Safety Code section 1367.03.¹⁰ Accordingly, due to SB 964, health plans annually submit to the DMHC both the timely access report (TAR) and the annual network report (ANR).

Since 2014, the DMHC has worked closely with stakeholders to develop and refine standardized methodologies for the annual timely access and annual network reports. For the past several years since the enactment of SB 964, health plans have built systems and implemented processes to gather and report timely access and network data in accordance with the DMHC’s APA-exempt methodology and other authority granted in the Knox-Keene Act. The proposed Rule includes some new provisions, which are described in detail in this ISOR. However, the proposed Rule is largely consistent with the existing reporting methodologies used by health plans for the past several years.

The APA exemption pursuant to Health and Safety Code section 1367.03 will expire on January 1, 2020. The DMHC is now initiating this rulemaking action to amend existing Rule 1300.67.2.2, and to adopt new Rule 1300.67.2.3, in order to implement, interpret, and make specific timely access and network requirements under the Knox-Keene Act, and to formally codify the reporting methodologies that the DMHC developed in consultation with stakeholders.

B. Overview of Timely Access Reporting and Annual Network Reporting

The following high-level overview provides helpful information to assist in understanding the general processes health plans use to gather and report timely access and network data.

⁷ Rule 1300.67.2.2 also specifies requirements for a health plan’s quality assurance processes (i.e., self-monitoring and corrective action), enrollee disclosure and education requirements, provisions regarding health plan requests for alternative timeliness standards, etc.

⁸ Senate Bill (SB) 964 (Hernandez, Chapter 573, Stats of 2014).

⁹ Health and Safety Code section 1367.03(f)(3).

¹⁰ Health and Safety Code section 1367.035(a).

i. TAR Overview: Timely Access Data Collection and Reporting:

The health plan TAR is based primarily on data and results from the Provider Appointment Availability Survey (PAAS). The PAAS is a survey that assesses availability of appointments for health plan enrollees within the timely access standards in Rule 1300.67.2.2(c)(5) (e.g., a non-urgent appointment for primary care must be available within ten business days of the request). On the network capture date,¹¹ health plans gather data about their networks. Health plans use that data to populate the health plan's Contact List Report Forms. Over the course of the year, health plans conduct the PAAS by contacting the providers on the health plan's Contact List Report Forms. Once the PAAS is finished, the health plans complete the Results Report Forms. The health plans then access the DMHC's web portal and submit their reports, including all information required by Rule 1300.67.2.2(g), to the DMHC by the specified deadline.

ii. ANR Overview: Annual Network Data Collection and Reporting:

The health plan ANR is based on the data the health plan collects on the Network Capture Date. Health plans use the network data to complete the Annual Network Review Report Forms according to DMHC instructions. Health plans then access the DMHC's web portal and submit their report by the deadline specified in Rule 1300.67.2.2.

C. Overview of Proposed Regulation

The proposed regulation codifies the TAR and ANR processes outlined above, in section B. The proposed regulation consists of Rule 1300.67.2.2 and Rule 1300.67.2.3, as well as several instruction manuals and report forms that will be incorporated by reference into Rule 1300.67.2.2. Thus, the entire proposed regulation consists of the following components:

- **Rule 1300.67.2.2, as proposed to be amended.**
 - Proposed Rule 1300.67.2.2 defines key terms; specifies how health plans must conduct surveys of providers and enrollees and gather data for the TAR and ANR, requirements for health plan quality assurance processes, reporting requirements; it incorporates key documents such as report forms and manuals; and includes other clarifying amendments.
 - Rule 1300.67.2.2 specifies delayed implementation dates for certain definitions (i.e., "network capture date," "pattern of non-compliance," requirements), as well as updated requirements for "quality assurance processes," PAAS procedures, and updated reporting requirements. The delayed implementation dates are necessary to allow time for health plans to adjust their procedures to comply with certain requirements in the proposed Rule. (See Table 1, below.)
- **Rule 1300.67.2.3, as proposed to be adopted.**
 - Proposed Rule 1300.67.2.3 preserves the requirements that exist under the

¹¹ "Network capture date" is proposed to be defined, in subsection (b)(6) of Rule 1300.67.2.2, as January 15, starting in 2022.

current version of the timely access Rule and ensures that, until the new provisions under proposed Rule 1300.67.2.2 take effect, health plans continue to comply with existing timely access monitoring, quality assurance, and reporting requirements.

- **Timely Access and Annual Network Submission Instruction Manual**
 - The Timely Access and Annual Network Submission Instruction Manual (**Instruction Manual**) explains to health plans how to complete the Network Access Profile and required report forms, and how to submit the annual TAR and ANR through the DMHC's web portal.
- **Provider Appointment Availability Survey Manual;**
 - The Provider Appointment Availability Survey Manual (**PAAS Manual**) instructs health plans how to conduct the PAAS, which is the way the health plan must gather and develop data for the TAR pursuant to proposed Rule 1300.67.2.2. This manual's step-by-step instructions will ensure health plans obtain PAAS data consistent with the DMHC's proposed methodology, in order to yield statistically valid results that accurately represent a health plan's rate of compliance with the timely access standards under Rule 1300.67.2.2(c)(5).
- **Provider Appointment Availability Survey [PAAS] Report Forms**
 - The PAAS Report Forms are part of the TAR. Health plans gather, develop, and report PAAS data using the PAAS Report Forms, in accordance with the instructions in two manuals: (1) the PAAS Manual, and (2) the Instruction Manual.
- **Annual Network Report Forms**
 - Health plans will gather, develop, and report the required network data using these ANR Report Forms in accordance with the instructions in the Instruction Manual.
- **Out of Network Payment Report Form**
 - Health plans will use this form to report information required by Health and Safety Code section 1371.31.

D. Overview of staggered effective dates in the proposed Rule

Some parts of the proposed regulation require delayed effective dates.¹² Certain requirements in the proposed Rule cannot take effect immediately upon promulgation because health plans gather data for the annual reports retrospectively. For example, a health plan's TAR is primarily based on data the health plan gathered by conducting the PAAS over the course of the *previous year*. Health plans therefore require time to implement changes in how they gather data for reports.

Since the health plan's reports are retrospective, the proposed updated reporting requirements cannot become effective immediately upon promulgation of the regulation. If, for example, the proposed regulation is effective on January 1, 2021, the next annual report would be due only a few months later. However, the health plan would have

¹² The specific purpose and necessity of the effective dates for various provisions are explained in detail in section E of this Initial statement of Reasons (ISOR).

already gathered the timely access data for that report during the previous calendar year (CY), *before the effective date of the proposed Rule*. It would be impossible for a health plan to submit its TAR due in 2021, pursuant to Rule 1300.67.2.2, as proposed to be amended. This is one example of why a staggered implementation for updated data-collection and reporting requirements is necessary for this proposed regulation. This example also shows why it is necessary to preserve the *existing* data gathering and reporting requirements for the period of time leading up to full implementation of the proposed Rule. Details regarding all of the staggered implementation dates for provisions of the proposed Rule may be found in section E of this ISOR. However, Table 1 provides a brief, at-a-glance summary of the implementation of the proposed regulation, organized by reporting requirements for each calendar year (CY).

Table 1:

| CY | Applicable Requirements for TAR and ANR |
|------|--|
| 2021 | <div>January 1:</div> <ul style="list-style-type: none"> Proposed Rule is effective except as specified in Rule. <div>March 31:</div> <ul style="list-style-type: none"> TAR and ANR due (Proposed Rule 1300.67.2.3(a)). These reports contain data gathered by health plans during previous CY (2020) pursuant to existing Rule 1300.67.2.2. <div>Ongoing (Jan – Dec.):</div> <ul style="list-style-type: none"> Health plans conduct quality assurance processes consistent with requirements in the existing Rule 1300.67.2.2 (preserved in proposed Rule 1300.67.2.3 (b)). <div>Ongoing (April –Dec.):</div> <ul style="list-style-type: none"> Health plans conduct the PAAS consistent with existing Rule 1300.67.2.2 (preserved in proposed Rule 1300.67.2.3(a) and (b)). <div>June 1:</div> <ul style="list-style-type: none"> Health plans file Policies and Procedures showing how the health plan will comply with the updated requirements for the TAR and ANR, due the next year, in 2022 (Proposed Rule 1300.67.2.2(h)(5)). <div>Dec. 31:</div> <ul style="list-style-type: none"> Proposed Rule 1300.67.2.3 becomes inoperative. |
| 2022 | <div>January 1:</div> <ul style="list-style-type: none"> Amended reporting requirements effective (proposed Rule 1300.67.2.3(h)). <div>Ongoing (Jan – Dec.):</div> <ul style="list-style-type: none"> Health plans conduct amended enrollee experience and provider satisfaction surveys (proposed Rule 1300.67.2.2(d)(2)(B)-(C)). <div>January 15:</div> <ul style="list-style-type: none"> Health Plans use this network capture date to gather data (proposed Rule 1300.67.2.2(h)(4)). <div>Ongoing (June - Dec):</div> <ul style="list-style-type: none"> Health Plans conduct the amended PAAS (proposed Rule 1300.67.2.2(f)). |

| CY | Applicable Requirements for TAR and ANR |
|------|---|
| | <p>May 1:</p> <ul style="list-style-type: none"> • TAR and ANR are due (Proposed Rule 1300.67.2.2(h)(1)). • TAR contains data gathered by health plans during the previous CY (2021), pursuant to proposed Rule 1300.67.2.3. • ANR contains data gathered using the proposed network capture date (Jan. 15, 2022) (proposed Rule 1300.67.2.2(h)(4)). |
| 2023 | <p>May 1:</p> <ul style="list-style-type: none"> • TAR and ANR are due (proposed Rule 1300.67.2.2(h)(1)). • TAR contains data gathered by health plans during the previous CY (2022), pursuant to proposed Rule 1300.67.2.2. • ANR contains data gathered using the proposed network capture date (Jan. 15) (proposed Rule 1300.67.2.2(h)(4)). |

The specific problems addressed and the necessity of the proposed regulation are described in greater detail in section II.E, below.

E. Specific Problems Addressed and Necessity of Regulation

i. Rule 1300.67.2.2, as proposed to be amended (necessity):

The title of Rule 1300.67.2.2 describes the topic of the regulation. The proposed amendments address that the existing title is incomplete because it pre-dates SB 964, which empowered the DMHC to specify standardized reporting methodologies, and added network adequacy data to the annual report required by Health and Safety Code section 1367.03. The proposed amendments are necessary to clarify that Rule 1300.67.2.2, as proposed to be amended, addresses both the TAR and ANR requirements. These amendments will result in the benefit of greater clarity that allows health plans and stakeholders to understand the scope of the Rule and file the correct data for DMHC review.

Subsections (a)(1)-(2) of Rule 1300.67.2.2 addresses the problem of inconsistency in how the current Rule describes health plan requirements. It is necessary to amend the language from plural to singular and remove extraneous words in order to improve the clarity of this subsection to give health plans and stakeholders a better understanding of the requirements of this subsection.

Subsection (a)(2) of Rule 1300.67.2.2 also addresses the problem that the existing Rule 1300.67.2.2 describes dental, vision, and other health plans without using the term “specialized” plan, which is the appropriate term pursuant to Health and Safety Code section 1345. The proposed amendments also address the problem that the existing cross-references do not clearly identify the relevant subsection being referenced. It is necessary to specify both the relevant subsections and subparagraphs for greater clarity

and understanding of how the different provisions of the Rule work together. The proposed amendment to subsection (a)(2) also repeals the cross-reference to (g)(1), which was a one-time filing that is now obsolete. This repeal is being done for clarity.

Subsection (a)(2) also specifies that certain specialized health plans must comply with subsection (h)(8)(A)-(C), which requires completion of the Network Access Profile. The Network Access Profile is part of the DMHC's online web portal for the TAR and ANR. In the Network Access Profile, each health plan annually updates its "profile" by entering high-level information about the health plan's networks, network service area(s), product lines that use the network, and any plan-to-plan contracts. Therefore, the Network Access Profile is part of the annual report pursuant to Health and Safety Code sections 1367.03(f) and 1367.035(a). To date, however, Rule 1300.67.2.2 has not required specialized dental, acupuncture, vision and chiropractic plans to complete the Network Access Profile. This gap in basic, high level information concerning these specialized health plans has made it difficult for the DMHC to obtain a complete picture of the licensed networks that operate in California. The gap in information also makes it difficult for the DMHC to determine what the services that are available to health plan enrollees in various regions throughout the state, either directly or through plan-to-plan contracts with full-service¹³ health plans. The limited view of the networks in California has also made it difficult for the DMHC to assess the capacity of health plan networks serving enrollees. Proposed Rule 1300.67.2.2(a)(2) would address this problem by adding specialized health plans to the types of plans who annually complete or update the Network Access Profile in the DMHC's web portal. This proposed change is necessary to fully effectuate the statutes requiring annual TAR and ANR because it will collect information allowing the DMHC to more comprehensively assess network adequacy pursuant to Health and Safety Code sections 1367 and 1367.035 and ensure enrollees are receiving access to adequate networks of providers.

Subsection (a)(3) of Rule 1300.67.2.2 contains a necessary update, changing the phrase "contracted" provider to "network" provider, consistent with the proposed definition of "network provider," in subsection (b)(9) of Rule 1300.67.2.2. The DMHC proposes similar amendments throughout the proposed Rule. Using consistent terminology will have the benefit of clarifying the regulation and allowing impacted stakeholders and health plans to better understand the regulatory requirements in this provision. Additionally, in subsection (a)(3), it is necessary to update the cross-reference to the definition of "material" change, in Health and Safety Code section 1375.7. The relevant statutory definition was formerly located in Health and Safety Code section 1375.7(g)(2), but the provision was relocated to subsection (h)(2).¹⁴ The update to the cross-reference will have the benefit of clarifying the Rule by directing stakeholders and health plans to the correct statutory definition.

Subsection (a)(4) contains a necessary update, changing the phrase "contracted provider network" to "network," consistent with the proposed definition of "network" in proposed

¹³ "Full-service" health plans, as opposed to specialized health plans, cover the full range of hospital, medical, surgical, and other health services required under the Knox-Keene Act.

¹⁴ AB 2252 (Gordon, Chapter 447, Statutes of 2012).

subsection (b)(5) of Rule 1300.67.2.2. The DMHC proposes similar amendments throughout the proposed Rule.¹⁵ This is a non-substantive change that clarifies the meaning of “network” in relation to network adequacy and timely access compliance, under Rule 1300.67.2.2. The existing Rule uses the terms “*contracted provider network*” and “*contracted provider*,” and the word “contracted” in these terms does not accurately reflect the entire scope of networks and providers that the DMHC has always assessed in relation to timely access compliance and network adequacy. As discussed in relation to the proposed definition of “network provider” (subsection (b)(9)), relevant providers who are part of a plan’s network may be contracted with the plan, but may also have other relationships with the health plan, including employment, etc. The amended terms, “network” and “network provider” are more descriptive and accurate. Using consistent terminology will have the benefit of clarifying the proposed Rule, which will make it easier for regulated health plans to understand their obligations.

Subsection (a)(5) of Rule 1300.67.2.2 specifies that all reports required under this section (Rule 1300.67.2.2) must be filed timely, accurately, and completely. Proposed subsection (a)(5) also specifies that material misstatements or omissions in the reported data or information must be construed as a lack of administrative capacity to fulfill the health plan’s duties, as described in section 1367(g) of the Knox-Keene Act. The purpose of this subsection is to implement the reporting requirement under Health and Safety Code sections 1367.03 and 1367.035 in a manner that makes health plans accountable for providing correct information to the DMHC by the required deadlines. Accurate, timely, and complete information is necessary to allow the DMHC to conduct its compliance review pursuant to Health and Safety Code sections 1367.03(g) and 1367.035(d). Proposed subsection (a)(5) is necessary to address the problem that health plans have historically provided incomplete, untimely, and inaccurate data in their annual reports to the DMHC. This provision is necessary to ensure health plans are aware of their reporting obligations, and to ensure the DMHC has enforcement remedies for material reporting failures by health plans. Robust reporting requirements and enforcement are necessary to effectuate the purpose of Health and Safety Code sections 1367.03 and 1367.035 because without timely, complete, and accurate reports, the DMHC cannot assess health plan compliance or require corrective action when health plans have not provided enrollees timely and reasonable access to necessary health care. The anticipated benefit of the requirement in subsection (a)(5) for timely, complete, and accurate reports is that health plans will take appropriate measures when filing their reports pursuant to this Rule, the quality of health plan reports will improve, and the DMHC will have the information necessary to assess health plan compliance with timely access and network adequacy standards.

The proposed amendments to subsection (b) of Rule 1300.67.2.2 (regarding definitions) address the problem of ambiguity in key terms related to timely access and network adequacy reports. The primary, overall purpose of this rulemaking action is to specify standardized reporting methodologies for the TAR and ANR pursuant to Health and Safety Code section 1367.03(f). Without amendments to subsection (b) of Rule 1300.67.2.2, the DMHC’s intended meaning for key terms related to the reports would be

¹⁵ See Rule 1300.67.2.2, subsection (a)(4), (c)(5), etc.

unclear and health plans would employ varying definitions causing confusion and potential enforcement issues. Health and Safety Code section 1367.03(f)(2) requires annual reports from health plans to “allow consumers to compare the performance of plans [...],” and the reports will not allow for that comparison if the reports are based on different definitions of key terms. Therefore, standard definitions are necessary to effectuate Health and Safety Code section 1367.03. The anticipated benefit of the proposed definitions in subsection (b) is clarity and uniformity in key terms, which will allow the annual reports to be comparable and consistent when reviewed by the DMHC and consumers. For example, subsections (b)(1) and (b)(2) are non-substantively amended to consistently use the defined terms in the proposed Rule: “provider group” and “network provider.” The proposed definitions will also result in the benefit of more efficient compliance review by the DMHC pursuant to Health and Safety Code sections 1367.03(g) and 1367.035(d), because the reporting plan and the DMHC will be able to operate and communicate using standardized terminology. The specific purpose and necessity of each definition is described, below.

The existing subsection (b)(3) of Rule 1300.67.2.2, defining “preventive care” is being repealed. The purpose of this repeal is to avoid inconsistency between Rule 1300.67.2.2 and more recent, controlling law. The Rule’s definition of preventive care was developed before the enactment of statutes that add to the definition of preventive care (see, e.g., Health and Safety Code section 1367.002, requiring compliance with the federal Public Health Services Act section 2713 (42 U.S.C. section 300gg-13, etc., which requires coverage of preventive health services, as defined¹⁶). This repeal will have the benefit of avoiding confusion regarding the meaning of preventive care and ensuring a consistent understanding of the term by health plans.

Subsection (b)(3) of Rule 1300.67.2.2, as proposed to be adopted, defines “measurement year,” effective on and after January 1, 2022. The purpose of this definition is to clarify the meaning of the term “measurement year,” as distinct from similar-sounding, but

¹⁶ Public Health Services Act section 2713 states, in pertinent part: “A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for-- (1) evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force; (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and (3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. (4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph. (5) for the purposes of this chapter, and for the purposes of any other provision of law, the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.”

different terms used in the Rule (e.g., “reporting year,” “calendar year,” etc.). Subsection (b)(3) will have the benefit of clarifying that “measurement year” means the year in which the data for the annual report is measured. Subsection (b)(3) will help clarify the reporting requirements throughout the Rule that use the term “measurement year”. Additionally, the purpose of this subsection is to clarify the distinct meanings of the term “measurement year” for the purpose of the timely access report (TAR), versus the Annual Network Report (ANR). The dual definition is necessary because the annual reports are both retrospective, in different ways, as shown in the examples, below.

Subsection (b)(3)(A) defines “measurement year” for the TAR. For the TAR, the “measurement year” means the calendar year before the year in which the TAR is submitted.

TAR “Measurement Year” Example:

Health plans gather timely access data using the PAAS during 2022, and report this TAR data in 2023. The TAR measurement year is 2022.

Subsection (b)(3)(B) defines “measurement year” for the ANR. The ANR “measurement year” is different from the TAR measurement year. Effective January 1, 2022, the “measurement year” for the ANR is the year in which the report is required to be submitted to the DMHC (except as specified).

ANR “Measurement Year” Example:

Health plans collect their network data on January 15, 2022 (the network capture date¹⁷). Health plans report the ANR data in 2022. The ANR measurement year is 2022.

The proposed definitions in subsection (b)(3) address the problem that health plans gather data differently for the TAR and ANR, as shown in the examples, above. The definitions address this problem by describing the distinct meanings of “measurement year” in the context of TAR versus ANR.

More specifically, the TAR is primarily based on the PAAS, which is a survey process health plans conduct over the entire year preceding the TAR’s due date. Conversely, for ANR, the proposed definition addresses the problem that providers enter and exit a health plan’s network continually, and so it is necessary to measure a health plan network as of a defined point in time (the network capture date).

Notably, the ANR-related definition of “measurement year” has two exceptions for requirements under proposed subsection (h)(7)(A)(iv) (regarding grievance data), and subsection (h)(7)(C) (regarding out-of-network claims data required pursuant to Health and Safety Code section 1371.31). Unlike the other network data requirements, which are based on a defined point in time, the excepted data pursuant to (h)(7)(A)(iv) and (h)(7)(C) are collected for the ANR over the course of the preceding year. So, it is necessary to

¹⁷ Proposed Rule 1300.67.2.2(b)(6) and (h)(4) define and describe the network capture date.

define the “measurement year” for those excepted data pursuant to subsection (b)(3)(A). Therefore, the proposed definitions in subsection (b)(3) have the benefit of accommodating these different modes of data collection, and clarifying the meaning of “measurement year” so that health plans can comply with TAR and ANR requirements. These definitions are necessary to effectuate the reporting requirements under Health and Safety Code sections 1367.03(f) and 1367.035(a) and to ensure health plans have a clear understanding of the information that must be reported to the DMHC.

Subsection (b)(4) of Rule 1300.67.2.2 defines “network” as a discrete set of network providers the health plan has designated to deliver all covered health services for a specific network service area. This definition is necessary to implement Health and Safety Code section 1367.03, particularly subsection (f)(3), which requires the DMHC’s standardized reporting methodology to be sufficient to determine compliance for different health plan networks. The proposed definition of “network” also addresses the problem that network is a term that can be interpreted in various ways, and health plans are likely to use many different interpretations unless the DMHC defines the term. This definition of network is necessary to describe the specific group of providers who the health plan has assigned to deliver care for a given geographic area (network service area). Defining “network” based on service area is consistent with the way the DMHC currently assesses network adequacy, under existing law (see, e.g., Rule 1300.67.2(a): “*Within each service area of a plan, [...] services shall be readily available and accessible to each of the plan’s enrollees [...]*”). This definition of network will result in the benefit of consistency in the terms used by health plans and the DMHC, clarity regarding network-related requirements, consistent and comparable health plan reports, and efficient DMHC compliance review pursuant to Health and Safety Code sections 1367.03 and 1367.035.

Subsection (b)(5) of Rule 1300.67.2.2 defines “network adequacy” as the ability of a health plan’s network to ensure delivery of all covered services, on an ongoing basis, in compliance with the Knox-Keene Act. This subsection is necessary to implement Health and Safety Code section 1367.035 (regarding submission of data regarding network adequacy). Subsection (b)(5) also addresses the problem that “network adequacy” is a broad concept that can be interpreted in various ways. This definition is necessary to clarify the term, allowing a health plan to understand its obligations when reporting information to the DMHC. The proposed definition is also necessary to allow the DMHC to perform compliance review pursuant to Health and Safety Code sections 1367.035(d), which requires the DMHC to review submitted network adequacy data for compliance with the Knox-Keene Act. Proposed subsection (b)(5) will result in the benefit of clarifying the standards relevant for network adequacy, including clarifying that health plans must maintain an adequate network to deliver necessary services to enrollees, on an ongoing basis. The clarification that network adequacy is an ongoing requirement is necessary to implement and be consistent with existing laws, including requirements for health plans to make services readily available consistent with good professional practice, and monitor enrollee access to care and address access problems as they arise (see, e.g., Health and Safety Code section 1367, Rule 1300.67.2(f), etc.). Proposed subsection (b)(5) is also consistent with Health and Safety Code section 1371.31(a)(5), which confirms existing “network adequacy requirements,” with references to Health and Safety Code section 1367(d)-(e), and existing title 28 regulations related to health plan licensure and

accessibility of services for enrollees.¹⁸

Subsection (b)(6) of Rule 1300.67.2.2 defines “network capture date.” As discussed in relation to the proposed definition of “measurement year” (proposed subsection (b)(3)), it is necessary to collect most network data at a defined point in time. Collecting network data in this manner addresses the problem that providers continually enter and exit a health plan’s network. The proposed definition of network capture date defines the point in time when health plans will collect their network data, which will result in the benefit of clarity and uniformity in how health plans collect and data. The network capture date is also pertinent to the TAR, because health plans gather network provider data on the network capture date, and use that data to populate their Contact List Report Forms. Health plans use the Contact List Report Forms to conduct the PAAS, which is the primary basis of the TAR. Proposed subsection (b)(6) also will result in the benefit of health plan ANRs that are comparable, and allow for efficient compliance review by the DMHC. This amendment is necessary to effectuate the purposes of Health and Safety Code sections 1367.03 and 1367.035.

Pursuant to subsection (b)(6), the network capture date will be January 15 of the measurement year, beginning January, 2022 – one year after promulgation of the proposed Rule. A delayed effective date is necessary because otherwise the network capture date would arrive only two weeks after this proposed Rule will be promulgated, leaving health plans too little time to have implemented the requirements of the proposed Rule. Notably, the January 15th date is a change in reporting procedure. Under the existing version of Rule 1300.67.2.2(g)(2), health plans have used a network capture date of December 31st. However, the DMHC has determined it necessary to specify a January network capture date under the proposed Rule 1300.67.2.2 because many provider-plan contracts are effective for a calendar year. From late December through early January of the next year, provider-plan contracts are often in a state of flux, as the health plans and providers enter, terminate, or renegotiate their contracts. Additionally, stakeholders informed the DMHC that January 15 is a feasible network capture date. Therefore, the DMHC determined that January 15 is the appropriate network capture date because the health plan networks are more stable by this time.

Subsection (b)(7) of Rule 1300.67.2.2 defines “network identifier” as the identifier assigned to each health plan network. This definition is necessary to clarify instructions related to completing the network access profile on the DMHC’s web portal. This definition is also necessary to effectuate the reporting requirements under Health and Safety Code sections 1367.03 and 1367.035, by ensuring that the DMHC can track a particular health plan network as it assesses compliance with the law. This will result in the benefit of efficient regulatory review by the DMHC.

Subsection (b)(8) of Rule 1300.67.2.2 defines “network name” as the name a health plan uses to identify a specific network in communications with and submissions to the DMHC. The purpose of this provision is to clarify the term “network name” as distinct from other similar-sounding, but different terms used in the Rule (e.g., “network,” proposed in

¹⁸ E.g., Exhibits (H) and (I) of subdivision (d) of Rule 1300.51.

subsection (b)(4), “network identifier,” proposed in subsection (b)(7), etc.). This definition addresses the problem that a health plan’s network may be described in many ways. Defining “name of network” will ensure that health plans and the DMHC use and understand this term consistently. Consistent terminology is necessary to implement the reports required under Health and Safety Code sections 1367.03 and 1367.035 by assisting health plans to complete report forms correctly before submission to the DMHC.

Subsection (b)(9) of Rule 1300.67.2.2 defines “network provider.” The definition’s reference to Health and Safety Code section 1345 ensures consistency with the statutory definition of “provider.”¹⁹ The definition specifies that a “network provider” is a provider who meets all specified criteria specified in subsection (b)(9) of the Rule.

Subsection (b)(9)(A) specifies the criterion that the provider is available to provide covered services to all health plan enrollees in all product lines²⁰ using the network. This criterion addresses the problem that health plans can specify rules or limits for accessing certain providers, which may have the practical effect of stratifying the network and impeding reasonable access to care, unless health plans ensure reasonable access to care *at the network level*. To effectuate Health and Safety Code section 1367.035(d) and accurately assess the adequacy of a health plan’s network, it is necessary to count only providers that serve a health plan’s entire network. Measuring network adequacy by counting providers that do not actually serve the whole network would prevent the statute’s purpose of ensuring enrollees have ready access to care. Thus, subsection (b)(9)(A) is necessary to ensure that only providers that serve the plan’s whole network count for the purpose of network adequacy.

Subsection (b)(9)(B) identifies what types of relationships a provider may have with a health plan, to be considered a “network provider.” Subsections (b)(9)(B)(i)-(v) specify employment and contractual relationships a network provider (or group of providers) may have with a health plan (or health plans), consistent with existing laws. It is necessary to specify that these relationships can support the categorization as a “network provider,” in order to clarify other provisions of the proposed Rule that use the term “network provider” (e.g., proposed Rule 1300.67.2.2(b)(4) and (b)(15)). Additionally, these criteria for status as a “network provider” are necessary to effectuate requirements under Health and Safety Code sections 1367.03 and 1367.035. As noted, standardized terminology is necessary to allow health plans to understand their obligations and to allow efficient compliance review by the DMHC. Additionally, this definition is necessary to effectuate the purpose of access-related laws such as Health and Safety Code section 1367, which requires health care services to be readily available at reasonable times. The proposed subsection (b)(9) implements the purpose of this statute by specifying what types of relationships may exist between providers and health plans. This information will enable the DMHC to ascertain that those providers are available to enrollees and the health plan’s provider network is adequate to serve its enrollees.

¹⁹ Health and Safety Code section 1345(i): “Provider” means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

²⁰ “Product line” is proposed to be defined in Rule 1300.67.2.2(b)(13).

Subsection (b)(9)(B)(v) specifies that a “network provider” may also be a provider that is required to be part of the health plan’s network under a corrective action plan pursuant to Health and Safety Code section 1373.65, or as otherwise ordered by the DMHC. This provision addresses the problem that the DMHC may require a health plan to include certain providers in the health plan’s network in a manner that does not clearly fall within the other provider/plan relationships described in subsection (b)(9)(B), but under circumstances where the provider should nonetheless be considered a “network provider.” For example, pursuant to Health and Safety Code section 1373.65, before a health plan terminates a contract with a provider group or general acute care hospital, the health plan must submit an “enrollee block transfer” filing to the DMHC and comply with statutory notice requirements. The purpose of Health and Safety Code section 1373.65 is to ensure that the termination of such a contract does not unduly disrupt care for the health plan’s enrollees, who would normally receive care from the hospital or provider group. Accordingly, when the DMHC receives a block transfer filing from a health plan, the DMHC reviews the health plan’s network to see whether the loss of the hospital or provider group would cause a deficiency in the health plan’s network. If there would be such a deficiency, the DMHC issues an Order designed to ensure that enrollees continue to access care. This Order may require the health plan to bolster the network by adding certain providers. Subsection (b)(9)(B)(v) ensures that providers required to be part of a health plan’s network pursuant to this type of Order are included as “network providers.” This provision will result in the benefit that health plans and the DMHC count all relevant providers for the purpose of assessing network adequacy, which is necessary to effectuate the purposes of Health and Safety Code sections 1367.03 and 1367.035.

Subsection (b)(9)(C) specifies that a network provider must be accessible to enrollees without limitations other than established in-network referral or authorization processes that apply to all network providers. Similar to subsection (b)(9)(A), subsection (b)(9)(C) addresses the problem that health plans may establish protocols enrollees must follow to see certain providers, and those protocols may interfere with reasonable access to care from those providers. Subsection (b)(9)(C) is necessary to ensure that only providers who are truly available to all enrollees served by the health plan’s network count for the purpose of assessing network adequacy.

Subsection (b)(9)(C) also specifies that where enrollees are assigned to a provider group a “network provider” must be accessible through established processes for changing provider groups consistent with Health and Safety Code section 1373.3. Health and Safety Code section 1373.3 ensures enrollees may choose any primary care physician (PCP) contracted with the health plan in the service area. Subsection (b)(9)(C) addresses the problem that it has become common for health plans to assign the health plan’s enrollees to an entity such as a provider group, and such assignment often determines what providers are immediately accessible to the assigned enrollees. When a health plan assigns its enrollee to a provider group, that enrollee may access care only within that specific provider group. However, it would be unfeasible for the health plan to maintain a comprehensive network applicable to each individual provider group, and it would also be unfeasible for the DMHC to assess the adequacy of the provider group as if it were a complete network. However, an enrollee assigned to a provider group has the option

pursuant to Health and Safety Code section 1373.3, to choose assignment to a different PCP. When an enrollee chooses a new PCP, the enrollee may access the health plan's network beyond the previously-assigned provider group. Subsection (b)(9)(C) therefore has the benefit of ensuring that health plans report network data appropriately in the context of enrollment assignment. This will result in a more efficient network adequacy compliance review by the DMHC.

Finally, subsection (b)(9)(D) excludes from the definition of "network provider" specified providers who must not be counted for the purpose of assessing the adequacy of a health plan's network. Subsection (b)(9)(D)(i) excludes providers available only through single-case agreements, letters of intent, or similarly limited contract agreements. These are all *ad hoc* agreements for a provider to render care to an enrollee, when the provider is out-of-network. Additionally, under subsection (b)(9)(D)(ii), in regard to lines of business that have an out-of-network benefit (such as a preferred provider organization (PPO) or point-of-service plan (POS)), network provider excludes those providers available only at out-of-network benefit levels. Although existing law requires health plans to arrange for care from out-of-network providers when necessary, and although some health plans pay for a portion of out-of-network services, these out-of-network providers do not count towards assessing network adequacy. The exclusion of out-of-network providers from the definition of "network provider" is logical and necessary to effectuate existing law, including Health and Safety Code section 1367.035, which requires reports regarding existing network adequacy and therefore should consider only providers who are truly in-network. Similarly, subsection (b)(9)(D)(iii) excludes noncontracting individual health professionals, as defined in Health and Safety Code section 1371.9, because those are out-of-network providers. This provision will result in the benefit of clear definitions that allow the health plan to understand its obligations when reporting and will support efficient compliance review by the DMHC.

Subsection (b)(10) of Rule 1300.67.2.2 defines "network service area" as the geographical area and population points contained within that geographical area where the health plan is approved by the DMHC to arrange health care services consistent with network adequacy requirements. Subsection (b)(10) further defines "population points" as a representation of where people live and work in California, based on United States Census Bureau (USCB) population data and United States Postal Service (USPS) delivery route data, accessible on the DMHC's web portal. Subsection (b)(10) is necessary to define "network service area" in a manner consistent with existing laws, and in a manner that accounts for California's geography. For example, subsection (b)(10) interprets Health and Safety Code section 1345(k)'s definition of "service area," ("*...a geographical area designated by the plan within which a plan shall provide health care services*"), by adding specificity for the purpose of network adequacy compliance. Currently, the DMHC approves health plan licenses for operation within specific geographic regions (service areas), and DMHC approval requires the health plan to demonstrate access to basic health care services throughout the service area.²¹ Existing health plan licensure regulations also state the DMHC's evaluation of accessibility will include consideration of actual and projected enrollment, based on the residence and

²¹ See HSC section 1367; see also Rule 1300.67.2

place of work of enrollees.²² The proposed subsection (b)(10)'s definition of "network service area" includes "population points" to address the problem that, within California, there are both densely populated areas and sparsely-populated areas or unpopulated areas. For example, a service area within San Bernardino County can include both very populous urban regions as well as extremely sparsely populated regions. To ensure meaningful accessibility of health care services within this county, it is necessary to consider population distribution so that the network truly serves the needs of the health plan enrollees. Consideration of population points is therefore necessary to implement the statutory definition of "service area," for the purpose of accessibility of health care services and network adequacy, by measuring population according to an objective data sources, namely USCB and USPS data. This definition will result in the benefit of network adequacy reporting and compliance review based on California's real geography and population.

Subsection (b)(11)(A) of Rule 1300.67.2.2 defines "patterns of non-compliance" (PON), effective January 1, 2022, as a network with a PAAS rate of compliance in a single measurement year of less than 70% for non-urgent or urgent appointments. The PON definition applies with respect to the standards set forth in subsection (c), i.e., timely access standards. The PAAS methodology²³ requires each health plan to survey its network to determine appointment availability and determine the percentage of providers in the network that have an appointment available within the regulatory timeframes required under Rule 1300.67.2.2(c)(5) (herein called the "time-elapsed standards"). The definition of PON is necessary to effectuate Health and Safety Code sections 1367, 1367.03, and 1367.035 by creating an unambiguous and enforceable compliance standard for the time-elapsed timely access standards in Rule 1300.67.2.2(c)(5). This definition is also necessary to result in a TAR that allows consumers to compare health plan performance regarding timely access to health care services.

The purpose of the proposed definition of PON is to clarify existing requirements under Rule 1300.67.2.2 and the DMHC's current-APA-exempt PAAS methodology. Specifically, existing Rule 1300.67.2.2(g)(2)(B) requires a health plan to report its rate of compliance with the time-elapsed standards, which health plans measure using results from the PAAS. The existing Rule 1300.67.2.2(g)(2)(C) also requires health plans to report whether the health plan identified any PON. Health and Safety Code section 1367.03(g)(1) and existing Rule 1300.67.2.2(g)(3) also both require the DMHC to "focus more" upon PON than on isolated episodes of non-compliance when determining a health plan's compliance with time-elapsed standards.

The proposed Rule 1300.67.2.2(b)(11)(A) addresses the problem that the existing Rule 1300.67.2.2 does not specify a standardized methodology a health plan must use to measure its rate of compliance. Health plans currently measure their rates of compliance using the results from their PAAS, but that requirement stems from the DMHC's APA-

²² See Rule 1300.51, item H.

²³ The details of the PAAS and the standardized PAAS methodology may be found in this ISOR's discussion of proposed Rule 1300.67.2.2(f) and the PAAS Manual, which is proposed to be incorporated by reference into Rule 1300.67.2.2.

exempt guidance issued pursuant to Health and Safety Code section 1367.03(f)(3), which expires January 1, 2020. After the APA exemption expires, the lack of a standardized methodology will mean health plans measure their rates of compliance in various ways, and no single, standardized minimum rate of compliance could be used for all health plans. The lack of a standardized way to measure the rate of compliance also will result in TARs that are not comparable, as required by Health and Safety Code section 1367.03(f)(2). Finally, proposed Rule 1300.67.2.2(b)(11)(A) addresses the problem that the DMHC must focus its timely access compliance review on PON, but PON is an ambiguous term. The ambiguity regarding what constitutes a PON makes compliance and enforcement challenging for health plans and the DMHC.

The DMHC now proposes to codify the status quo²⁴ and add to Rule 1300.67.2.2 the requirement for require health plans to measure their rates of compliance with time-elapsd standards by administering the PAAS in accordance with the proposed Rule's standardized methodology.

The proposed subsection (b)(11)(A) would also add a definition of PON based on specified threshold (minimum) rates of compliance. Since the proposed Rule will require all health plans to use the standardized PAAS methodology to uniformly measure network adequacy under the time-elapsd standards, it is now also appropriate to set a threshold rate of compliance that will establish a consistent compliance threshold for all health plans. The proposed threshold (minimum) rates of compliance in subsection (b)(11)(A) address the ambiguity problem by establishing what rate of compliance the DMHC will consider to be a PON (and thus, the focus of the Department's timely access and network adequacy compliance reviews). The definition of PON will result in the benefit of a clear and uniform compliance standard that will help health plans understand their obligations and requirements under the Knox-Keene Act. The proposed definition of PON will also result in a TAR that is comparable, as required by Health and Safety Code section 1367.03(f)(2).

The DMHC determined that the specific 70% rate for both non-urgent and urgent appointments is necessary because the rate:(1) allows enrollees to obtain timely appointments, (2) requires reasonable efforts (rather than extraordinary efforts and associated expenditures) on the part of health plans, and (3) considers appropriate patterns of practice of delivering health care services by the types of providers measured across the health care industry. The specific rationale for the 70% threshold rates of compliance is outlined, below.

Rationale for Threshold Rates of Compliance in Proposed Subsection (b)(11)(A)

Although each health plan enrollee has the right to access an appointment with a provider in the enrollee's assigned network within the timeframes set forth in Rule

²⁴ Regarding the status quo: health plans currently conduct the PAAS according to the Department's methodology, required under APA-exempt guidance (HSC section 1367.03(f)(3)). Details of the standardized PAAS methodology are discussed in connection with proposed Rule 1300.67.2.2(f), and the PAAS Manual.

1300.67.2.2(c)(5), the Knox-Keene Act does not require each network provider to maintain (at all times) an appointment available within the time-elapsed standards. Requiring all providers to constantly maintain appointment availability within the time-elapsed standards would significantly limit a provider's ability to take a leave of absence and such a requirement could significantly increase provider contract costs, ultimately leading to premium increases for consumers. It is also important to note that the Knox-Keene Act does not require that an enrollee have access to a timely appointment with a specific provider or at a specific time that is convenient for the enrollee's schedule. As a result, a 100% threshold rate of compliance for time-elapsed standards is unworkable, and is also inconsistent with the requirements and goals of existing timely access laws. If a provider does not have an appointment available within the time-elapsed standards, but the health plan is able to provide an appointment with another appropriate provider in the health plan's network within the regulatory timeframes, the health plan's network has met its Knox-Keene Act requirements for the enrollee.

The PAAS determines the likelihood of an enrollee obtaining an appointment after contacting the initial provider. Allowing the possibility of additional contacts in connection with measuring network compliance with time-elapse standards is necessary to account for realistic conditions, patterns of practice within the health care industry. Allowing the possibility of additional contacts is also necessary because, under the law, a timely appointment must be available somewhere within the network, but not necessarily on the schedule of each individual provider.

In either a PPO model or HMO model health plan, more than one contact may be required in order to obtain an appointment within the time-elapsed standards. In a PPO model, an enrollee may typically obtain services from any provider within the network. As a result, the enrollee may need to contact more than one provider to obtain a timely appointment. In an HMO model, the following examples are common situations where additional contacts requesting an appointment are necessary:

- If an enrollee's assigned PCP is not available when needed or within the required regulatory timeframes, the appointment scheduler may review the schedules of other providers and offer a timely appointment with a different PCP in the same office or elsewhere within the provider group. Although, in this situation, an enrollee may ultimately arrange an appointment by making a single telephone call, each provider schedule reviewed by the scheduler when making the appointment constitutes a "contact" for purposes of the tables set forth below. In the HMO model, if a timely appointment cannot be obtained (or if the enrollee is dissatisfied with what is available), the enrollee may also choose to contact his or her health plan for assistance in scheduling the appointment and/or locating an appropriate provider.
- If an enrollee receives a referral to a specific provider (e.g., a particular specialist physician or ancillary provider) who does not have a timely appointment, the enrollee can contact his or her health plan to seek assistance in obtaining a timely

appointment with another specialist or ancillary provider within the health plan's network. In such situations, the health plan may contact network providers on behalf of the enrollee to secure a timely appointment.

The situations noted above are not intended to present an exhaustive explanation as to how enrollees obtain appointments within HMO and PPO model health plans. Rather, the goal of these examples is to lay a foundation for the analysis found in the table set forth below, which explains how checking the schedule of multiple providers for availability (which frequently occurs in both the HMO and PPO models, as explained above) naturally leads to a higher probability that an enrollee will receive a timely appointment. The purpose is to explain how checking schedules for appointment availability under the PAAS translates (to the extent possible) to real-world appointment availability for a particular enrollee who contacts his or her PCP or is referred to a specialist.

In any of the above situations, an enrollee in a PPO or HMO may contact the DMHC's Help Center for additional assistance. The DMHC may contact the health plan and/or network providers on behalf of the enrollee to obtain a timely appointment.

By requiring that a health plan's network be sufficient to provide an appointment within the time-elapsd standards across no more than three contacts, the DMHC has specified the number of attempts an enrollee can reasonably be expected to make, to get an appointment within the time-elapsd standards. In other words, the DMHC has set a maximum level of effort required to obtain a timely appointment and accounted for the patterns of practice in which health care is delivered. Further, the DMHC is able to maintain statistical validity of the reported results (i.e., no results from providers who were not included in random sampling under the PAAS), while leveling the playing field among differing provider office sizes, health plans, more various contracting arrangements, and variations between particular geographic areas.

Table 2, below, shows the results of the PAAS in the first column and the likelihood of an enrollee obtaining a timely appointment when **three** providers are contacted within a health plans network.

Table 2:

| One Contact (PAAS Results) | Three Contacts (Likelihood that an enrollee will obtain a timely appointment) |
|----------------------------------|--|
| 30% | 66% |
| 35% | 73% |
| 40% | 78% |
| 45% | 83% |
| 50% | 88% |
| 55% | 91% |
| 60% | 94% |
| 65% | 96% |

| One Contact (PAAS Results) | Three Contacts (Likelihood that an enrollee will obtain a timely appointment) |
|----------------------------------|--|
| 70% | 97% |
| 75% | 98% |

Subsection (b)(11)(B) further defines PON to include circumstances where the DMHC finds three or more instances within a period of a year or less when the health plan's network was unable to deliver timely, available or accessible health care services in accordance with the Rule's timely access standards, as demonstrated by additional sources of data or information, including DMHC findings of non-compliance pursuant to proposed Rule 1300.67.2.2(i)(1)(B). The definition of PON, including these types of recurrent failures, is necessary to effectuate the purpose of Health and Safety Code section 1367.03, which directs the DMHC to focus its compliance reviews on PON. While subparagraph (A) is specific to rates of compliance measured by the PAAS, subparagraph (B) is necessary to ensure that the DMHC can also enforce requirements for timely access to health care services based on other appropriate sources of information.

Subsection (b)(12) of Rule 1300.67.2.2 defines "plan-to-plan contract" as an arrangement between two health plans, in which the subcontracted plan makes network providers available to primary plan enrollees, and may be responsible for primary plan functions. Subsection (b)(12)(A) defines "primary plan," and (b)(12)(B) defines "subcontracted plan." The network providers accessible to primary plan enrollees through a plan-to-plan contract are part of the primary plan's network,²⁵ for the purpose of assessing network adequacy. Without a definition of a plan-to-plan contract, it is unclear what arrangements constitute a plan-to-plan contract for the purpose of network adequacy reporting and compliance review. This could lead to reporting errors and potential compliance issues and so it is necessary to define these terms.

The definition of plan-to-plan contract specifies that administrative services agreements (ASA), management services agreements (MSA), and other contracts between a primary plan and subcontracted plan fall under the definition of "plan-to-plan" contract. This definition addresses the problem that a licensed health plan can make many types of contractual arrangements to let enrollees access another health plan's network. Health plans sometimes make sub-delegation arrangements, under which a subcontracted plan contracts with another subcontracted plan. Such contracts are permissible, but can create confusion about each health plan's responsibilities for Knox-Keene Act compliance, depending on how the health plans characterize the contracts, and whether the contracts are disclosed to the DMHC. For example, in the DMHC's experience, some health plans have questioned whether an ASA is a plan-to-plan contract that must be reported to the DMHC. In order for the DMHC to enforce network adequacy for the primary plan, it is necessary for Rule 1300.67.2.2 to address all plan-to-plan contracts that impact the

²⁵ See proposed Rule 1300.67.2.2(b)(9)(B)(iv), regarding network providers designated to deliver covered services to enrollees in the network through a plan-to-plan contract.

primary plan's network. Addressing all of these contracts is necessary to implement Health and Safety Code section 1367, which states in part: "[t]he obligation of the plan to comply with this chapter [the Knox-Keene Act] shall not be waived when the plan delegates any services that it is required to perform to its [...] contracting entities." In other words, a health plan may contractually delegate functions to another entity, but the health plan remains responsible for complying with the Knox-Keene Act. It is necessary to clearly define "plan-to-plan contract" to realize the statute's purpose that a primary health plan remains ultimately responsible for complying with network adequacy laws under the law. This will result in the benefit of effective compliance review by the DMHC, even in the context of complex plan-to-plan contractual arrangements.

Subsection (b)(13) of Rule 1300.67.2.2 defines "product line" as the combination of the health plan's product and the type of market segment (e.g., individual, large group, small group, or government) within a network service area. It is necessary to define "product line" to implement the purpose of Health and Safety Code section 1367.035(b)-(c), which require separate submission of network adequacy data by product line. Further, subsection (b)(13) defines "product" as a discrete package of health care benefits the health plan is licensed to offer using a particular line of business (e.g., health maintenance organization (HMO), PPO, POS, and exclusive provider organization (EPO)) within a network service area. It is necessary to define "product" in this manner to clarify the related definition of "product line," while remaining consistent with the related federal definition of "product" at 45 C.F.R. section 144.103.²⁶ These definitions of product line and product will ensure that health plans and the DMHC each use consistent terminology, which will allow health plans to understand their obligations and support efficient compliance review by the DMHC.

Subsection (b)(14) of Rule 1300.67.2.2 defines "provider group." This existing definition was formerly designated (b)(4) in Rule 1300.67.2.2, and has been renumbered to accommodate the new, proposed definitions in subsection (b). This definition has been amended non-substantively for greater clarity and consistency with the rest of the proposed rule (e.g., referencing the "Knox-Keene" Act).

Subsection (b)(15) of Rule 1300.67.2.2 defines "provider survey types" as the five types of network providers required to be surveys in the PAAS Manual, pursuant to subsection (f) of Rule 1300.67.2.2. Health plans have conducted the PAAS using these provider survey types for the past several years, since the enactment of SB 964, and the proposed Rule would codify the requirement in anticipation of the expiration of the APA exemption under Health and Safety Code section 1367.03(f)(3) on January 1, 2020. This definition of "provider survey types" is necessary to effectuate the purpose of Health and Safety Code section 1367.03(f), which requires the annual TAR. Under the proposed Rule 1300.67.2.2, and as described in subsection (f) and the PAAS Manual, health plans report timely access compliance pursuant to Health and Safety Code section 1367.03(f) using

²⁶ 45 C.F.R. section 144.103, in pertinent part, defines "product" as a discrete package of health insurance coverage benefits that are offered using a particular product network type (such as health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity) within a service area.

results from the PAAS. Health plans conduct the PAAS by surveying five types of providers: (A) PCPs and non-physician medical practitioners providing primary care; (B) specialist physicians; (C) psychiatrists; (D) non-physician mental health care providers; and (E) ancillary service providers. It is necessary to require the PAAS to survey these five types of providers so that the health plan TAR addresses a comprehensive range of providers who serve enrollees, and to align with existing law. Existing Rule 1300.67.2.2(c)(5) establishes time-elapsed standards for the same five provider types. It is necessary to align the PAAS with the provider types in subsection (c)(5) because health plans use the PAAS to measure and report their compliance with subsection (c)(5). Additionally, it is necessary to identify the provider survey types based on the ability of health plan's to clearly identify the provider to produce reliable and comparable results across the industry. The definition of "provider survey types" will result in the benefit of clarity regarding what providers must be surveyed during the PAAS.

Subsection (b)(16) of Rule 1300.67.2.2 defines "reporting plan" as the health plan required to submit the reports in subsection (h) (i.e., the TAR and ANR), on behalf of itself or on behalf of a subcontracted plan. The definition of "reporting plan" is necessary to clarify what health plan must submit the TAR and ANR, and addresses the problem that complex contracting arrangements between different health plans cause confusion about who must submit the TAR and ANR. This definition will result in the benefit of clarity regarding health plan reporting obligations under Health and Safety Code sections 1367.03 and 1367.035, and Rule 1300.67.2.2.

Subsection (b)(17) of Rule 1300.67.2.2 defines "reporting year" as the calendar year (CY) in which the health plan's TAR or ANR is submitted to the DMHC. The definition of "reporting year" is necessary to clarify the meaning of that term, as distinct from similar-sounding terms in Rule 1300.67.2.2 (e.g., "measurement year"). This definition is necessary to implement the reporting requirements under Health and Safety Code sections 1367.03 and 1367.035 by establishing clear terminology that will allow health plans to understand their reporting obligations. The term "reporting year" is particularly important for understanding some of the implementation dates within proposed Rule 1300.67.2.2. Specifically, proposed subsection (h) is titled "Filing, Implementation and Reporting Requirements for Reporting Year 2022 [...]." Subsection (h) describes TAR- and ANR-related requirements for reporting year 2022 and beyond, i.e., the reports annually due on May 1, 2022. As noted in section II.D of this ISOR, the proposed new data collection and reporting requirements must take effect the year *following* promulgation of this regulation package, to give health plans the necessary time to update their processes and comply. In the meantime, proposed Rule 1300.67.2.3 preserves the current data collection and reporting processes for the first year after promulgation of this regulation package (measurement year 2021). Thus, the term "reporting year" must be clearly defined in order to direct health plans to the requirements effective for 2021 and 2022, and beyond. This will result in the benefit of health plans understanding which rules govern their TAR and ANR.

Subsection (b)(18) of Rule 1300.67.2.2 defines "Triage" or "screening." Subsection (b)(19) defines "Triage or screening waiting time." Subsection (b)(20) defines "urgent care." These definitions exist in the current Rule 1300.67.2.2, and are substantively

unchanged except for having been renumbered to accommodate the other, new definitions in subsection (b), as proposed to be amended.

The large majority of subsection (c) of Rule 1300.67.2.2 has been amended non-substantively for consistency with newly-defined terms in proposed subsection (b), and reduced redundancy with other provisions of the regulation. Subsection (c)(1) is amended to use the now-defined term “network,” instead of “provider networks,” in order to be consistent with the definition in proposed subsection (b)(5). Additionally, it is necessary to remove the word “provider,” because the proposed definition of “network” now clarifies that the term refers to providers, and qualifying the term “network” further would be redundant and potentially confusing for impacted stakeholders. This repeal will result in the benefit of consistency and clarity within the Rule.

Subsection (c)(2) of Rule 1300.67.2.2 repeals language specifying that health plans shall ensure that all health plan and provider processes necessary to obtain covered health care services, including, “*but not limited to*”, the noted processes. It is necessary to strike the phrase “but not limited to” because it is redundant; the word “including” means that the noted processes are not an exhaustive list. The DMHC also repealed the phrase “but not limited to,” for the same redundancy reasons throughout the proposed Rule.²⁷ These repeals will result in the benefit of reduced redundancy, which will improve the clarity of the Rule. Additionally, the DMHC replaced “prior authorization processes,” with “the processes required under section 1367.01 of the Knox-Keene Act.” This repeal and adoption is necessary to clarify the meaning of the term “prior authorization processes.” Health and Safety Code section 1367.01 contains the relevant requirements for prior authorization processes, and referencing this specific statute will result in the benefit of greater clarity by directing health plans and stakeholders to the correct law for compliance purposes.

Subsection (c)(3) of Rule 1300.67.2.2 contains non-substantive amendments for consistent formatting, by removing the capital “S” in “section,” and referencing the “Knox-Keene” Act rather than just “Act.” Using consistent terminology will have the benefit of clarifying the regulation and allowing impacted stakeholders and health plans to better understand the regulatory requirements and where to locate them when they are referenced in this provision. The DMHC made these same amendments in relevant provisions throughout the proposed Rule, for the same reasons.

Subsection (c)(4) of Rule 1300.67.2.2 contains the same non-substantive amendments referenced in subsection (c)(3), and also repeals the reference to “Title 28,” because this reference is unnecessary. The DMHC similarly repealed references to Title 28 throughout the Rule, to remove extraneous language and clarify the Rule. This is a non-substantive amendment to the Rule. Additionally, subsection (c)(4) addresses the problem that the existing requirement for coordination of interpretation services may be misinterpreted in an overly prescriptive way. Specifically, the proposed amendment to subsection (c)(4) addresses the problem that the existing rule could be misinterpreted to require scheduling

²⁷ See Rule 1300.67.2.2, subsections (c)(5)(H), (d)(2)(D), (d)(3), (g)(2), (i)(1) and Rule 1300.67.2.3, subsections (b)(3).

interpreter services when the appointment is scheduled. The proposed amendment clarifies that while interpreter services shall be coordinated with scheduled appointments in a manner that ensures the provision of those services at the time of the appointment, interpreter services are not required to be scheduled at the same as the scheduling of the appointment. Although the amendment does not modify any existing requirements in Health and Safety Code section 1367.04 (regarding access to language assistance services) or Rule 1300.67.04 (Language Assistance Programs), this provision is necessary to clarify the existing requirement for coordination of interpreter services. The proposed amendment will clarify that health plans may schedule and coordinate interpreter services, consistent with existing law, including Rule 1300.67.04(c)(2)(G)(v).²⁸

Subsection (c)(5) of Rule 1300.67.2.2 amends “contracted provider network” to use the now-defined term “network” for the same reasons discussed in subsection (a)(3): using consistent terminology will have the benefit of clarifying the regulation and allowing impacted stakeholders and health plans to better understand the regulatory requirements in this provision. In subsection (c)(5)(H), it is necessary to repeal the reference to the definition of preventive care services contained in the previous version of subsection (b)(3), because that definition has been deleted. In subsection (c)(6), it is necessary to replace “contracted dental provider networks” with “dental networks,” to be consistent with the definition of “network” in proposed subsection (b)(4). Additionally, it is necessary to repeal the word “provider,” because the proposed definition of “network” now clarifies that the term refers to providers, and qualifying the term “network” with the word “provider” would be redundant and confusing. This repeal will result in the benefit of consistency and clarity within the Rule.

Subsection (c)(7) contains non-substantive amendments. The non-substantive amendments include changing the phrase “contracted providers” to “network providers” to be consistent with proposed subsection (b)(9), and deleting the language, “...of Title 28,” for the same reasons previously described in subsection (c)(4): the reference to “Title 28,” is unnecessary and removing extraneous language clarifies the Rule. This subsection also non-substantively updates the reference to “service areas” to “network service areas,” consistent with the proposed definition in subsection (b)(10). Using consistent terminology will have the benefit of clarifying the regulation and allowing impacted stakeholders and health plans to better understand the regulatory requirements contained in this provision. The DMHC made these same amendments in relevant provisions throughout the proposed Rule, for further consistency in the regulation.

²⁸ E.g., Rule 1300.67.04(c)(2)(G)(v) states, in pertinent part: “Processes and standards for providing individual enrollee access to interpretation services at points of contact at no charge, including, but not limited to: [...] For purposes of this subsection “timely” means in a manner appropriate for the situation in which language assistance is needed. Interpretation services are not timely if delay results in the effective denial of the service, benefit, or right at issue. A plan's language assistance program shall specify quality assurance standards for timely delivery of language assistance services for emergency, urgent and routine health care services, and shall include standards for coordinating interpretation services with appointment scheduling.”

Subsection (c)(7)(A) contains a non-substantive amendment to reference plural “ratios” of providers-to-enrollees, which is consistent with and more clearly descriptive of existing Health and Safety Code section 1375.9. Subsection (c)(7)(B) also adds a reference to point-of-service (POS) plan networks, in addition to PPO networks. Similar to PPOs, POS health plans include an out-of-network benefit, and health plans must assist enrollees to locate network providers in neighboring service areas, when necessary. These amendments will clarify the existing requirements and allow health plans to understand the regulatory requirements contained in these provisions.

Additionally, subsection (c)(7)(C) contains amendments necessary to clarify a health plan’s obligations to arrange for the provision of covered services from out-of-network providers if the services are unavailable within the health plan’s network. Instead of referencing “specialty” services from “specialists,” the amended language refers to “covered services” from “providers.” The amendment is necessary to implement Health and Safety Code section 1367, which requires plans to provide “ready referral of patients to other providers,” consistent with good professional practice. That statutory requirement is not limited to specialist providers, so the Rule must be clarified to avoid appearing to impair the scope of the statute. The amended language also conforms to the DMHC’s practice in resolving consumer complaints regarding timely access to any covered service – not just specialist services. Additionally, the amended language will not necessitate a change for health plan operations, because existing law already requires health plans applications for licensure to include a detailed description of the health plan’s referral system, including its procedures for following up on in-network *and out-of-network* referrals.²⁹ The Rule’s original language highlighted specialist services from specialist providers because it was the DMHC’s understanding at the time that this was the primary context for out-of-network referrals. Subsequent to the original Rule, however, experience has shown that such referrals are common for other provider types, included non-specialists. The proposed amendment will result in the benefit of clarifying that the requirements for arranging out-of-network services is not limited to specialty services and prevent confusion amongst impacted stakeholders.

The proposed amendment to subsection (c)(7)(C) is also amended to clarify that “[p]lans shall ensure that” enrollee cost sharing (e.g., copayments, coinsurance, and deductibles) do not exceed applicable “in-network” amounts. The amendment addresses the problem that enrollees typically pay their cost sharing to providers at the time of service, and without necessarily involving the health plan, meaning there is a significant potential for incorrect billing of cost sharing amounts. The amendment also addresses the issue that the meaning of “applicable” cost-sharing may be misunderstood by health plans and enrollees. The clarifying amendments are necessary to implement Health and Safety Code sections 1367 and 1367.035, both of which require health plans to ensure ready access to necessary health services, and to maintain adequate networks. The proposed language, “[p]lans shall ensure...”, is necessary to clarify that the health plan bears the responsibility to ensure that the enrollee is not overcharged for accessing services. Subsection (c)(7) pertains to circumstances where the necessary provider is not available within the health plan’s network, and the health plan must refer the enrollee to an out-of-

²⁹ See Rule 1300.51, Exhibit I-6.

network provider, pursuant to Health and Safety Code section 1367(d). The existing Rule 1300.67.2.2 states that, under those circumstances, the enrollee will pay only the “applicable” cost sharing amounts, which is intended to ensure enrollees do not incur financial detriment as a result of a health plan’s failure to maintain an adequate network of providers. However, the word “applicable” is vague and has raised the question of whether, in those cases, the “applicable” cost sharing is the amount for *out-of-network* services, or the amount for *in-network* services, under the enrollee’s health plan contract. The amendment clarifies that the “applicable” cost sharing under subsection (c)(7)(C) is the amount the enrollee would have paid if the appropriate provider had been available in-network: *the in-network cost sharing amount*. The amendments will result in the benefit of correct charges to enrollees, and greater clarity for health plans in understanding their financial obligations under this Rule.

Subsection (c)(8) of Rule 1300.67.2.2, contains non-substantive amendments to conform the formatting to the rest of the Rule, such as referring to singular term, health “plan,” rather than plural (health plans), capitalization, amendments to other terms that are defined under the proposed Rule, and updated cross-references to accommodate the renumbered definitions under the Rule. Subsection (c)(8) has also been reorganized and its subsections have been re-numbered for consistency with the formatting of the rest of the Rule. These changes will improve the clarity of the Rule, and help health plans understand their requirements and where to find relevant information under the new Rule.

Subsection (c)(8)(B)(i)a. of Rule 1300.67.2.2 pertains to telephone triage, and clarifies that the length of wait for a return call from a provider shall not exceed 30 minutes. This amendment is necessary to clarify Health and Safety Code section 1367.03(a)(3), which requires the Department’s timely access regulation to consider waiting times to speak to a provider who is trained to screen or triage an enrollee who may need care. However, this amendment does not change the existing standard because it is consistent with the existing Rule 1300.67.2.2(c)(8)(A), which specifies that triage or screening waiting time must not exceed 30 minutes. Proposed subsection (c)(8)(B)(i)a. merely reiterates that standard, which will have the benefit of ensuring that health plan’s understand the required timeframe for return calls to enrollees.

Subsection (c)(8)(B)(ii)-(iii) of Rule 1300.67.2.2 contains non-substantive amendments, including re-numbering the subsection, using the now-defined terms, and re-wording sentences for internal consistency. Additionally, subsection (c)(8)(B)(iii) repeals the language regarding “an attempt” to assess, etc., the condition of an enrollee, because that language is vague as to what “attempt” means, and the provision is more clear without that word. These amendments do not impact the existing standards. However, consistent formatting and terminology will improve the clarity of the Rule, and help health plans better understand this provision.

Subsection (c)(9) of Rule 1300.67.2.2 contains amendments to clarify that “[a] plan that provides” dental, vision, and other specified services shall ensure that network providers “delivering these health care services” employ an answering service or machine, as specified. This amendment is necessary to address the problem that full-service health plans may also provide the listed types of services. For example, dental services are not

provided only by dental plans. This amendment is necessary to implement Health and Safety Code section 1367 and ensure enrollees have appropriate access to after-hours care consistent with good professional practice for urgent or emergency care.

Subsection (c)(10) of Rule 1300.67.2.2 contains a non-substantive amendment to reference “a plan,” consistent with the rest of the Rule, for the same reasons as discussed in subsection (a)(1)-(2): It is necessary to amend the language from plural to singular and remove extraneous words in order to improve the clarity of this subsection to give health plans and stakeholders a better understanding of the requirements of this subsection.

Subsection (d) of Rule 1300.67.2.2 specifies requirements for a health plan’s quality assurance processes (QAP), effective January 1, 2022.³⁰ It is necessary to specify this delayed effective date to give health plans the time necessary to update their policies and procedures for self-monitoring to be compliant with the requirements of the new Rule. For example, subsection (d)(2)(A) has been amended to specify new subsections (i) and (ii), regarding the requirement for the health plan to track and document its network capacity and availability. The original Rule required tracking/documenting with respect to the standards in subsection (c) (Standards for Timely Access to Care). However, the proposed amendments in subsection (d)(2)(A)(i)-(ii) are necessary to account for the requirement in the proposed Rule to assess compliance with the time-elapsing standards in subsection (c)(5) by administering the PAAS, in accordance with the DMHC’s standardized methodology, pursuant to proposed subsection (f). The requirement for health plans to conduct the PAAS according to the DMHC’s methodology is not new; it has been required pursuant to the DMHC’s APA-exempt methodology for several years. However, this proposed subsection codifies the requirement to measure timely access compliance using the PAAS in Rule 1300.67.2.2. Subsection (d)(2)(A)(i), however, clarifies that, with respect to the other provisions in subsection (c), health plans may track and document network capacity and availability as they see fit. This has the benefit of preserving the existing Rule’s flexibility for health plans to determine how to conduct QAP compliance monitoring for the timely access requirements under subsections (c)(1)-(4) and (c)(6)-(10).

Subsection (d)(2)(B) of Rule 1300.67.2.2 amends the existing requirement for an annual enrollee experience survey (EES), which is one of the existing self-monitoring processes required under the Rule. A non-substantive amendment capitalizes the name of the EES, which will help health plans and stakeholders recognize the EES as distinct from other QAP surveys required under subsection (d), such as the Provider Satisfaction Survey (PSS) conducted pursuant to proposed subsection (d)(2)(C).

Subsection (d)(2)(B)(i) of Rule 1300.67.2.2 contains amendments specifying that the EES shall be conducted in accordance with “a statistically” valid and reliable survey methodology; this amendment addresses a problem with the existing language requiring the EES to be conducted in accordance with a, “valid and reliable survey methodology.”

³⁰ Between the effective date of the proposed Rule 1300.67.2.2 and January 1, 2022, health plan QAP will be governed by proposed Rule 1300.67.2.3(b) (Quality Assurance Processes for Measurement Year 2021).

This existing language is vague because it does not state how the DMHC and health plans determine the survey methodology is valid and reliable. The proposed amendment will add non-prescriptive context appropriate for the survey by clarifying that the health plan's EES methodology should be statistically valid. The resulting benefit is that health plans will understand the requirement of this provision and conduct the EES in a manner that yields useful information about the enrollee experience.

Subsection (d)(2)(B)(ii) of Rule 1300.67.2.2 amends the existing Rule's requirement for the EES to, "ascertain compliance with the standards set forth at subsection (c)." The proposed amendment to this provision clarifies that the EES *must obtain the enrollees' perspectives and concerns regarding obtaining timely appointments* in compliance with the timeliness standards in subsection (c). This is a clarifying change because the EES is already a survey of the health plan's enrollees. However, enrollees are not clinical experts who can assess the clinical appropriateness of their waiting times for appointments, but their perceptions of accessibility and availability still provide valuable insight into the health plan's provision of timely appointments. This amendment will have the benefit of maintaining a non-prescriptive performance standard, while clarifying the information that health plans should obtain through the EES.

Subsection (d)(2)(iii) of Rule 1300.67.2.2 adds to the existing EES a requirement to provide certain notices of rights. Specifically, the amended subsection requires a health plan to inform enrollees of their right to a timely appointment in accordance with the Rule's standards, and their right to receive interpreter services at that appointment, in accordance with existing law. The amendments requiring notice of the right to timely appointments and language assistance are necessary to address the problem that, despite other periodic notices under existing law (e.g., Health and Safety Code section 1367.031, requiring annual notice of timely access and interpreter service rights), enrollees are often unaware of these important rights. In order to implement Health and Safety Code sections 1367, 1367.03, and 1367.04's requirements for timely access to necessary care and appropriate language assistance, it is necessary for enrollees to be aware of their rights. Knowledge of these rights will allow enrollees to seek assistance from the health plan or the DMHC's Help Center when the health plan has not complied with the standards. This, in turn, will allow the health plan and the DMHC to take corrective action to provide timely access and language assistance to the enrollee. Providing notice of these rights with the EES builds upon an existing point-of-contact between health plans and enrollees and will result in the benefit of providing enrollees with information necessary to access timely care in with appropriate interpreter services.

Subsection (d)(2)(B)(iv) of Rule 1300.67.2.2 contains amendments necessary to implement Health and Safety Code sections 1367 and 1367.04, which require clinically appropriate and timely access to health care services, consistent with existing requirements for language assistance programs.³¹ Existing language assistance requirements include coordination of interpreter services with appointments,³² and interpreters who are proficient, knowledgeable about health care terms and concepts, and

³¹ Health and Safety Code sections 1367(e)(3) and 1367.04; see also Rule 1300.67.04.

³² See Rule 1300.67.2.2(c)(4).

who adhere to ethical standards.³³ Although enrollees may be laypersons, their perceptions and perspectives regarding the health plan's interpreter services provide valuable insight into the health plan's language assistance program and its success in ensuring Limited English Proficient (LEP) enrollees can access health care services with the aid of interpreters who allow them to communicate effectively with their provider. The proposed amendments in subdivision (d)(2)(B)(iv) implement Health and Safety Code sections 1367, 1367.03, and 1367.04 by requiring the health plan's EES to evaluate the experience of LEP enrollees in obtaining interpreters services by obtaining the LEP enrollee's perspectives and concerns regarding: 1) coordination of appointments with an interpreter, 2) the availability of appropriate interpreters, and 3) the quality and accuracy of the interpreter services received. These amendments will result in the benefit of information about LEP enrollee experience that will allow the health plan to adjust its processes if the health plan determines an adjustment is appropriate to offer better services to LEP enrollees.

Subsection (d)(2)(B)(v) of Rule 1300.67.2.2 would require the health plan to translate the EES into the enrollee's language, if the health plan knows what the preferred language is and if it is one of the fifteen languages most commonly spoken by LEP enrollees in California, as determined by the Department of Health Care Services (DHCS). As discussed in connection with proposed subsection (d)(2)(B)(iii)-(iv), providing notice of language assistance rights and assessing LEP enrollees' experience are necessary to implement existing timely access and language assistance statutes, including Health and Safety Code sections 1367, 1367.03, and 1367.04. Accordingly, proposed subsections (d)(2)(iii)-(iv) require notice of language assistance rights and seek responses from LEP enrollees. In order for LEP enrollees to understand these notices and provide the requested feedback, the EES must be presented in a language the enrollee understands. The proposed translation requirement is also largely consistent with the existing requirements for health plan language assistance programs, which require health plans to assess the linguistic needs of the enrollee population, to survey enrollees in a manner designed to identify the linguistic needs of each enrollee, and have processes and standards for providing individual enrollee access to interpretation services at points of contact.³⁴ Health plan have the information necessary to appropriately translate the EES so that it is accessible to the target LEP population. This amendment will result in the benefit that LEP enrollees will be able to understand and participate in the EES, which will give the health plan valuable insight to allow the health plan to adjust its language assistance processes if the health plan determines adjustment is appropriate to offer better services for LEP enrollees.

Finally, subsection (d) also contains non-substantive amendments for consistent terminology and formatting, consistent with similar amendments previously described in this ISOR.

Subsection (d)(2)(C) of Rule 1300.67.2.2 amends the existing requirement for an annual provider satisfaction survey (PSS), which is one of the existing self-monitoring processes

³³ See Health and Safety Code section 1367.04(b)(4)(A).

³⁴ See Rule 1300.67.04(c).

required under the Rule. An amendment capitalizes the name of the PSS, which will help health plans and stakeholders recognize the PSS as distinct from other QAP surveys required under subsection (d), such as the EES conducted pursuant to proposed subsection (d)(2)(B). Amendments to subsection (d)(2)(C) also specify the PSS shall be conducted in accordance with “a statistically” valid and reliable survey methodology; this amendment addresses the problem that the existing language requiring the PSS to be conducted in accordance with a, “valid and reliable survey methodology” is vague. Similar to the proposed amendments in subsection (b)(2)(B) (re the EES), the proposed amendment in subsection (d)(2)(C) will add non-prescriptive context appropriate for how a health plan must “obtain” information using the survey by clarifying that the health plan’s PSS methodology should be statistically valid. The resulting benefit is that health plans will understand the requirement of this provision and conduct the PSS in a manner that yields useful information about provider perspectives and concerns regarding existing the health plan’s compliance with timely access standards.

Subsection (d)(2)(C) of Rule 1300.67.2.2, including (i)-(iii), also contain amendments necessary to implement Health and Safety Code sections 1367, 1367.03, and 1367.04, by evaluating provider perspectives and concerns with the health plan’s language assistance program. In particular, the PSS must evaluate provider feedback regarding coordination of appointments with an interpreter, the availability of an appropriate interpreter, and the ability of the interpreter to effectively communicate with the provider on behalf of the enrollee. These amendments are necessary for the same reasons discussed in regard to proposed subsection (d)(2)(B), which added LEP-targeted inquiries to the EES. The existing PSS solicits provider concerns regarding accessibility of health services. LEP enrollees may face obstacles in receiving health care, communicating their needs, and understanding information from their provider. These reasons may all make it particularly difficult for LEP enrollees to receive timely, appropriate health care services. Therefore, it is necessary to include LEP-specific information in the PPS to obtain important feedback directly from the plan’s provider network regarding the efficacy of the health plan’s language assistance program.

Subsection (d)(2)(D) of Rule 1300.67.2.2 contains amendments clarifying a health plan’s requirement to quarterly review information regarding access to services. The amendment adds requirements for a health plan to review network capacity, timely access, and network adequacy requirements set forth in the Knox-Keene Act, which will clarify the existing review requirement. This amendment is necessary to ensure health plans self-monitor their networks and implement Health and Safety Code sections 1367 (ready access to care, including referrals), 1367.03 (timely access to care), and 1367.035 (network adequacy). Subsection (d)(2)(D) is also consistent with the requirements of Rule 1300.70(b)(2), which states that a, *“plan’s governing body, its [quality assurance] QA committee, if any, and any internal or contracting providers to whom QA program responsibilities have been delegated, shall each meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities.”* A minimum quarterly review of the network information available to the health plan is consistent with the quarterly review pursuant to subsection 1300.67.2.2(d)(2)(D), and is necessary to ensure early identification, investigation, and correction of network deficiencies that could lead to inaccessibility of health care services.

Additionally, in the existing language of subsection (d)(2)(D), the word “including” means the information in the subsection is not exhaustive, so the phrase “but not limited to” is repealed because it is redundant and unnecessary. Additionally, the language referencing the EES, PSS, and other specific sources of information is repealed, because it is unnecessary in light of the proposed clarifying amendments described in this paragraph and subsection (d)(2)(F). These amendments will assist health plans in understanding their requirements under this subsection.

Subsection (d)(2)(E) of Rule 1300.67.2.2 amends the existing requirement for health plans to verify the advanced access programs. Advanced access means availability of a primary care appointment within the same or next day of the enrollee’s request as described in Rule 1300.67.2.2(b)(1). The existing Rule requires health plans to confirm that appointments are scheduled in this manner. The proposed amendment clarifies that the verification requirement is every three years. The amendment specifying the three-year verification cycle addresses the problem that the existing Rule is silent about the required interval of the verification, and the proposed language will clarify this issue so that health plans understand the requirement of this provision of the Rule. Additionally, it is appropriate to specify a three-year verification interval because health plans typically credential their network providers on a three-year cycle, and it would be efficient to include the advanced access verification using the same timeframe. However, subsection (d)(2)(E) also specifies that if a provider leaves the advanced access program, the provider must notify the health plan within thirty calendar days. It is necessary to require this notice because otherwise the health plan could assume the provider participates in the advanced access program for the next three years. The health plans must have accurate information or it will impact the accuracy of the health plan’s annual TAR and ANR. The three-year advanced access verification cycle will result in the benefit that health plans continue to confirm that advanced access programs meet the Rule’s definition in practice, while also clarifying the verification requirement in a manner that aligns with other existing health plan practices. Finally, subsection (d)(2)(E)’s references to medical groups and independent practice associations are repealed because those terms are redundant in light of the existing, defined term, “provider groups.”

Subsection (d)(2)(F) of Rule 1300.67.2.2 contains amendments to clarify the existing requirement for health plans to appropriately monitor network adequacy, in light of the amendments to subsection (d)(2)(D). Specifically, health plans providing services through a preferred provider organization (PPO) line of business may, for that product line, demonstrate compliance with the timely access and continuity of care requirements of proposed subsections (d)(2)(A)(i) and within subsection (d)(2)(D), through annual monitoring, as specified. This amendment preserves the existing ability for a PPO plan to demonstrate compliance with those requirements through annual monitoring. However, the amendment clarifies that the ability for a PPO plan demonstrate compliance in that manner remains limited to timely access and continuity of care, and does not extend to the other compliance areas in the amended subsection (d)(2)(D) (i.e., network capacity and adequacy). Thus, subsection (d)(2)(F) clarifies that this subsection does not exempt a health plan providing services through a PPO line of business from other (non-timely access/continuity of care) requirements under subsection (d)(2)(D). The proposed amendments to subsection (d)(2)(F) also specify that a health plan must monitor the

results of the EES and PSS, which will have the benefit of ensuring that the EES and PPS are meaningful and allow health plans to review results and make appropriate adjustments, resulting in health plan programs that better serve enrollees. Finally, subsection (d)(2)(F) repeals the requirement for health plans to monitor the number of PPO primary care and specialty physicians because that monitoring is encompassed by subsection (d)(2)(D), as proposed to be amended. These amendments will allow health plans offering services through a PPO line of business to understand the Rule's requirements for compliance and monitoring.

Subsection (d)(3) amends existing requirements for a health plan's quality assurance program (QAP) by specifying that a health plan must document as well as implement prompt investigation and corrective action when the health plan's compliance monitoring discloses that a network is insufficient. The amendment requiring documentation of the health plan's investigation and corrective action is necessary to ensure that the health plan keeps a record of its network monitoring and corrective efforts. The documentation will allow the DMHC to efficiently review the health plan's response to timely access and network deficiencies, e.g., during regulatory audits pursuant to Health and Safety Code section 1380. Additionally, the amendment specifying that a plan shall document and implement investigation and corrective action when its monitoring shows network inadequacy is necessary to implement Health and Safety Code sections 1367, which requires ready access to necessary health care services, and 1367.035, requiring annual network adequacy data and compliance review. The existing provision of the Rule, which references only deficiencies related to timely access to care, was promulgated prior to SB 964, which added Health and Safety Code 1367.035. It is necessary to add network adequacy issues to the deficiencies that the health plan must address with investigation and corrective action to ensure that the amended Rule 1300.67.2.2 covers both timely access and annual network review. Finally, subsection (d)(3) is amended for grammatical consistency with subsection (d)'s introductory language: "[...]a plan's quality assurance program shall address:[...] "(3) A plan's processes [...]" Rephrasing the language in this manner will allow health plans and stakeholders to better understand the requirements of this subsection.

Subsection (e) of Rule 1300.67.2.2 pertains to "Enrollee Disclosure and Education." Subsection (e)(1) contains amendments to capitalize "Evidence of Coverage," which will help health plans and stakeholders recognize that this phrase refers to a particular document describing coverage under a health plan contract.³⁵ Subsection (e)(1) also repeals language requiring health plans to disclose standards for timely access "annually, in plan newsletters or comparable enrollee communications." Instead, the amended subsection (e)(1) requires the health plan to make that disclosure "in the manner required under section 1367.031 of the Knox-Keene Act." This amendment addresses the problem that Health and Safety Code section 1367.031 governs the annual disclosure and the existing language in subsection (e)(1) could be misinterpreted to narrow the meaning of the standards in the statute. The amended reference to Health and Safety Code section 1367.031 is necessary to ensure consistency between the Rule and the statute, and will result in the benefit that health plans will more clearly understand the requirements of the

³⁵ See Rule 1300.63.1 (Evidence of Coverage).

disclosure provision.

Subsection (f) of Rule 1300.67.2 pertains to the PAAS (the Provider Appointment Availability Survey). As previously noted, under the proposed Rule, the PAAS is the primary way health plans measure a network's compliance with the time-elapsed standards in Rule 1300.67.2.2(c)(5). That is, the PAAS measures a network's ability to offer timely urgent and non-urgent appointments. Health plans use the results from the PAAS to determine and report the network's rate of compliance, which must meet or exceed the minimum rate established in proposed subsection (b)(11)(A) (defining PON). Thus, the PAAS results are a primary component of the health plan's TAR.

Subsection (f)(1)'s requirement for a health plan to report the rate of compliance is necessary because rates of compliance reported pursuant to the proposed Rule's standardized methodology will allow the DMHC and consumers to assess and compare the performance of health plan networks with timely access standards. Subsection (f) of Rule 1300.67.2.2 is necessary to implement Health and Safety Code section 1367.03(f)(2), which requires health plans to annually report to the DMHC on compliance with the timely access standards, which are specified in Rule 1300.67.2.2(c)(5). Further, Health and Safety Code section 1367.03(f)(2) requires a health plan's TAR to allow consumers to compare the performance of health plans and their providers in complying with the timely access standards, as well as changes in the compliance of health plans with these standards (e.g., changes in health plan compliance, from year-to-year). It is therefore necessary to ensure that health plans use a standardized methodology to measure and report their compliance with timely access requirements in the TAR. The PAAS methodology described in proposed subsection (f) and in the PAAS Manual implements the statute by standardizing measurements and report forms for the TAR. The standardized PAAS methodology will ensure the TAR accurately represents the health plan's compliance with timely access, and that the TARs from different health plans are comparable by consumers as required by the statute.

Notably, the amended subsection (f) is largely consistent with the status quo because health plans have complied with a standardized PAAS methodology mandated by the DMHC for the past several years.³⁶ However, the proposed subsection (f) codifies in Rule 1300.67.2.2 the requirement to use the DMHC's standardized PAAS methodology, as described in the PAAS Manual and Instruction Manual that are incorporated by reference. Codifying the PAAS methodology that the DMHC developed through a robust, multi-year stakeholder engagement process will have the benefit of relatively low operational burden on health plans (because the methodology is very similar to existing processes). Codifying the DMHC's PAAS methodology will also result in the benefit of a survey process that yields statistically valid and comparable results and accurately reflects a health plan network's compliance with the time-elapsed standards. Finally, the PAAS methodology will help standardize health plan TARs, allowing the DMHC to efficiently and effectively monitor health plan timely access compliance, and to take appropriate enforcement action, when necessary, which will ultimately result in networks that better

³⁶ The DMHC's standardized PAAS methodology has been mandatory for the past several years pursuant to the APA exemption in Health and Safety Code section 1367.03(f)(3).

serve the needs of enrollees.

Subsection (f)(1) of Rule 1300.67.2.2 also specifies that this provision takes effect beginning January 1, 2022, which is necessary because health plans conduct their PAAS over the course of the year before the TAR is due. This means that health plans will begin the PAAS shortly after the proposed Rule is promulgated. The delayed 2022 effective date is necessary to allow health plans to update their policies and procedures for conducting the PAAS in accordance with the updated standardized methodology codified in proposed subsection (f) of Rule 1300.67.2.2, and explained in detail in the PAAS Manual and the Instruction Manual.

The PAAS Manual provides the detailed, step-by-step instructions for how health plans must conduct the PAAS. Paragraphs 1-5 of the PAAS Manual contain an introduction to the PAAS, and are intended to explain the general purpose and components of the PAAS and to enable plans to understand why this information needs to be provided to the DMHC. Paragraph 1 of the PAAS Manual explains that the PAAS methodology is set forth in the PAAS Manual and the PAAS Report Form Instructions (located in the Instruction Manual, and described in section E.ii of this ISOR). Paragraph 2 of the PAAS Manual provides context for the PAAS by describing the purpose of the PAAS (to measure a network's ability to offer timely appointments), and by reciting the Knox-Keene Act's requirements for health plans to maintain adequate networks sufficient to meet time-elapsed standards. Paragraph 2 of the PAAS Manual also provides an overview of the PAAS process, including the requirements to sample network providers, measure responses, calculate results, and submit the results (including any identified PON) in the health plan's TAR. Later sections of the PAAS Manual address these requirements in greater detail, but paragraph 2 provides an overview that will help health plans understand the PAAS process. Paragraph 3 of the PAAS Manual restates the requirement for a health plan to annually submit the TAR, including the listed PAAS Report Forms, by May 1st of each year, pursuant to Rule 1300.67.2.2(h)(1)(A). This assists plans in knowing when this information must be provided to ensure compliance with the requirements of the proposed Rule. Paragraphs 4-5 of the PAAS Manual reiterate that health plans must conduct the PAAS and complete the PAAS Report Forms and submit the TAR in accordance with the PAAS Manual and the Instruction Manual, which reiterates requirements in Rule 1300.67.2.2 subsections (b)(11) [determining rate of compliance using the PAAS]; (f)(1) [requirement to conduct the PAAS according to the PAAS Manual and Instruction Manual]; and (h)(6) [requirement to submit the TAR in accordance with the requirements in the Instruction Manual; requirement to submit PAAS results in accordance with the PAAS Manual]. In sum, the "Introduction to the Provider Appointment Availability Survey" merely restates requirements established elsewhere in the Rule or the incorporated Manuals, but the overview and introduction it provides will result in the benefit that health plans can more easily understand and comply with the requirement to complete the PAAS and report the results in the TAR.

The PAAS Manual contains the detailed, step-by-step instructions for the PAAS, but for the sake of clarity, Rule 1300.67.2.2(f)(1)(A)-(I) also outlines the main requirements explained in the PAAS Manual. The purpose, necessity, and benefits of those main requirements, and the related instructions from the PAAS Manual, are as follows:

Subsection (f)(1)(A): Determine the networks required to be surveyed [PAAS Manual, pp.4-5]

As stated previously, the PAAS is the survey health plans must use to measure the ability of the health plan's networks to offer appointments within the time-elapsed standards. Paragraph 6 of the PAAS Manual instructs a health plan to report a percentage of providers with a timely appointment available for each provider survey type, in each county in each network (county/network), including counties adjacent to the health plan's network service area. It is necessary for health plans to report separate timely access rates of compliance with the time-elapsed standards for each county within each network.³⁷ This requirement for separately-reported rates of compliance is consistent with existing law under Rule 1300.67.2.2(g)(2)(B).³⁸ This requirement is also necessary to implement Health and Safety Code section 1367.02(f)(2)-(3), which require health plans to submit an annual TAR showing the health plan's compliance with timely access standards, in accordance with a standardized methodology established by the DMHC. Reporting by county and provider survey type for each network will provide information on the performance of each network, for each of the five defined provider survey types, in each county of the network. That information is necessary to result in a TAR that reasonably "allow[s] consumers to compare the performance of plans and their contracting providers in complying with the [timely access] standards," as required by the statute.³⁹

Before administering the PAAS, it is necessary for the health plan to identify which networks it will survey. Paragraph 7 of the PAAS Manual clarifies that a health plan will not survey networks for which the health plan is not required to report a timely access rate of compliance, namely, networks exclusively serving Medicare Advantage, CalMediConnect, or Employee Assistance Program enrollees. Medicare Advantage plans are primarily governed by federal law, as are the relevant portions of CalMediConnect coverage for dually-eligible Medicare/Medi-Cal beneficiaries. Employee Assistance Programs do not offer full-scope health coverage. These types of networks are therefore not currently subject to DMHC regulation pursuant to the proposed Rule. Excluding these networks will have the benefit of avoiding unnecessary surveys of networks that are irrelevant to the TAR and will save the health plans time and money by more clearly specifying the types of networks that must be surveyed.

³⁷ Provider survey type is defined in proposed subsection (b)(15) of Rule 1300.67.2.2.

³⁸ Existing Rule 1300.67.2.2(g)(2): The health plan TAR "shall document the following information: [...] (B) The rate of compliance, during the reporting period, with the time elapsed standards set forth in subsection (c)(5), separately reported for each of the plan's contracted provider groups located in each county of the plan's service area. [...]"

³⁹ Health and Safety Code section 1367.03(f)(2).

As described in subsection (b)(12) (defining plan-to-plan contract), health plans may delegate functions to another health plan (subcontracted plan) and arrange for the primary health plan's enrollees to access providers through the subcontracted plan's network. Paragraph 8 of the PAAS Manual clarifies how to report timely access data, when there is a plan-to-plan contract, by referencing the requirement in Rule 1300.67.2.2(h)(3): the primary plan is responsible for reporting all required data for providers made available through a plan-to-plan contract. Paragraph 8a-b further describes the ways a health plan may collect the required survey information (i.e., the primary plan may survey the subcontracted plan's providers, or the subcontracted plan may survey its providers, as specified). Paragraph 8b and 11 clarify that when a subcontracted plan surveys its providers, the primary plan must report the information using separate forms and calculations; this will help the primary plan and the DMHC identify instances where a specific subcontracted plan network is deficient. Paragraph 8 will allow the primary and subcontracted plans to choose a division of labor for the PAAS that best serves the health plans' operations, and it will also help health plans to clearly understand their reporting obligations, in the context of plan-to-plan contracts.

Subsection (f)(1)(B): Complete a Contact List Report Form for each of the Provider Survey Types [PAAS Manual pp. 5-8].

It is necessary for the health plan to identify which network providers are subject to the PAAS. To do so, the health plan completes the Contact List Report Form,⁴⁰ which the health plans must use to calculate the required "sample size" and select a random sample of network providers to survey for each county/network. (See Paragraph 9 of the PAAS Manual; see also Appendix 1: Sample Size Chart). The purpose of the required sample size is to ensure that the PAAS yields results that are statistically valid reliable, meaning the survey is based on a large enough portion of the network providers in the county to constitute a reasonable estimate of the network's ability to provide timely access in compliance with the time-elapsed standards in Rule 1300.67.2.2(c)(5)(A)-(F). As stated in the PAAS Manual, the DMHC calculated sample sizes for each County/Network/provider type to produce confidence limits of +/- 5% for an expected compliance rate of 85% with a 95% confidence level.⁴¹ Combining results across provider types when calculating the rate of compliance should decrease the confidence interval, resulting in greater precision, but this increase in precision may be countered if surveyed compliance rates are lower than 85%. Due to the variability in estimated compliance rates, and the variability in the number of counties served by networks, these sample sizes are expected to produce maximum confidence limits of +/- 5% for County/Networks across all provider types regardless of network size or compliance rates. The DMHC determined that these confidence limits will allow for sufficient precision in PAAS results to evaluate the network's compliance with the timely access standards.

Paragraph 9a-d of the PAAS Manual specify the criteria for a network provider to be included in the Contact List Report Form. These criteria are intended to ensure the health

⁴⁰ The Contact List Report Forms are incorporated by reference in Rule 1300.67.2.2(h)(6)(B).

⁴¹ See footnote 17 of the PAAS Manual

plan surveys appropriate network providers whose survey responses will accurately represent the network's ability to offer timely appointments to enrollees. Paragraph 9a requires the network provider to have participated in the network as of the network capture date. This criterion addresses the problem that network providers enter and exit a health plan's network throughout the year, and so it is necessary to measure the network at a defined point in time: the network capture date. The benefit of requiring in the PAAS Contact List Report Form only providers who were in-network on the network capture date is that health plans will understand how to create the Contact List of providers who can participate in the PAAS. Paragraph 9b requires the network provider to be located either in any county in the health plan's approved network services area, or in an adjoining county, as specified. This provision ensures that network providers who are likely to serve enrollees who live or work in the network service area are included in the contact list. Paragraph 9c specifies that the provider must deliver health care service through appointments; this is necessary because the PAAS measures the availability of appointments. Therefore, this criterion has the benefit of excluding network providers who do not offer appointments (e.g., certain specialists), and are not relevant to the PAAS. Paragraph 9d requires the provider to be one of the five specified provider survey types (which are defined in Rule 1300.67.2.2(b)(15)). These provider survey types, and the resulting benefits, are the same as those describe in (b)(15), with additional clarification on the applicable sub-types of each provider survey type (e.g., Primary Care Physician is one type of Primary Care Provider). It is necessary to specify the sub-types because the listed subtypes are clearly identifiable by the health plan, allow for comparable results across the industry, and are high-utilization specialists and ancillary providers. Overall, the criteria for inclusion in a health plan Contact List Report Form ensure that the PAAS includes a comprehensive range of relevant network providers, and accurately reflects the adequacy of a network to provide timely appointments.

Paragraph 10 of the PAAS Manual describes the separate Contact List Report Forms, which is consistent with Rule 1300.67.2.2(h)(6)(B)(a)-(e), and instructs health plans to put results for each provider survey type in the relevant, Contact List Report Form. This consistency with the Rule will assist health plans in providing the DMHC information used to accurately assess the health plan's network. Paragraph 11 of the PAAS Manual clarifies how to fill out Contact List Report Forms when the health plan has a plan-to-plan contract (see paragraph 8 of the PAAS Manual). This instruction will assist health plans in providing the DMHC information used to accurately assess the health plan's network. Paragraph 12 refers a health plan to the relevant portion of the Instruction Manual for more information on how to complete these report forms. These provisions allow a health plan to understand how to fill out the Contact List Report Forms and report results for the five types of providers. These paragraphs results in the benefit that the health plan will understand how to comply with Health and Safety Code section 1367.03's requirement to annually submit the TAR.

Paragraph 13 of the PAAS Manual specifies that Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC) must be included in the Contact List Report Form and surveyed without regard to the availability of an individual provider. That requirement is necessary for consistency with Welfare and Institutions Code section 14087.325(b), which requires enrollees to be assigned to the FQHC/RHC itself, rather than a particular

individual provider. Paragraph 14 of the PAAS Manual specifies how the health plan shall populate the FQHC/RHC's contact information in the Contact List Report Form to ensure individual providers are not unduly burdened by the PAAS. These paragraphs result in the benefit that the health plan will understand how to comply with Health and Safety Code section 1367.03's requirement to annually submit the TAR with consistent and correct information.

Paragraphs 15-19 of the PAAS Manual specify how a health plan must identify unique providers on the Contact List Report Form. The purpose of these paragraphs is to ensure the health plan identifies which providers are unique, to ensure that a provider who serves a network in several capacities (e.g., with several specialties or practice addresses in a single county), is not included multiple times in a Contact List Report Form for a given county/network. In other words, identifying unique providers prevents a single network provider from being surveyed more than once in the PAAS. The PAAS Manual specifies what report form fields the health plan will use to identify non-unique (duplicate) providers (e.g., first name, last name, etc.). Identifying unique providers will result in the benefit that the health plan's random sample of network providers for the PAAS reflects the true ability of a network to offer timely appointments because the PAAS will not repeatedly survey the same network providers thereby skewing the results of the survey.

Subsection (f)(1)(C): Determine the number of network providers from which the plan is required to obtain survey responses to meet the required sample size [PAAS Manual pp. 8-10]

Once the health plan has completed its Contact List Report Forms, the health plan must determine the required sample size. The required sample size is the minimum number of survey responses the health plan must obtain from its random sample of each provider survey type, according to the instructions in paragraphs 20-23 of the PAAS Manual. Appendix 1 of the PAAS Manual identifies required sample sizes, based on the number of unique providers within a county/network. As described in regard to subsection (f)(1)(B), the required sample sizes ensure that the PAAS surveys enough network providers to produce results with appropriate statistical confidence limits. The required sample size therefore results in the benefit of ensuring a health plan surveys an appropriate number of network providers for each county/network, to produce statistically reliable and comparable results across all health plans, as required by Health and Safety Code section 1367.03(f)(2).⁴²

As an alternative to the approach where a health plan surveys a random sample of unique providers in a county/network (the random sample approach), the PAAS Manual also specifies that a health plan may choose to survey all unique providers in a county/network (the census approach; see paragraphs 21-22 of the PAAS Manual). The census approach alternative provides a health plan the flexibility to conduct the PAAS in the manner that best fits the health plan's operations. Paragraph 22 also specifies that the

⁴² See also paragraphs 35-36 of the PAAS Manual, discussed in this ISOR, for information on provider outreach to increase provider participation in the PAAS, which helps the health plan achieve the required sample size.

health plan must obtain the required number of valid survey responses regardless of whether the health plan uses the random sample approach or the census approach. This requirement addresses the problem that some eligible providers may not wish to participate in the PAAS. However, Health and Safety Code section 1367.03(f)(1) requires contracts between health plans and providers to comply with the DMHC's TAR standards. Paragraph 22 implements that statute by requiring health plans to enforce their contracts with providers and ensure the network providers participate in the PAAS. This will result in the benefit of a PAAS that surveys an appropriate number of providers and yields statistically valid and reliable results that accurately reflect a network's compliance with timely access standards.

Paragraph 23 of the PAAS manual clarifies that a health plan may survey more network providers than the required sample size, but the health plan must include data and results on the report forms only for all providers (the census approach), or the required sample size. Paragraph 30 similarly limits the number of network providers. This provision is necessary to ensure that health plans conduct the PAAS consistently, and that the results are comparable, as required by Health and Safety Code section 1367.03(f)(2).

Additionally, paragraphs 24-26 of the PAAS Manual specify how a health plan that uses the random sample approach for the PAAS must determine an oversample size for replacement providers. The PAAS Manual explains that an oversample is a randomly selected group of network providers who will serve as replacements, if the providers in the health plan's random sample turn out to be ineligible for the PAAS, or refuse to participate (as further specified in PAAS Manual paragraphs 58-61). The oversample methodology results in the benefit that the health plan will have a back-up list of providers for the PAAS, and will be able to efficiently conduct the PAAS by surveying the required sample size. This ensures the DMHC receives enough information on provider availability to review the adequacy of the health plan network.

Subsection (f)(1)(D): Select the network providers to be surveyed for each network [PAAS Manual pp. 10-11].

After a health plan has completed its Contact List Report Forms, identified unique providers, and determined its required sample size, the health plan must select which network providers to survey. Paragraph 27 of the PAAS Manual specifies how a health plan must identify which network providers to survey, using the random sample selection process. This requirement addresses the problem that failing to randomize the unique providers may result in skewed PAAS results. For example, if a health plan simply surveyed the first 100 unique providers in an alphabetized contact list, providers with names starting with letters early in the alphabet would be surveyed unduly often, and providers whose names start with letters late in the alphabet would be overlooked. Accordingly, the PAAS Manual instructs the health plan to assign a random number to each unique provider in the Contact List Report Form (paragraph 28 clarifies that a health plan may use Excel or other software to assign the random number), sort the Contact List Report Form for each provider survey type, and select the required number of providers (required sample size and oversample). Finally, paragraph 27 of the PAAS manual also refers health plans with only one network in a county to step 5 of the PAAS Manual

(engage in provider outreach to increase participation in the PAAS). These instructions ensure that a health plan's sample of unique providers is randomized, which prevents the same network providers from being repeatedly surveyed, and ensures the PAAS receives results from a complete range of unique providers in the county/network.

Paragraphs 29-32 of the PAAS Manual specify how a health plan must conduct the PAAS when the health plan has multiple networks in a county. The purpose of these requirements is to sample the smallest number of providers needed to produce results for all networks in the county, while achieving the required sample size and, if necessary, using the oversample process. The PAAS Manual instructs a health plan to select a random sample from the network in the county with the largest number of providers. The health plan must then identify what providers who also participate in other networks in the county, and then apply the provider to the smaller network, too. This process results in the benefit that the PAAS will reflect all networks in the county, but each network provider will be surveyed by the health plan only once, even if the provider participates in several networks in the county. That will result in the benefit of an efficient PAAS process that does not overburden providers by requiring unnecessary or redundant survey participation.

Paragraphs 33-34 of the PAAS Manual specify how a health plan may use a centralized survey administration process. A centralized survey administration process can identify overlap in providers in multiple health plans' networks, and apply the provider's survey responses across all applicable networks. Similar to paragraphs 29-32, the purpose is to promote efficiency in the administration of the PAAS, and reduce the number of times a particular provider is contacted. This has the benefit of reducing the burden on providers, because the provider can respond to a single PAAS request for all networks in which the provider participates. The purpose of paragraphs 33-34 is also to ensure that health plans using a centralized survey administration process do so in a manner that avoids redundantly surveying the same providers, while also adhering to the standardized PAAS methodology. This approach ensures the PAAS is not delayed, and yields statistically reliable results that accurately represent the ability of the networks to offer timely appointments.

Paragraphs 35-36 of the PAAS Manual reiterate the requirement for a health plan to survey enough providers to result in accurate reporting of network performance (this is consistent with the required sample size, described previously). The purpose of paragraphs 35-36 is to implement Health and Safety Code section 1367.03(f)(2)-(3) by specifying the ways a health plan may engage in provider outreach to increase provider participation in the PAAS. The benefit is that providers will better understand the purpose and importance of the PAAS, the timing of the PAAS, any relevant contractual obligations to participate (pursuant to Health and Safety Code section 1367.03(f)(1)), and the options for provider participation. This information will increase the likelihood providers will participate, leading to PAAS results based on a sufficient number of responses that more accurately reflect the health plan network's performance. These paragraphs also clarify that any health plan outreach materials must inform providers that the providers must not respond directly to the DMHC. This will have the benefit of clarifying for providers that the DMHC cannot answer questions about the PAAS outreach, which will avoid inefficient use

of provider and DMHC communication resources.

Subsection (f)(1)(E): Prepare the survey questions [PAAS Manual pp. 12-13; Appendix 2]

Paragraphs 37-40 of the PAAS Manual specify how a health plan will prepare survey questions in preparation for conducting the PAAS. Appendix 2 of the PAAS Manual contains a Survey Tool with standardized survey questions, which the health plan must not amend (except as specified). The Survey Tool includes two scripts for (A) surveys administered by email, electronic communication, or fax, and (B) surveys by telephone, which each contain information reminding health plans how to record certain data correctly in the PAAS Report Forms. The Survey Tool will have the benefit of ensuring consistency in administration of the PAAS, which will help ensure TARs are comparable, as required by Health and Safety Code section 1367.03(f)(2). The Survey Tool scripts request the following information:

(A) Survey Tool Script for Email, Electronic communication, or Fax:

- The survey tool introduces and explains the purpose of the PAAS and specifies a request for response, with notice that if no response is received, the survey vendor will contact the provider to complete the survey via telephone. Providers are more likely to participate in the PAAS when they understand the process and its importance. This information is therefore necessary to inform the provider of the nature of the PAAS and help ensure accurate survey participation by providers. This will result in PAAS and TARs that accurately reflect the health plan network's ability to provide timely appointments.
- This survey tool also requires the health plan to confirm the provider's contact information, including name and specialty. This will help ensure the health plan can communicate with the network provider and complete the PAAS, and will also help the health plan keep its record and provider directories current. This will assist enrollees to be able to find network providers and obtain health care services.
- This survey tool requests information about the network provider's eligibility to participate in the PAAS (e.g., whether the provider is retired), which will help ensure the health plan can populate its Contact List Report Forms with eligible providers who can provide valid PAAS responses.
- This survey tool requests information about same-day appointment availability, and asks when the next urgent and non-urgent appointments are available. This survey tool also reminds health plans how to complete and record the calculation of whether the survey response shows availability of a timely appointment. The data, gathered using standardized methods, is necessary to implement Health and Safety Code section 1367.03(f)(2), by obtaining information about the availability of an appointment within the time-elapsed standards of Rule 1300.67.2.2(c)(5).

(B) Survey Tool Script for Telephonic Survey:

- The telephonic script requests information necessary to complete the PAAS Report Forms (e.g., date survey completed, provider first name, etc.)
- Similar to the email/fax script, the telephonic script introduces and explains the PAAS to ensure accurate information is obtained.

- The telephonic script informs the surveyed person of the anticipated duration of the survey, which will have the benefit of informing participants that the survey takes only a few minutes. This will help ensure maximum survey participation, because participants will know the survey will not take long.
- The telephonic survey script confirms that the person speaking is able to respond to the survey. This will have the benefit of ensuring responses to the survey are from a knowledgeable source in the network provider's office, which will make the resulting TAR reliable and accurate.
- Similar to the email/fax script, the telephonic script validates provider information.
- Similar to the email/fax script, the telephonic script asks when the next urgent and non-urgent appointments are available. This survey tool also reminds health plans how to complete and record the calculation of whether the survey response shows availability of a timely appointment. This information, gathered using standardized methods, is necessary to implement Health and Safety Code section 1367.03(f)(2), by obtaining information about the availability of an appointment within the time-elapsd standards of Rule 1300.67.2.2(c)(5).

It is necessary to standardize the survey questions so that PAAS results are comparable, as required by Health and Safety Code section 1367.03(f)(2). In addition to allowing for comparison of timely access compliance, the standardization of survey questions will have the benefit of promoting efficient PAAS administration, because health plans will not have to develop their own survey questions.

The core PAAS survey questions are standardized in the Survey Tool contained in Appendix 2 of the PAAS Manual. However, paragraphs 38-39 of the PAAS Manual describe revisions to the Survey Tool health plans may make to the Survey Tool, and paragraph 40 specifies when a health plan may use software or a computer program to capture survey data. The purpose of these paragraphs is to grant reasonable flexibility to health plans, while preserving the integrity of the standardized PAAS methodology. These paragraphs allow health plans to use efficient technology, or appropriately customize the language of the health plan's PAAS. Specifically, health plans may make minor adjustments to the survey's introductory language, indicate any relevant contractual provisions that obligate the provider to respond, incorporate additional questions the health plan wishes to ask, and incorporate provider identification information, including information set forth in Health and Safety Code section 1367.27 (requiring health plans to publish provider directories and update them when informed of certain changes in status of a network provider, or availability of the provider, as specified).⁴³ However, paragraph 39 specifies that any adjustments of the Survey Tool must not interfere with administration

⁴³ Health and Safety Code section 1367.27 requires a health plan to publish and maintain a provider directory. Consumers use provider directories to see what providers are available in a health plan's network. Provider directories must be kept reasonably up-to-date to be useful to consumers, so section 1367.27 requires health plans to update providers, at a minimum, quarterly update printed directories, and weekly update online directories, when the health plan is informed of certain changes in provider availability (e.g., the provider is no longer in the network, etc.). The PAAS is one way a health plan may become aware of those changes in network provider status.

of the standardized Survey Tool questions according to the methodology described in the PAAS Manual. Similarly, paragraph 40 specifies that a health plan may use software or a computer program to collect survey data only in a manner consistent with the PAAS Manual. These limits on customization of the survey questions are necessary to ensure that PAAS results are comparable, as required by Health and Safety Code section 1367.03(f)(2). Finally, paragraph 39 requires a health plan to identify any revision to the Survey Tool; this is necessary to allow the DMHC to review health plan revisions and ensure they comply with the Rule and PAAS Manual.

Subsection (f)(1)(F): Administer the PAAS [PAAS Manual pp. 13-20].

Paragraph 41 of the PAAS Manual requires surveys be completed in two waves, between June 1 through December 31 of each measurement year, as specified. This standardized timeframe addresses the historical problem that some health plans have waited until late in the year and had insufficient time to complete the PAAS. Also, provider availability may differ throughout the year, and so health plans who complete the PAAS early in the year may obtain PAAS results that are not comparable with the results from a health plan that administered the PAAS early in the year. The standardized timeframe in paragraph 41 will implement Health and Safety Code section 1367.03(f)(2), which requires comparable TARs, by ensuring all health plans survey during the same part of the year. Additionally, this six-month timeframe will have the benefit of ensuring health plans have enough time to complete the PAAS, allowing them to submit the TAR on time. Paragraph 41 requires the health plans to complete the PAAS in two waves, spaced out over several weeks, with each wave contributing between 50-60% of the survey results. This provision addresses the problem that if the PAAS were conducted in a single wave, the results may not fairly represent the performance of that network, over a period of time. The provision requiring two waves will have the benefit of ensuring that the PAAS samples providers broadly, ensuring that the results accurately reflect the network's ability to offer timely network provider appointments.

Subsection (f)(1)(F) of Rule 1300.67.2.2 and paragraph 42 of the PAAS manual require a health plan to administer the PAAS in accordance with the PAAS Manual using one of three modalities:

1. Option 1: Extraction,
2. Option 2: Three Step Protocol, or
3. Option 3: Qualified Advanced Access Provider (QAAP).

Like most aspects of the standardized PAAS methodology, this provision specifying the three PAAS modalities codified in Rule 1300.67.2.2, is the status quo because health plans have used these three modalities to administer the PAAS for the past several years. The purpose of this provision is to implement Health and Safety Code section 1367.03(f)(2) by requiring health plans to collect timely access compliance data in a standardized manner, resulting in TARs that are comparable, as required by Health and Safety Code section 1367.03. The benefit of this provision is that health plans will understand how to comply with the TAR requirements. Additionally, the DMHC developed the modalities for administering the PAAS in consultation with health plan stakeholder

input. Originally, health plans administered the PAAS almost exclusively by telephone. However, the DMHC received stakeholder feedback indicating health plans wished to survey all provider survey types by fax or email to avoid repetitious phone call surveys. As a result, the DMHC developed the Three Step Protocol (discussed in detail, below). Additionally, the DMHC received stakeholder feedback indicating some provider groups were willing to provide appointment data through extraction (which is akin to a data download) to avoid responding to surveys via phone, fax or email. These modalities therefore have the benefit that they are the product of stakeholder input, and work efficiently with existing health plan and stakeholder systems and operations. This results in the benefit of greater provider participation, which leads to PAAS results that more accurately reflect the health plan network's ability to offer timely appointments.

Option 1: Extraction Modality

Paragraphs 43-45 instruct health plans how to use the Extraction modality to administer the PAAS. Paragraph 43 explains there are two forms of Extraction: Manual Extraction (a person manually checks the provider's schedule and obtains appointment data from the provider's practice management software), and Electronic Extraction (a health plan obtains the appointment data directly from the provider's practice management software by downloading the data). Paragraph 44 explains the requirements for using the Extraction modality. The requirements specify the following: 1) the health plan must have identified providers willing to participate in the Extraction process; 2) the method used to extract data and populate the PAAS Report Forms is reliable and accurate; 3) the Extraction method allows the health plan to identify whether responding providers are eligible for the PAAS; and 4) the Extraction method adheres to the PAAS Methodology (including the requirement for two PAAS waves, consistent with paragraph 41). Additionally, paragraph 43 clarifies that the random sample of providers (discussed in paragraphs 20-34) must be selected irrespective of whether the network provider's appointment data can be accessed via the Extraction Modality. This provision has the benefit of ensuring that the PAAS samples the entire network and is not unduly skewed toward providers with the technical capacity for Extraction. This will allow the PAAS to more accurately measure the ability of the network to provide timely appointments.

Option 2: Three-Step Protocol Modality

Paragraphs 46-53 instruct health plans how to use the Three Step Protocol modality to administer the PAAS, in accordance with the timelines established in Rule 1300.67.2.2(f)(1)(F)(i)-(vii). The purpose of the Three Step Protocol modality is to specify how a health plan may administer the PAAS in a manner that is non-disruptive to providers. As previously described, stakeholders requested this type of modality be available. Paragraphs 47-48 provide examples of how long a Three-Step Protocol PAAS may take to complete. The examples specify the number of days between inviting the network provider to the survey and obtaining the network provider's survey response (a maximum of 17 days). The timelines specified in subsection (f)(1)(F)(i)-(vii) will help a health plan to understand how to administer the PAAS and will provide uniformity in how a health plan contacts network providers, reducing disruption. For example, the PAAS Manual instructs health plans to wait two days for the network provider's response to the initial invitation to take the survey, before sending a reminder message. This will ensure that the health plan gives its network providers a reasonable amount of time to respond,

before contacting the provider again. The timelines in these paragraphs and in subsections (f)(1)(F) also ensure that the entire PAAS process for a particular network provider is completed within a reasonable timeframe, which will help ensure that health plans have sufficient time to replace non-responding providers, if necessary. That will ensure the PAAS results reflect a sufficient number of network providers, and accurately represent the network's ability to offer timely appointments. These paragraphs will also help a health plan understand how to administer the PAAS using the Three-Step Protocol, using various communication methods, including email, electronic communication, fax, or the telephone. Paragraphs 49-51 explain the steps of the Three-Step Protocol.

Step One is to initiate the survey, and record the date of initiation. Paragraph 49 of the PAAS Manual clarifies that the survey may address several providers, but each provider must respond individually; this is necessary to ensure the PAAS consistently surveys individual providers, and results in a comparable TAR, as required by Health and Safety Code section 1367.03(f)(2). Paragraph 49 also requires the survey invitation to include the survey or direct the network provider to take the survey, and indicate the network provider has five business days to respond before the health plan contacts the provider to conduct the survey over the phone. This has the benefit of clearly telling the provider how to participate in the PAAS, which will increase provider participation and result in a PAAS that more accurately reflects the ability of the health plan network to deliver timely appointments.

Step Two provides health plans the *option* of sending the provider a survey reminder within two business days of Step One, if the provider has not already responded. The reminder does not extend the network provider's timeframe for response, but informs the provider of the remaining time before the health plan will contact the provider to conduct the PAAS over the phone. This has the benefit of giving the network provider another opportunity to participate in the PAAS online or in another form, which may be less disruptive to the provider than participating over the phone.

Step Three requires the health plan to conduct a telephone survey if the network provider did not already complete the PAAS within the first five business days. Consistent with Rule 1300.67.2.2(f)(1)(F), paragraph 51 clarifies that if the network provider does not respond to the first telephone call, the health plan must call back on or before the next business day, and the telephone survey must occur between days 6-15 of the process. These timeframes are necessary to ensure uniformity in how a health plan conducts the PAAS and to ensure the process is completed within a reasonable timeframe, with maximum possible provider participation. Paragraph 51 also instructs the health plan how to input information about the date the health plan initiated the survey into the Raw Data Report Form. The paragraph also clarifies that a health plan may survey several providers during a single phone call, which will allow the health plan to administer the PAAS efficiently, with minimal disruption to the network provider's office. These provisions will ensure the information from various health plans is reported to the DMHC consistently and uniformly, resulting in a comparable TAR, as required by Health and Safety Code section 1367.03(f)(2). Paragraph 51 also clarifies that if a network provider declines to respond to the telephone survey, the health plan can reschedule the telephone survey within the next two business days, which will help increase the number of

responsive providers.

Paragraph 52-53 explains how a health plan shall report PAAS results when a network provider does not complete the telephone survey or when the health plan was unable to initiate a telephonic survey within ten business days of inviting the provider to take the survey. These instructions will allow health plans to understand how to consistently record responses under these circumstances, and correctly complete the PAAS Report Forms. In this situation, non-responding providers must be replaced with a network provider from the health plan's oversample, consistent with paragraphs 24-26 of the PAAS Manual. These provisions of the Rule and PAAS Manual result in the benefit that health plans will understand how to properly respond and continue with the PAAS process when some network providers do not respond. This, in turn, will help health plans properly administer the PAAS and the resulting TAR will more accurately reflect the network's overall performance.

Option 3: Qualified Advanced Access Provider (QAAP) Modality

Finally, paragraphs 54-57 of the PAAS Manual describe the third permissible PAAS modality: the QAAP modality. The purpose of this QAAP modality is to eliminate unnecessary surveys. This modality eliminates unnecessary surveys by deeming certain providers compliant because those providers have been verified to provide "advanced access," meaning they certainly provide care within the time-elapsed standards (the "deemed compliance" is also specified in paragraph 70.a of the PAAS Manual). The existing Rule 1300.67.2.2 supports this modality. Specifically, the existing Rule 1300.67.2.2(c)(5)(i) states, "[a] plan may demonstrate compliance with the primary care time-elapsed standards established by this subsection through implementation of standards, processes and systems providing advanced access to primary care appointments, as defined at subsection (b)(1)." Under the existing Rule 1300.67.2.2(d)(2)(E), health plans are also required to verify "advanced access programs reported by contracted providers, medical groups and independent practice associations to confirm that appointments are scheduled consistent with the definition of advanced access in subsection (b)(1)." The QAAP modality is consistent with these existing provisions in Rule 1300.67.2.2. The QAAP modality allows a health plan to deem a provider compliant (i.e., able to offer timely appointments), if the health plan has independently verified that the provider is actually scheduling advanced access appointments. Advanced access providers that the health plan already verified are "qualified advanced access providers" and may be included in the PAAS using the QAAP modality. The QAAP modality has the benefit of reducing administrative burden on providers and health plans by avoiding that are unnecessary because the health plan has already verified that the QAAP offers advanced access. Paragraphs 55 and 57 of the PAAS Manual also specify how a health plan must record a QAAP in the relevant PAAS Report Form, which as the benefit of ensuring uniform reporting and comparable TARs, as required by Health and Safety Code section 1367.03(f)(2).

The QAAP modality pertains to advanced access providers who the health plan verified, independent of the PAAS. However, Paragraph 56 of the PAAS Manual also specifies that a health plan may choose to use the PAAS to verify an advanced access program (as noted previously, verification that these providers are actually offering advanced access is

required under existing Rule 1300.67.2.2(d)(2)(E)). This has the benefit of allowing a health plan to fulfill the existing requirement to verify advanced access providers while it administers the PAAS, which is efficient. However, these providers were *not already verified*, are therefore non-qualified advanced access providers for the purpose of the TAR, and non-qualified advanced access providers are not “deemed compliant” with the time-elapsing standards. Instead, the health plan must survey the non-qualified advanced access providers using modality options 1 or 2, not option three (QAAP). This provision is necessary because an advanced access provider *that has not already been verified* cannot be deemed compliant with the PAAS because the network provider has not been verified as providing advanced access. This will result in the benefit of surveying non-qualified advanced access providers in a manner that results in a PAAS and TAR that accurately reflects the network’s ability to provide timely appointments.

Paragraph 58 of the PAAS Manual describes what constitutes a non-responding provider, including network providers who decline to respond, do not answer all survey questions, or reply after the end of the measurement year or after the timeframes allowed in the Rule and PAAS Manual (e.g., 17 days to complete the survey process). This paragraph also instructs health plans how to describe the types of non-response, in the Raw Data forms, which is necessary to ensure uniform reporting resulting in comparable TARs, as required by Health and Safety Code section 1367.03(f)(2).

Paragraphs 59-61 of the PAAS Manual specify what providers are ineligible to participate in the PAAS, including what subsequent actions a health plan must take after learning a provider is ineligible. Although, as described in paragraph 9 of the PAAS Manual, health plans take specified steps to ensure their sample pool of providers appear to be eligible, the health plan could become aware that a provider is ineligible, later in the process. For example, the health plan may try to invite a provider to participate in the PAAS, and learn that the provider has retired. Paragraph 59 clarifies providers are ineligible when: 1) they are no longer in the network, 2) when they are not practicing in the relevant county during the relevant time period, 3) when they are retired or deceased, 4) when the provider was included in the Contact List Report Form under an incorrect specialty, 5) when the provider was unable to be surveyed due to incorrect contact information; or 6) the provider does not offer appointments. These exclusionary criteria will ensure the PAAS includes only relevant, active network providers whose survey results will accurately reflect the network’s ability to offer timely appointments, consistent with Health and Safety Code section 1367.03(f)(2).

Paragraph 60 requires a health plan to update its provider directory, if required by Health and Safety Code section 1367.27 (which requires health plans to update provider directories upon receipt of certain information about the provider’s availability). This has the benefit of helping to ensure the health plan’s provider directories are up-to-date and accurate, allowing consumers to see which network providers are truly available. Paragraph 60 also requires the health plan to use the information to update and improve the Contact List Report Form for future years; this will have the benefit of promoting an efficient PAAS process. For example, if a health plan learns a certain doctor is deceased, the health plan should remove that network provider from the records so that the deceased provider does not appear again on the next year’s Contact List Report Form.

Finally, paragraph 61 clarifies how a health plan shall record ineligible providers in the PAAS Report Forms, and reiterates the requirement to replace the provider in the survey with an eligible oversample provider.

Paragraph 62 of the PAAS Manual contains survey administration notes of requirements for the PAAS. Paragraph 62.a specifies that if a network provider reports the date/time of the next available appointment depending on whether the patient is a new or existing patient, the health plan shall obtain both appointment dates and use the earlier date for the purposes of determining whether the network provider is offering a timely appointment. This provision implements Health and Safety Code section 1367.03(f)(2) by ensuring health plans report timely access compliance in a standardized fashion that results in a comparable TAR. Additionally, this provision ensures that the recorded appointment timeframe will support a viable enforcement action, if the DMHC determines that the health plan is non-compliant with timely access requirements regarding the “earliest date offered,” consistent with the definition of “appointment” in Rule 1300.67.2.2(b)(2). Paragraph 62.b-e of the PAAS Manual describes how a health plan must record results in the PAAS Report Forms when the network provider being surveyed says patients are served on a walk-in-basis, when a patient would be referred to a different provider, when a surveyed provider does not offer urgent appointments, or when the provider is not scheduling appointments because the provider is out of the office (on leave, etc.) Regarding instances when a patient would be referred to a different provider (paragraph 62.c), the health plan must not record the appointment with the different provider as a result for the initially surveyed provider. For example, if the health plan calls a network provider’s office to administer the PAAS to Dr. A and learns that Dr. A is on vacation but an appointment with Dr. B is available, Dr. B’s appointment cannot be recorded for Dr. A. Finally, paragraph 62.f requires the PAAS phone calls to occur during specified business hours. These provisions are necessary to ensure standardized data collection and reporting of PAAS results, and to ensure PAAS results reflect the availability of the provider in the Contact List Report Form. These provisions will help ensure the PAAS results and TAR accurately represent the network’s ability to offer timely appointments, consistent with Health and Safety Code section 1367.03(f)(2).

Paragraph 63 instructs a health plan how to record the survey response or outcome on the Raw Data Report Form, in the applicable fields of the form, using a standardized phrase that describes the survey response/outcome (e.g., “eligible – completed survey,” when the provider responded or was a QAAP). These instructions ensure that health plans report PAAS results data completely and consistently, which will result in a TAR that is comparable, as required by Health and Safety Code section 1367.03(f)(2). It will also result in the benefit that the TAR will accurately reflect the network’s ability to offer timely appointments to enrollees.

Subsection (f)(1)(G)-(H) : Record the survey outcome, the provider’s survey responses, and compliance determinations on the Raw Data Report Form; and calculate and record the results of the PAAS on the Results Report Form [PAAS Manual pp. 20-28].

Paragraphs 64-80 of the PAAS Manual explain how a plan must comply with subsections

(f)(1)(G) and (H) of Rule 1300.67.2.2. The purpose of these provisions in the Rule and PAAS Manual is to ensure health plans record the PAAS outcome and provider responses accurately and consistently, and determine compliance with time-elapsd standards for appointments reliably, so that the resulting TAR is comparable as required by Health and Safety Code section 1367.03(f)(2). This will result in the benefit of PAAS results and a TAR that represents the network's ability to offer timely appointments accurately, in a manner that allows consumers to compare the performance of different health plans. This will allow consumers to shop for health coverage in an informed manner, and will allow the DMHC to assess health plans' compliance with timely access standards (including compliance changes relative to previous reporting years), and determine the potential need for updated standards to "further protect enrollees," consistent with Health and Safety Code section 1367.03(i). The following sections describe the specifics of each component of paragraphs 64-80 of the PAAS Manual.

Paragraph 64 of the PAAS Manual reiterates the requirement to calculate the rate of compliance (Rule 1300.67.2.2(b)(11) and (f)), as well as the number of providers surveyed, whether it surveyed the required sample size, and the percentage of providers that were ineligible or non-responsive. The PAAS manual specifies these figures must be calculated for each county/network for each provider survey type. Reporting by county and provider survey type for each network will provide information on the performance of each network, for each of the five defined provider survey types, in each county of the network. That information is necessary to result in a TAR that reasonably "allow[s] consumers to compare the performance of plans and their contracting providers in complying with the [timely access] standards," as required by the statute.⁴⁴ All of this information is necessary for the health plan to report the network's ability to offer timely appointments, as required for the TAR pursuant to Health and Safety Code section 1367.03(f)(2). Additionally, this paragraph will have the benefit of clearly identifying for health plans where to find the instructions for completing the required report forms; this will allow health plans to clearly understand how to correctly complete the PAAS process and report results to the DMHC.

Paragraph 65 of the PAAS Manual explains, step-by-step, how the health plan must calculate the total number of providers surveyed, including recording what survey modality the health plan used for each provider in the appropriate field of the relevant report forms. This will allow the health plan to clearly understand how to comply with subsections (f)(1)(G)-(H), will allow the DMHC to see what survey modalities the health plan used, and ensure the health plan adhered to the PAAS Manual and Rule, as required. This paragraph reiterates that only primary care providers may be surveyed using the QAAP modality, which is consistent with existing Rule 1300.67.2.2(c)(5)(I) (previously discussed in regard to PAAS Manual paragraphs 54-57). The PAAS Results Report Form includes functionality to automatically calculate the total, which has the benefit of fewer calculation errors, and results in a TAR that will accurately reflect the network's ability to offer timely appointments.

Paragraph 66 of the PAAS Manual reiterates the requirement for the health plan to survey

⁴⁴ Health and Safety Code section 1367.03(f)(2).

a sufficient number of network providers, or “required sample size.” Required sample sizes ensure that the PAAS surveys enough network providers to produce results with appropriate statistical confidence limits. The required sample size therefore results in the benefit of ensuring a health plan surveys an appropriate number of network providers for each county/network, to produce statistically reliable and comparable results across all health plans, as required by Health and Safety Code section 1367.03(f)(2). Paragraph 66 explains, step-by-step, how the health plan must identify whether it achieved the required sample size, which will allow a health plan to clearly understand how to report this information in the relevant PAAS Report Forms. It is necessary for the health plan to indicate whether it achieved the required sample size so that the DMHC can determine whether the health plan has complied with the Rule and PAAS Manual, and take appropriate enforcement action, if necessary. This provision will result in the benefit of efficient and effective DMHC compliance review and enforcement action leading to corrective action on the part of the health plan. This will result in more accurate future PAAS results for the health plan.

Paragraph 67 of the PAAS Manual specifies requirements when a health plan was unable to survey the required sample size, including explaining in the health plan’s Quality Assurance Report the reason and the health plan’s corrective action to ensure it surveys enough providers, in future reporting years. Paragraph 67 provides an example of a possible reason for failing to have the required sample size to help health plans clearly understand how to explain the failure to achieve the required sample size. This paragraph also clarifies that failure to achieve the required sample size does not excuse the health plan from reporting all required information in the Results Report Form, which will have the benefit of ensuring health plans report the PAAS results information that is available. This requirement has the benefit of ensuring health plans report the available information regarding their network’s performance, which will make it possible for the DMHC to assess timely access compliance.

Paragraphs 68-69 of the PAAS Manual specify how a health plan must calculate appointment wait-times, including illustrative examples to help health plans clearly understand the requirement. As stated previously in this ISOR, the PAAS is a survey process. Health plans contact network providers and determine when the provider can offer an appointment. Health plans must then make a compliance determination – i.e., indicate whether the network provider offered an appointment compliant with the maximum wait time (i.e., time-elapsed standards) in Rule 1300.67.2.2(c)(5). Paragraphs 68-69 instruct the health plan how to calculate the appointment wait times obtained during the PAAS. These requirements include clarification of the point in time from which the health plan should count hours/days to determine the wait time for the appointment. The requirements also include specification of how a health plan shall calculate non-urgent appointment wait times consistently, by counting *calendar days* in a manner equivalent to *business days*, and by excluding specified holidays, consistently. The purpose of these provisions in the PAAS Manual is to ensure health plans calculate this information in accordance with existing law (e.g. the requirement for urgent appointments within a specified number of hours), and to ensure health plans calculate this information accurately and consistently to produce comparable TARs, as required by Health and Safety Code section 1367.01(f)(2).

Paragraph 70 of the PAAS Manual specifies how a health plan must make and properly record in the PAAS Report Forms *compliance determinations* (i.e., determinations as to whether a provider in a survey offered a timely non-urgent or urgent appointment, pursuant to the standards in Rule 1300.67.2.2(c)(5)). Paragraph 70 clarifies how a health plan must complete the Raw Data Report Form, depending on which survey modality the health plan used to obtain each survey result (QAAP, Extraction, or Three-Step Protocol). The step-by-step instructions reiterate the time-elapsed standards in Rule 1300.67.2.2(c)(5), and identify the relevant report form fields the health plan must complete to record the compliance determination. Without these instructions, health plans might report compliance results any number of various ways, preventing accurate comparison of the results. To prevent this variation in reporting, these provisions of the PAAS Manual (and related instructions in the Instruction Manual) standardize the manner a health plan must report compliance. These instructions have the benefit of ensuring health plans report these determinations consistently and in a manner that promotes efficient compliance review by the DMHC, and which results in a comparable TAR, as required by Health and Safety Code section 1367.01(f)(2).

Paragraph 71 of the PAAS Manual specifies how a health plan must *calculate the percentage* of network providers with compliant results (i.e., timely urgent and non-urgent appointments), and how to properly record this information in the PAAS Report Forms. Paragraph 72 clarifies how to use the Raw Data Report Forms to determine the numerator and denominator necessary to calculate a percentage of compliant providers. The instructions in paragraph 72 ensure that health plans know which Raw Data Report Form fields to reference for urgent vs. non-urgent appointment survey results, and ensure health plans exclude irrelevant survey responses (such as “NA” for non-applicable.) The report form automatically divides the numerator by the denominator to result in the unweighted percentage. This automatic calculation will have the benefit of reducing calculation errors by the health plan. These step-by-step instructions explaining how to complete these tasks will help health plans understand what they must do to comply with the PAAS Manual and Rule. Without these instructions, health plans might report compliance results any number of various ways, preventing accurate comparison of the results. To prevent this variation in reporting, these provisions of the PAAS Manual (and related instructions in the Instruction Manual) standardize the manner a health plan must report compliance. These instructions have the benefit of ensuring health plans report these determinations consistently and in a manner that promotes efficient compliance review by the DMHC, and which results in a comparable TAR, as required by Health and Safety Code section 1367.01(f)(2).

Paragraphs 73-74 of the PAAS Manual specifies how a health plan must *calculate the weighted percentage* of network providers with compliant results (i.e., timely urgent and non-urgent appointments), and how to correctly complete the Results Report Form to allow the form to perform specified automatic calculations. In order to reduce calculation errors, the Results Report Form contains functionality to automatically calculate a weighted percentage for each provider survey type, and transfer this weighted percentage to the appropriate fields in the Summary of Rates of Compliance Tab within the Results Report Form. Paragraph 74 of the PAAS Manual explains how the percentage is “weighted.” The weighting process is intended to ensure the health plan’s reported rate of

compliance accurately reflects the composition of the surveyed network, by accounting for the varying numbers of the five provider survey types (e.g., Primary Care Provider (PCP), Ancillary provider, etc.). These provisions therefore help ensure the TAR accurately reflects the ability of a network to offer timely appointments, including consideration of the relative numbers of the provider survey types (e.g., a network with five times as many PCP as any other provider survey type would yield a weighted percentage and rate of compliance that reflects the higher proportion of PCPs). This is beneficial because accurate and consistently reported PAAS results will result in comparable health plan TARs, as required by Health and Safety Code section 1367.03(f)(2).

Paragraphs 75-76 of the PAAS Manual specify how a health plan must calculate the rate of compliance. This requirement is consistent with existing law in Rule 1300.67.2.2(g)(2)(B), which requires a health plan TAR to include the rate of compliance with time-elapsed standards. Similar to PAAS Manual paragraphs 73-74, the PAAS Report Forms contain functionality to automatically calculate these rates of compliance, using the data entered into the report forms by the health plan, in order to reduce the likelihood of calculation errors. The form's calculation of weighted rates of compliance is intended, similar to paragraph 74, to ensure the reported rate of compliance is a statistically valid representation of the health plan network, in regard to both urgent and non-urgent appointments for all provider survey types in the network. The specific calculations are included in the Instruction Manual to further clarify for health plans how the rates of compliance are calculated. These paragraphs state, however, that the health plan must enter all required information into the report forms to allow the automatic calculation to correctly proceed, and yield accurate and complete results. These provisions have the benefit of clarifying how a health plan must correctly complete the report forms. This will result in more accurate PAAS results and TARs, that accurately reflect the network's compliance with timely access standards, pursuant to Health and Safety Code section 1367.03.

Paragraph 77 of the PAAS Manual reiterates the requirement for the health plan to review its rates of compliance to identify PON (patterns of non-compliance). This is consistent with existing law, in Rule 1300.67.2.2(g)(2)(C), which requires a health plan to include in the TAR whether it identified any PON. It also implements Health and Safety Code section 1367.03(g), which directs the DMHC to "focus more" on PON, when evaluating compliance with timely access standards. This requirement to identify PON is necessary to allow a health plan to know when its PAAS results show that the network is often unable to provide timely appointments to enrollees, so the health plan can take corrective action and improve its network. Paragraph 77 also ensure health plans have the information necessary to comply with proposed subsection (f)(1)(I) (requirement to Identify whether each network met or exceeded the threshold rate of compliance set forth in subsection (b)(11)(A). Paragraph 77 also reiterates the requirement to include in the TAR information about any PON, as required under Rule 1300.67.2.2(h)(6)(C) (discussed later in this ISOR).

Paragraphs 78-80 of the PAAS Manual specify how a health plan must calculate the percentage of providers who were ineligible and non-responsive to the PAAS. It is necessary to collect data on these percentages for the following reasons. First, large percentages of ineligible providers raises question about PAAS data quality, leading to

both statistical reliability and bias concerns. If health plans cannot reliably identify eligible network providers, as indicated by samples with large percentages of ineligible providers, it raises concern that health plan's Contact List Report Forms may not include all eligible providers. If health plans are not successfully identifying eligible network providers, and non-identified providers show a different likelihood of having an available appointment within timely access standards, then samples drawn from the incomplete or incorrect sample frames may be biased. Second, large percentages of network providers who fail or refuse to respond raise concern for statistical bias in the sample. If network providers who fail or refuse to respond have a different likelihood of having an available appointment within the timely access standards, then results calculated from the sample may be biased. Having information on the percentage of ineligible and non-responding network providers allows the DMHC to conduct analysis to understand what is the typical or expected shares for these values, what levels would be considered outliers, and potentially the levels that trigger concern for bias. This ultimately results in a more effective timely access compliance review by the DMHC, which allows the DMHC to better protect enrollees by ensuring health plans comply with timely access requirements.

This information about ineligible and non-responding providers is also necessary to implement Health and Safety Code section 1367.03(f)'s requirement for a standardized TAR. Similar to other calculations described in the PAAS Manual, the Results Report Form automatically calculates the information, in order to reduce the likelihood of calculation errors. However, the automatic calculation depends on accurate and complete information entered into the report form by the health plan; accordingly, paragraphs 79-80 clarify how a health plan must indicate the relevant data for ineligible and non-responding providers. These instructions help ensure the PAAS data is reported correctly and consistently and that resulting TARs are comparable, as required by Health and Safety Code section 1367.03(f)(2).

Subsection (f)(1)(J): Conduct the quality assurance review and create the quality assurance report.

Health plans must have a quality assurance process and produce a quality assurance report to ensure the PAAS results are correct and follow the standardized methodology, including all requirements in the Rule and PAAS Manual. The detailed necessity, purpose, and benefits of the quality assurance review and report are described in subsection (f)(3) of Rule 1300.67.2.2 and pp. 29-32 of the PAAS Manual (discussed later in this ISOR).

Subsection (f)(1)(K): Submit the TAR in accordance with the PAAS Manual and Instruction Manual [PAAS Manual p 32].⁴⁵

The PAAS Manual reiterates that the TAR is due annually on May 1 (consistent with proposed Rule 1300.67.2.2(h)), and that it must be submitted through the DMHC's web portal, according to instructions in the Instruction Manual. This has the benefit of clarifying

⁴⁵ The Instruction Manual, described later in this ISOR, details the TAR submission process.

for health plans the requirement to submit the TAR required by Health and Safety Code section 1367.03(f)(2) and ensure the information is inputted correctly.

Subsection (f)(2) of Rule 1300.67.2.2 specifies that a health plan must use the information from the PAAS to complete the PAAS Report Forms listed in subsection (h)(6)(B), in accordance with the instructions in the PAAS Manual and Instruction Manual. Subsection (f)(2) also specifies that a health plan's final rates of compliance, including survey results from network providers available from subcontracted plans, must be determined and calculated in accordance with all requirements and instructions set forth in the PAAS Manual and the Instruction Manual. These manuals are incorporated by reference in Rule 1300.67.2.2. These requirements address the problem that without uniformity in how health plans measure and report compliance with time-elapsed standards in the Rule, health plans will use varying methods and the resulting reports will not allow consumers to compare the performance of health plans, as required by Health and Safety Code section 1367.03(f)(2). In other words, subsection (f)(2) will result in the benefit of comparable TARs. This subsection will also ensure that the reported final rates of compliance include network providers available through subcontracted health plans, which is necessary to ensure the reported rate of compliance represents the health plan's entire network as defined in proposed subsection (b)(5) and (b)(9)(B)(iv). Finally, this subsection will result in the benefit that health plans will understand what forms they must use and how the forms must be completed, in order to submit the TAR to the DMHC.

Subsection (f)(3) of Rule 1300.67.2.2 codifies the existing requirement for health plans to have an external vendor that is unaffiliated with the health plan conduct a quality assurance review, and document the review in a quality assurance report, regarding the health plan's PAAS results. This requirement for quality assurance review by an external vendor is necessary to implement Health and Safety Code section 1367.03(f), which requires the annual TAR to allow the DMHC to conduct timely access compliance reviews and to allow consumers to compare health plans' performance in complying with timely access standards. Reports will only be meaningfully reviewable by the DMHC and comparable by consumers if the reports are valid (e.g., based on accurate data, developed in accordance with the DMHC's standardized methodology). The external vendor will ensure that the TAR is valid, i.e., based on true, complete, and accurate data, and contains correctly completed report forms. Quality assurance review by an external vendor is necessary because, in the DMHC's experience over the past several years, health plan TARs often contain "significant and extensive data errors."⁴⁶ The incomplete and poor-quality timely access data in the health plan reports made the DMHC's review of timely access compliance difficult and made comparison of compliance between different health plans nearly impossible. Accordingly, pursuant to Health and Safety Code section 1367.03(f)(3), for the past several years, the DMHC has required health plans to utilize an external vendor to validate health plan timely access data and conduct quality assurance

⁴⁶ See, DMHC All Plan Letter (APL) 17-007 (OPM) TIMELY ACCESS COMPLIANCE REPORTS, MEASUREMENT YEARS 2016 and 2017, available here: <https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL%2017-007%20-%20Timely%20Access%20Compliance%20Reports%20Measurement%20Years%202016%20%26%202017%20%2804-07-2017%29.pdf>.

review.⁴⁷ Subsection (f)(3) codifies the external vendor requirement in Rule 1300.67.2.2, which will result in the benefit of valid TARs that accurately reflect the health plan's compliance with timely access requirements. Accurate TARs will allow the DMHC to complete timely access compliance review pursuant to Health and Safety Code section 1367.03, and they will allow consumers to compare the performance of health plans in complying with timely access standards pursuant to Health and Safety Code section 1367.03(f)(2).

Subsection (f)(3)(A)-(B) of Rule 1300.67.2.2 outline the requirements for the external vendor's quality assurance report. It is necessary for the quality assurance report to ensure the health plan followed statutory and regulatory requirements related to the PAAS, the PAAS Manual, and the Instruction Manual, and that all information in the PAAS Report Forms is true, complete and accurate. These requirements implement Health and Safety Code section 1367.03(f) by ensuring the TAR is valid, reviewable by the DMHC, and comparable by consumers. Subsection (f)(4) of Rule 1300.67.2.2 requires a health plan and its vendor to perform specified PAAS-related tasks in the manner described in the PAAS Manual and Instruction Manual. The Manuals provide detailed instructions for the tasks. However, for the sake of clarity, subsection (f)(4) outlines the requirements for the vendor:

- (A) Gather Provider Appointment Availability Survey data.
- (B) Validate the data included in the PAAS Report Forms and rectify any errors.
- (C) Verify all providers in the PAAS Report Forms meet all eligibility criteria.
- (D) Report any data errors the plan did not correct, and identify the health plan's remedial steps. Nothing in this section shall relieve the plan of its obligation to report accurate data.

The PAAS Manual (pp. 29-32) explains the requirements of subsections (f)(3)-(4) in additional detail. Paragraphs 81-84 of the PAAS Manual reiterate the requirement for a health plan to conduct quality assurance review for the PAAS, and to contract with an external vendor, consistent with subsections (f)(1)(J) and (f)(3)-(4). Paragraph 82 specifies that the quality assurance report must summarize the findings and document any changes or corrections made by the external vendor. This is necessary to allow the DMHC to monitor a health plan's adherence to the Rule and the PAAS Manual. Ensuring adherence to the Rule and the PAAS Manual will hold health plan's accountable for maintaining appropriate systems and protocols necessary to produce true and accurate PAAS data, and an accurate TAR. Paragraph 83 specifies minimum requirements for the

⁴⁷ *Id.*, and see also DMHC APL 18-002 (OPM) TIMELY ACCESS COMPLIANCE REPORTS, MEASUREMENT YEAR 2018 (MY 2018), available here: <https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL%2018-002%20-%20Timely%20Access%20Compliance%20Reports%20MY%202018%20%2801-19-2018%29.pdf>, and DMHC APL 19-008 (OPM) TIMELY ACCESS COMPLIANCE REPORTS, MEASUREMENT YEAR 2019 (MY 2019), available here: <https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL%2019-008%20-%20Timely%20Access%20Compliance%20Reports%20MY%202019%20%283-8-2019%29.pdf>.

external vendor's review, to ensure the health plan conducted the PAAS consistent with the Rule and the PAAS Manual. The minimum criteria include a review for accuracy and completeness of PAAS data, compliance with the PAAS Manual, required PAAS Report Forms, etc., as specified in detail. These provisions will help ensure the resulting TAR accurately reflects a health plan's timely access compliance, and allows the DMHC to conduct its timely access compliance review.

Paragraph 85 of the PAAS Manual specifies the contents of the quality assurance report required by Rule 1300.67.2.2(f)(1)(J) and (f)(3). Required contents include: 1) an explanation of the process used by vendor to verify the required items; 2) a summary of findings; 3) identification of changes/corrections made as a result of the quality assurance review; 4) the health plan's explanations of issues identified by the vendor; and 5) a comparison of the health plan's PAAS Report Forms necessary to ensure all providers are actually part of the health plan's network on the network capture date (with a corresponding health plan explanation for any discrepancies). The required quality assurance report is necessary and beneficial to allow the DMHC to monitor a health plan's adherence to the Rule and the PAAS Manual. Ensuring adherence to the Rule and the PAAS Manual will hold health plans accountable for maintaining appropriate systems and protocols necessary to produce true and accurate PAAS data, and an accurate TAR..

Subsection (f)(5) of Rule 1300.67.2.2 prohibits a health plan from requiring or instructing network providers to hold appointments open that are not available to enrollees for the purpose of satisfying the Rule. This provision addresses the problem that the PAAS results will not accurately reflect appointment availability within a network if the provider reserves appointment times so those appointments appear to be available during the PAAS. The benefit of this prohibition is that the PAAS will measure the actual availability of appointments and result in a true and accurate TAR.

Subsection (f)(6) of Rule 1300.67.2.2 clarifies that subsection (f) does not modify the requirements for a health plan to maintain an adequate network. This provision is necessary to clarify the scope of subsection (f), which is to specify how health plans must use the PAAS to measure a network's ability to offer timely appointments. This provision has the benefit of ensuring that health plans do not misinterpret subsection (f) and fail to comply with other existing laws.

Subsection (g) of Rule 1300.67.2.2 (which was formerly lettered (f)), pertains to health plan requests for alternative access compliance standards. This provision implements the directive in Health and Safety Code section 1367.03 that the DMHC, in developing standards for timely access to health care services, consider a number of factors as specified in the statute and provide a mechanism for the DMHC to consider these and other relevant factors as the health care industry and health care delivery systems continue to evolve after implementation of this regulation. This provision ensures that health plans file information sufficient for the DMHC to determine whether the proposed alternative standard is more appropriate than a time-elapsing standard. In particular, this subsection implements Health and Safety Code section 1367.03(j), which allows the DMHC to approve alternative timely access standards. Accordingly, the existing Rule

allows health plans to file, by notice of material modification,⁴⁸ a request for the DMHC's approval of alternative time-elapsed standards or alternatives to time-elapsed standards, and specifies what information the health plan's request must include in notice of material modification filings.

The proposed amendments in subsection (g) address the problem that other existing Rules also address the topic of how health plans may request approval of alternative access standards, which has raised questions about how those Rules interact with Rule 1300.67.2.2. The proposed amendments to subsection (g) of Rule 1300.67.2.2 clarify that a request for alternative standards pursuant to subsection (g) may be in addition to a request for alternative standards or ratios pursuant to Rule 1300.67.2.1 (Geographic Accessibility Standards), which also allows health plans to request DMHC approval of alternative compliance standards. This amendment will result in the benefit that health plans will understand their options for alternative compliance standards and requesting the DMHC's review of these alternative standards.

Subsection (g) also contains amendments to allow health plans to request DMHC approval of an alternative standard for the threshold rate of compliance set forth in proposed subsection (b)(11)(A). The proposed Rule specifies in subsection (b)(11) that failure to meet the threshold rate of compliance constitutes a PON with timely access standards. However, the proposed Rule at subsection (g) would allow health plans to request an alternative standard for the rate of compliance, for the same reasons health plans may request alternative standards for time-elapsed standards under the existing Rule. This amendment will result in the benefit that health plans will understand their options for alternative standards and requesting the DMHC's review of these alternative types of standards.

Subsection (g)(1) of Rule 1300.67.2.2 describes the information a health plan's request for an alternative time-elapsed standard, or alternative to time-elapsed standards, must contain. Subsection (g)(1) contains amendments necessary to account for the new type of alternative standard that health plans may request: an alternative standard for the threshold rate of compliance. For example, subsection (g)(1)(B) is amended to reference both the standards in subsection (c) (timely access standards), as well as subsection (b)(11)(A) (regarding the threshold rate of compliance). Subsection (g)(1)(B) is also amended to rephrase the requirement for a health plan to demonstrate and substantiate why a proposed alternative standard is more appropriate, in order to make this provision syntactically consistent with the introductory sentence in subsection (g)(1). These amendments will result in the benefit that health plans will understand their options for alternative standards and the information required when requesting the DMHC's review of these alternative types of standards.

Subsection (g)(2) of Rule 1300.67.2.2 contains language relocated from existing Rule 1300.67.2.2(f)(3). This language describes what factors the DMHC may consider in approving or disapproving a health plan's proposed alternative standard. This language has been relocated to the new subsection (g)(2) because this provision specifies the

⁴⁸ See Health and Safety Code section 1352 and Rule 1300.52.1.

scope of the DMHC's review of alternative access requests, rather than specifying the required *content* of such a request from a health plan. This relocation will have the benefit of allowing health plans to more clearly understand what information must be submitted when requesting the DMHC's review of these alternative types of standards.

Subsection (g)(3) of Rule 1300.67.2.2 specifies that a request for an alternative standard to the threshold rate of compliance shall include the information listed in subsection (g)(1)(B)-(C). Those requirements for alternative access standard requests are not new; subsections (g)(1)(B)-(C) contain language that was merely relocated from subsection (f)(2) of the existing Rule. It is not necessary, however, to require health plans seeking approval of an alternative standard to the threshold rate of compliance to submit the information in subsection (g)(1)(A), because that information is not necessary for the DMHC to review a request for an alternative rate of compliance. Subsection (g)(1)(A) relates to clinical reasons supporting an alternative standard, which is relevant to the decision whether to allow different appointment waiting times (i.e., alternative time-elapsed standards and/or alternatives to the time-elapsed standards). Conversely, clinical reasons are not pertinent to the decision whether to allow an entire network to meet a lower threshold rate of compliance standard. For example, a health plan may provide information on studies indicating that the timeframe to see a dermatologist for diagnosis of a skin cancer should occur within a specified timeframe in order to achieve the best clinical outcome, and that study may support the health plan's request for an alternative dermatology appointment standard. However, there is no clinical analysis for the sufficiency of the network to provide timely access, so clinical information is not relevant to a request for alternative threshold rate of compliance standards. Subsection (g)(3) also specifies that a health plan's request for an alternative standard to the threshold rate of compliance shall be subject to subsection (g)(2), which describes the factors the DMHC may consider in approving or disapproving a plan's proposal. These amendments will result in the benefit that health plans will understand their options for alternative standards and the information that must be submitted when requesting the DMHC's review of these alternative types of standards.

Finally, subsection (g) of Rule 1300.67.2.2 contains various non-substantive amendments for clarity, including amendments for consistent formatting (e.g., renumbered subparagraphs, consistent capitalization, use of singular "plan" instead of plural "plans," referencing the "Knox-Keene" Act and repealing unnecessary reference to "Title 28," etc.), or to conform to proposed definitions (e.g., "network provider" instead of "contracted health care provider"). These non-substantive changes are necessary for the same reasons discussed in previous sections of this ISOR (e.g., in regard to subsections (a)(1)-(2), (c)(4), and (c)(8)).

Subsection (h) of Rule 1300.67.2.2 (formerly lettered (g)) specifies health plan filing, implementation, and reporting requirements for reporting year⁴⁹ 2022. Additionally, the Instruction Manual contains related instructions to help health plans correctly complete

⁴⁹ Reporting year is proposed to be defined in subsection (b)(17) as the calendar year in which the plan's TAR or ANR is submitted to the DMHC.

and file the TAR and ANR.⁵⁰ Overall, subsection (h) and the Instruction Manual are necessary to implement Health and Safety Code sections 1367 (requiring health plans to ensure enrollees have ready access to necessary health care), 1367.03 (requiring health plans to submit to the DMHC an annual TAR), and 1367.035 (requiring health plans to submit to the DMHC an annual ANR). The following paragraphs describe the specific purpose and necessity of each component of subsection (h), and related provisions in the Instruction Manual.⁵¹

The heading of subsection (h) includes an amendment specifying that the amended subsection contains requirements “beginning for Reporting Year 2022.” Additionally, subsection (h)(1) specifies that the subsection is effective on and after January 1, 2022, except as specified.⁵² The delayed effective date of Rule 1300.67.2.2(h) is necessary to give health plans the necessary time to update their policies and procedures and gather timely access and network compliance data for the TAR and ANR pursuant to the proposed Rule.⁵³ The amendments regarding the effective dates of the provisions for the TAR and ANR will also have the benefit of clarifying what Rule governs the TAR/ANR due in calendar year 2021 (see proposed Rule 1300.67.2.3(a)), versus the TAR/ANR due in calendar year 2022 (Rule 1300.67.2.2(h)). This will allow health plans to understand how to gather and report data for the TAR and ANR in the years following promulgation of the proposed Rule.

The existing subsection (g)(1)-(2) in Rule 1300.67.2.2 are repealed. These provisions relate to obsolete, phased implementation provisions and health plan filing requirements that were previously required in order to show the health plan’s readiness to comply with the original Rule 1300.67.2.2, promulgated in 2009. Those provisions are now obsolete, because the original Rule’s implementation period has passed. The repealed subsection (g)(2) of Rule 1300.67.2.2 contained the initial due-date for the TAR, which must be repealed because the proposed Rule specify a new due date for the TAR and ANR, beginning in 2022 (see proposed Rule 1300.67.2.2(h)(1)(A)).

Subsection (h)(1)(A) of Rule 1300.67.2.2 specifies the proposed May 1st annual deadline for the TAR and the ANR, which is necessary to implement Health and Safety Code sections 1367.03(f) and 1367.035(a). This subsection clarifies that the requirements for the TAR are found in subsection (h)(6), the requirements for the ANR are found in subsection (h)(7), and the requirements for the Network Access Profile (which is part of the TAR/ANR) are found in subsection (h)(8). This language will help health plans

⁵⁰ See Instruction Manual, p. 9, which reiterates general TAR and ANR reporting requirements by citing to relevant provisions of subsection (h). Also note that the PAAS Manual also relates to the TAR, as discussed in connection with Rule 1300.67.2.2(f).

⁵¹ Note: some provisions in the Instruction Manual use terms defined in the Instruction Manual. The purpose and necessity of the definitions in the Instruction Manual are described in section II.E.iv of this ISOR.

⁵² The exception to the January 1, 2022, effective date for subsection (h) is explained in the paragraph of this ISOR addressing subsection (h)(5).

⁵³ Note that proposed Rule 1300.67.2.3 contains requirements for the TAR and ANR due for submission to the DMHC in calendar year 2021.

understand where to find the relevant reporting requirements pursuant to Health and Safety Code sections 1367.03 and 1367.035. The 2022 implementation date for this reporting provision is necessary to give health plans the necessary time to update their data collection and reporting procedures pursuant to the proposed Rule.

Subsection (h)(1)(B) of Rule 1300.67.2.2 and requires a subcontracted health plan to complete, by May 1, 2022, and annually thereafter, specified portions of the Network Access Profile on the DMHC's web portal.⁵⁴ As described in relation to proposed subsection (a)(2) of Rule 1300.67.2.2, the Network Access Profile is part of the DMHC's online web portal for the TAR and ANR. In the Network Access Profile, a health plan completes or updates its "profile" by entering high-level information about the health plan's networks, network service area(s), product lines that use the network, and any plan-to-plan contracts. Therefore, the Network Access Profile is part of the annual report required pursuant to Health and Safety Code sections 1367.03(f) and 1367.035(a). In the past, the DMHC has allowed a primary plan to delegate TAR and ANR reporting responsibilities to its subcontracted plan(s). However, this delegation created confusion about which health plan is ultimately responsible for the reports and with compliance with the related laws under the Knox-Keene Act. Accordingly, under proposed Rule 1300.67.2.2(h), the primary plan is the reporting health plan and is responsible for submitting all TAR and ANR data, including information from its subcontracted plan (see proposed subsection (h)(3)). This requirement is necessary to implement Health and Safety Code section 1367, which holds a health plan ultimately responsible for compliance with the Knox-Keene Act, notwithstanding delegation of functions to other entities. However, in order for a reporting health plan to be able to accurately and timely complete its TAR and ANR in the DMHC's web portal, its subcontracted health plans must have completed their own Network Access Profiles by the May 1st deadline. Once a subcontracted health plan completes its Network Access Profile, information from the subcontracted health plan's Network Access Profile becomes available to the reporting health plan. That information allows the reporting plan to accurately report its plan-to-plan contracts. Thus, the proposed requirement for subcontracted plans to annually complete their Network Access Profile is necessary to fully effectuate the statutes requiring annual TAR and ANR, because it will allow reporting health plans to timely and accurately complete their TAR and ANR pursuant to Health and Safety Code sections 1367.03 and 1367.035.

Subsection (h)(2) of Rule 1300.67.2.2 specifies that a health plan shall submit the TAR and ANR using the report form templates incorporated by reference in Rule 1300.67.2.2, through the DMHC's web portal.⁵⁵ This provision is necessary to implement the reporting requirements of Health and Safety Code sections 1367.03 and 1367.035 and to exercise the DMHC's authority to specify standardized reporting methodologies. The requirement to use standardized report forms addresses the problem that, without standardization, health plans will use varying forms to submit their TAR and ANR. That variation would mean resulting reports would not allow consumers to compare the performance of

⁵⁴ Section II.A (p. 14) of the Instruction Manual reiterates the requirement of subsection (h)(1)(B).

⁵⁵ Section I.A of the Instruction Manual reiterates the requirement to use only the report forms identified in Rule 1300.67.2.2 for the annual reports.

different health plans, as required by Health and Safety Code section 1367.03. Additionally, form variation would make the DMHC's compliance review much more time-consuming and difficult. The standardized forms will result in the benefit of comparable reports and regulatory efficiency.

Subsection (h)(2) of Rule 1300.67.2.2 also requires a health plan to designate a compliance officer responsible for reviewing and submitting the reports and verifying, pursuant to Rule 1004,⁵⁶ the information and data is true and correct and contain no material misstatements or omissions.⁵⁷ Subsection (h)(8) also specifies health plans must comply with subsection (h)(2) before submitting the report, and section I.B.6 of the Instruction Manual (p. 13) requires the health plan to indicate in the DMHC's web portal which report forms the health plan will submit for each reported network. These provisions are necessary to ensure health plans are aware of, and held accountable for, their reporting obligations. It is also necessary ensure the DMHC has enforcement remedies for material reporting failures by health plans. Robust reporting requirements and enforcement are necessary to effectuate the purpose of Health and Safety Code sections 1367.03 and 1367.035. Without timely, complete, and accurate reports, the DMHC cannot assess health plan compliance or require corrective action when health plans have not provided enrollees timely and reasonable access to necessary health care. The anticipated benefit of the requirement in subsection (h)(2) for complete, and accurate reports is health plans will take appropriate measures when filing their reports pursuant to this Rule, the quality of health plan reports will improve, and the DMHC will have the information necessary to assess health plan compliance with timely access and network adequacy standards.

Subsection (h)(3) of Rule 1300.67.2.2 specifies that for all plan-to-plan contracts, the primary plan is the reporting health plan and is responsible for submitting all annual reporting data pursuant to Rule 1300.67.2.2. Subsection (h)(3) further clarifies that the primary plan's submission shall include all network providers, enrollment, grievance, and other required data, whether maintained by the primary plan, a subcontracted plan, or a delegated provider group (see also: Instruction Manual section II.A). Similar to proposed subsection (h)(1)(B), the provision in subsection (h)(3) designating the primary plan the reporting plan for all required data is necessary to implement Health and Safety Code section 1367, which holds the licensed health plan ultimately responsible for compliance with the Knox-Keene Act, notwithstanding delegation of functions to other entities. Subsection (h)(3) will result in the benefit that health plans clearly understand their reporting responsibilities, and the DMHC has appropriate, clear enforcement authority related to the TAR and the ANR.

Subsection (h)(4) of Rule 1300.67.2.2 specifies that, beginning with January 15, 2022, health plans must submit the TAR and ANR information using the network capture date

⁵⁶ Rule 1004 states, in pertinent part, "Whenever a statute, regulation or the Director requires that a document filed with the Department be verified, the verification shall be by declaration under penalty of perjury pursuant to Code of Civil Procedure section 2015.5."

⁵⁷ Section I.B.8 of the Instruction Manual reiterates the requirement to verify the accuracy of the submission, in accordance with subsection (h)(2).

for the applicable measurement year. This provision is consistent with the proposed definition of network capture date in subsection (b)(6), and is necessary for the same reasons, and will result in the same benefits, described in relation to that proposed subsection. Specifically, it is necessary to collect most network data at a defined point in time. Collecting network data in this manner addresses the problem that providers continually enter and exit a health plan's network. The proposed definition of network capture date defines the point in time when health plans will collect their network data, which will result in the benefit of clarity and uniformity in how health plans collect and data. The network capture date is also pertinent to the TAR, because health plans gather network provider data on the network capture date, and use that data to populate their Contact List Report Forms. Health plans use the Contact List Report Forms to conduct the PAAS, which is a primary component of the TAR. Proposed subsection (b)(6) also will result in the benefit of health plan ANRs that are comparable, and allow for efficient compliance review by the DMHC. This amendment is necessary to effectuate the purposes of Health and Safety Code sections 1367.03 and 1367.035, and ensure consistency in the way health plans gather TAR and ANR data. Additionally, as noted in regard to subsection (b)(6), stakeholders informed the DMHC that January 15 is a feasible network capture date, so it has the benefit of being non-disruptive to health plan operations.

Subsection (h)(5) of Rule 1300.67.2.2 requires health plans to file, on or before June 1, 2021, an amendment pursuant to Health and Safety Code section 1352, containing policies and procedures showing how the health plan will comply with the requirements of proposed Rule 1300.67.2.2. It is necessary to specify a filing deadline in June of 2021 to give health plans time to develop the relevant policies and procedures after promulgation of the Rule in 2021. This will ensure health plans have the time necessary to implement those policies and procedures before the January 1, 2022 effective dates for the Rule's new data gathering and reporting requirements. The June 2021 filing will result in the benefit that the DMHC has the opportunity to engage with and advise health plans about any issues with the health plan's anticipated method for complying with the 2022 Rule. This gives the health plans time to rectify any problems and stand ready to comply with the proposed Rule when they become effective. This will avoid confusion and inappropriate delay regarding implementation of proposed Rule 1300.67.2.2.

TAR Requirements, beginning in Reporting Year 2022:

Subsection (h)(6) of Rule 1300.67.2.2 describes the required contents of a health plan's TAR, including the report forms that are incorporated by reference into the Rule.⁵⁸ This subsection and Instruction Manual are necessary to implement Health and Safety Code sections 1367 (requiring ready access to necessary care) and 1367.03 (requiring annual submission of the TAR, in the manner specified by the DMHC). Subsection (h)(6) also requires the TAR to be submitted in accordance with the requirements in the Instruction Manual, which is incorporated by reference into the Rule, and which contains detailed

⁵⁸ Additional requirements for the annual TAR and ANR are set forth in subsection (h)(8) (Network Access Profile) and related provisions of the Instruction Manual, and are described later in this ISOR.

instructions for how to fill out required report forms and submit the TAR through the DMHC's web portal (see Instruction Manual, section III). The Instruction Manual clarifies that health plans may submit several documents for any section of the DMHC's web portal, but must label its documents; this will allow the DMHC to clearly understand the documents submitted by health plans. It is necessary to specify the required contents of the TAR so health plans understand what is required to be filed to comply with Health and Safety Code section 1367.03(f), and to ensure standardization and comparability of TARs, as required by Health and Safety Code section 1367.03(f)(2). Subsection (h)(6) contains requirements from the existing Rule 1300.67.2.2(g), which have been amended and are described in detail in the following paragraphs.

Subsection (h)(6)(A) of Rule 1300.67.2.2 amends the requirement in existing subsection (g)(2)(A) for the health plans to submit their policies and procedures setting forth the health plan's timely access standards including any DMHC-approved alternative standards, as described in its subsections (h)(6)(A)(i)-(iii). The amendments to proposed subsection (h)(6)(A) include non-substantive renumbering and reorganization of the subparagraphs, as well as specification that the health plan's standards must be consistent with Rule 1300.67.2.2(c). Specifying that the "timely access standards" must be consistent with the Rule's timely access standards set forth in subsection (c) addresses the problem that the existing language could be misinterpreted to allow the health plan to set its own standards. The benefit of the amendment to subsection (h)(6)(A)(i) is that health plans will clearly understand that their timely access policies and procedures must be consistent with the relevant Rule.

Related Instruction Manual Requirements for subsection (h)(6)(A):

The Instruction Manual (p. 17) further specifies that the timely access policies and procedures filed by the health plan pursuant to subsection (h)(6)(A) must be the relevant policies and procedures in effect during the measurement year and on file with the DMHC. This requirement addresses the problem that some health plans occasionally amend their timely access policies and procedures without filing the amendment with the DMHC, creating a discrepancy that hinders the DMHC's review of the documents. The Instruction Manual also requires the plan to identify the page numbers in the relevant filings. These requirements will help ensure health plans provide the DMHC the relevant policies and procedures and allow the DMHC to easily find the relevant sections, and will result in the benefit of efficient regulatory review by the DMHC.

The Instruction Manual also specifies the relevant sections of the DMHC's web portal where the health plan must submit the information required under subsection (h)(6)(A) (e.g., the "Time-Elapsed Standards" section, or the "Approved Alternative Access Standards" section of the DMHC's web portal, etc.). These instructions will allow health plans to more clearly understand where, within the DMHC's web portal, the documents should be filed. Correctly and consistently formatted TAR submissions will result in efficient DMHC compliance review.

The existing subsection (g)(2)(B) of Rule 1300.67.2.2 is removed, and components of that

provision have been relocated and amended. The requirement for a health plan to determine and report its rates of compliance with the timely-access standards is relocated to proposed subsections (f), (d)(2)(B)-(C), (h)(6)(B)(i)k1-5 [i.e., the Results Report Forms, which calculate the rate of compliance], and related portions of the PAAS Manual and Instruction Manual. These amendments align Rule 1300.67.2.2 with requirements that have existed for the past several years, because health plans have been required to use the PAAS to measure their compliance with timely access standards pursuant to APA-exempt DMHC guidance under Health and Safety Code section 1367.03(f). However, for the sake of clarity, the proposed Rule relocates the requirement for health plans to report their rates of compliance with timely-access standards to proposed subsection (f) and other PAAS-related provisions of the proposed Rule because that is where proposed Rule codifies the requirement for health plans to use the PAAS to measure their rates of compliance with timely access standards. Similarly, the existing language stating a health plan, “may develop data regarding rates of compliance through statistically reliable sampling methodology,[...]”, etc., has been repealed in proposed Rule 1300.67.2.2.⁵⁹ This was done because the proposed Rule requires the health plan to determine its rate of compliance using the PAAS (see, e.g., subsections (f) and (b)(11)(A)).

Subsection (h)(6)(A)(ii) of Rule 1300.67.2.2 requires a health plan to include in its TAR the health plan’s Quality Assurance Processes (QAP) for monitoring each timely access standards.⁶⁰ This subsection also requires the health plan to implement corrective action pursuant to proposed subsection (d) and the PAAS Manual, including any alternative standards approved by the DMHC pursuant to proposed subsection (g). This amendment is consistent with existing requirements. Specifically, Rule 1300.67.2.2(d) requires the health plan to have written QAP policies and procedures,⁶¹ and health plans currently include these policies and procedures in the TAR.⁶² However, because the DMHC’s APA-exemption under Health and Safety Code section 1367.03(f) expires on January 1, 2020, it is now necessary to amend the existing Rule to codify the requirement to include policies and procedures in the TAR, as specified. Annual submission of these policies and procedures will result in the benefit that the DMHC has the information necessary to ensure health plans meet their QAP obligations and correct any deficiencies. Subdivision (h)(6)(A)(ii) is necessary to implement Health and Safety Code sections 1367 and 1367.03, because a health plan’s swift correction of access deficiencies helps to ensure

⁵⁹ Note that the language in existing Rule 1300.67.2.2(g)(2)(B) remains in proposed Rule 1300.67.2.3(a)(2)(B). As discussed in this ISOR, that provision is necessary to preserve existing requirements for the interim between promulgation of these proposed Rule 1300.67.2.2 and CY 2022, when the proposed data collection and reporting requirements become effective.

⁶⁰ Section III.B of the Instruction Manual reiterates the requirement of subsection (h)(6)(A)(iii).

⁶¹ Note that proposed Rule 1300.67.2.3(b) preserves the existing requirement for written health plan QAP policies and procedures during the interim between promulgation of these proposed Rule 1300.67.2.2 and CY 2022, when the proposed data collection and reporting requirements become effective.

⁶² See, e.g., Annual Timely Access Compliance Report Instructions Measurement Year 2019.

enrollees have timely access to necessary health care services.

Related Instruction Manual Requirements for subsection (h)(6)(A)(ii):

The Instruction Manual (pp. 18-19) reiterates requirements of subsection (h)(6)(A)(ii)-(iii) and (f), and provides relevant instruction to health plans, including clarification that the QAP policies and procedures shall be the relevant policies and procedures in effect during the measurement year and on file with the DMHC. This requirement addresses the problem that some health plans occasionally amend their timely access policies and procedures without filing the amendment with the DMHC, creating a discrepancy that hinders the DMHC's review of the documents. The Instruction Manual also requires the plan to identify the page numbers in the relevant filings. The Instruction Manual also specifies the health plan must submit the survey the health plan used for its PAAS, which will allow the DMHC to ensure the health plan adhered to the PAAS methodology required under subsection (f) and the PAAS Manual.

These requirements will help ensure health plans provide the DMHC the relevant policies and procedures and allow the DMHC to easily find the relevant sections, and will result in the benefit of efficient regulatory review by the DMHC.

Subsection (h)(6)(A)(iii) of Rule 1300.67.2.2 requires a health plan to include in its TAR the health plan's oversight procedures for ensuring compliance with timely access standards in subsection (c) of Rule 1300.67.2.2, including any periodic reporting requirements related to plan-to-plan contracts. This provision is necessary to implement Health and Safety Code section 1367, which holds a health plan ultimately responsible for compliance with the Knox-Keene Act, notwithstanding delegation of functions to other entities. To satisfy the responsibility under Health and Safety Code sections 1367, and the TAR requirement under Health and Safety Code section 1367.03(f), the health plan must exercise oversight of delegated entities (e.g., entities who are a party to a plan-to-plan contract). Subsection (b)(6)(A)(iii) does not contain a prescriptive standard for the health plan oversight, but requires health plans to include their relevant oversight policies and procedures in the health plan's TAR. This subsection will result in the benefit of allowing the DMHC to ensure the health plan satisfies its requirement to comply with the Knox-Keene Act.

Subsection (h)(6)(B) of Rule 1300.67.2.2 specifies what report forms a health plan must complete and submit for its TAR: the Provider Appointment Availability Survey Report Forms, numbered 40-254 through 40-264 (collectively called the PAAS Report Forms) .⁶³ The PAAS Report Forms, listed below, are incorporated by reference in the proposed Rule:

- a. Primary Care Physicians and Providers Contact List Report Form, No. 40-254;
- b. Non-Physician Mental Health Care Providers Contact List Report Form, No.40-

⁶³ Section I.A of the Instruction Manual reiterates the requirement to use only the report forms identified in Rule 1300.67.2.2 for the annual reports.

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- c. Specialist Physicians Contact List Report Form, No. 40-256;
- d. Psychiatrists Contact List Report Form, No. 40-257;
- e. Ancillary Service Providers Contact List Report Form, No. 40-258;
- f. Primary Care Physicians and Providers Raw Data Report Form, No. 40-259;
- g. Non-Physician Mental Health Care Providers Raw Data Report Form, No. 40-260;
- h. Specialist Physicians Raw Data Report Form, No. 40-261;
- i. Psychiatrists Raw Data Report Form, No. 40-262;
- j. Ancillary Service Providers Raw Data Report Form, No. 40-263; and
- k. Results Report Form, No. 40-264, which includes:
 - 1. Primary Care Physicians and Providers Results Tab;
 - 2. Non-Physician Mental Health Care Providers Results Tab;
 - 3. Specialist Physicians Results Tab;
 - 4. Psychiatrists Results Tab;
 - 5. Ancillary Service Providers Results Tab;
 - 6. Summary of Rate of Compliance (ROC) Tab; and
 - 7. Network by Provider Survey Type Tab.

Further, subsection (h)(6)(B)(ii) of Rule 1300.67.2.2 specifies that a health plan must complete the PAAS Report Forms, listed above, according to instructions in the PAAS Manual and Instruction Manual.

Subsection (h)(6)(B) of Rule 1300.67.2.2 is necessary to implement Health and Safety Code section 1367.03(f), which requires health plans to annually submit a TAR in the manner specified by the DMHC. The DMHC proposes to specify the manner by which a health plan must submit the TAR by requiring health plans to use the listed, standardized report forms, completed and submitted according to the instructions in the PAAS Manual and Instruction Manual. This subsection addresses the problem that without standardized data collection and reporting requirements, health plans will use various methods, resulting in TARs that are not comparable. It is necessary to standardize the way health plans collect and report TAR data in order to implement the requirement in Health and Safety Code section 1367.03(f)(2) for the TAR to allow consumers to compare the performance of health plans. It is also necessary to standardize the TAR so that the DMHC can perform timely access compliance review in an efficient manner.

Subsection (h)(6)(B)(ii) of Rule 1300.67.2.2 codifies existing TAR requirements by specifying a health plan's submission of the PAAS Report Forms. The purpose of this subsection is to ensure that the health plans submit a complete TAR, in the correct format. For example, the proposed Rule requires a health plan to submit a Contact List Report Form for each provider survey type. The provider survey types defined in subsection (b)(15) and explained in the PAAS Manual (paragraph 9.d), are necessary to ensure the PAAS and TAR cover an appropriate and comprehensive range of provider types.

Subsection (h)(6)(B)(ii) also clarifies the health plan must complete the Contact List Report Form using network providers specified in the PAAS Manual as of the applicable network capture date (see proposed subsection (h)(6)(B)(ii)a.). Subsection (h)(6)(B)(ii)b.

specifies a health plan must submit at least one Raw Data Report Form, as specified, and subsection (h)(6)(B)(ii)c. specifies the required manner of reporting the results of the PAAS using a single Results Report Form, which is necessary to allow the forms to automatically calculate results (as described in regard to subsection (f)). These standardized forms, and the specification of how a health plan must submit the forms to the DMHC, are necessary to ensure complete and consistent reporting of PAAS data to result in TARs that are comparable, as required by Health and Safety Code section 1367.03(f)(2). Subsection (h)(6)(B)(ii)c. also specifies that the Results Report Form will automatically calculate the health plan's rate of compliance using identified formulas. The purpose of this provision is to clarify that the report forms themselves perform the necessary calculation of the rate of compliance based on the data the health plan enters into the report form. As noted in regarding subsection (f), the PAAS Manual also explains automatic calculation by report forms. Subsection (h)(6)(B)(ii) will result in several benefits: the health plan TAR will include comprehensive information, including key provider types, regarding the health plan's compliance with timely access standards; additionally, the calculation function built into the report forms will reduce administrative burden on reporting plans, and it will reduce the likelihood of calculation errors. Finally, this subsection will help ensure the TARs from health plans are comparable, as required by Health and Safety Code section 1367.03(f)(2).

Related Instruction Manual Requirements for subsection (h)(6)(B):

Sections III.C (p. 19) and IV (pp. 23-24) of the Instruction Manual reiterate subsection (h)(6)(B)'s requirements for health plans to use the PAAS Report Forms, and related requirements from the PAAS Manual. The Instruction Manual specifies that each required form must be submitted in the applicable sections of the DMHC's web portal. Section IV of the Instruction Manual specifically reiterates the requirements of subsection (h)(6)(B)(ii)(a)-(c), and clarifies the health plan must use each Contact List Report Form to select unique providers in each county from each network to survey (which is consistent with instructions in the PAAS Manual). The Instruction Manual also reiterates that specified tabs within the Results Report Form are auto-calculated (as explained in the PAAS Manual). Reiterating this information in the Instruction Manuals will help ensure health plans clearly understand how all of the PAAS Report Forms work together to form the TAR required under subsection (h). The Instruction Manual also requires the health plan to complete the "Health Plan Information Tab" within each of the PAAS Report Forms; this is necessary to ensure each report form bears key identifying information for the reporting plan, so the DMHC can easily tell which health plan and measurement year the form describes. Finally, the Instruction Manual reminds health plans that failure to complete the PAAS Report Forms according to the instructions may result in a DMHC finding of non-compliance pursuant to Rule 1300.67.2.2(f) and (i).

All of these instructions will help ensure health plans clearly understand their responsibility for compliance, and understand how to comply with subsection (h)(6)(B) by submitting the required PAAS report forms within the DMHC's web portal.

Subsection (h)(6)(C) describes the next item health plans must include in the TAR. This provision amends existing subsection (g)(2)(C) by reorganizing the provision into sub-parts to make the requirements easier to read, and by further specifying the reporting requirements, as described in the following paragraphs. These provisions in subsection (h)(6)(C) will result in the benefit that health plans will correctly report their procedures and actions related to self-monitoring, allowing the DMHC to review the health plan's procedures and responsive actions for consistency with the Rule and Knox-Keene Act. This will help ensure that health plans maintain appropriate self-monitoring and corrective processes to ensure health plans provide timely access to health care to enrollees.

Under subsection (h)(6)(C)(i), health plans must include in the TAR a description of the health plan's process for identifying PON (patterns of non-compliance) and any incidents of non-compliance resulting in substantial harm to an enrollee. The description must include three components:

- (a) The health plan's definition of "incident of non-compliance resulting in substantial harm to an enrollee";
- (b) The health plan's definition of PON; and
- (c) The health plan's monitoring mechanism and sources of information used to identify the PON and incidents of non-compliance.⁶⁴

As described previously, the existing Rule 1300.67.2.2 already requires health plans to self-monitor (see existing subsection (d)), and to include in the TAR whether the health plan identified any PON or incidents of non-compliance resulting in substantial harm to an enrollee (see existing subsection (g)(2)(C)). However, the proposed amendments in subsection (h)(6)(C)(i) further specify these requirements. The proposed amendments specify the health plan must tell the DMHC the health plan's definitions of PON and incident of non-compliance resulting in substantial harm to an enrollee (which must at least be consistent with proposed definitions in the Rule and the Civil Code).⁶⁵ These amendments are necessary to implement Health and Safety Code section 1367.03. Specifically, Health and Safety Code section 1367.03(g)(2) authorizes the DMHC to take certain enforcement actions when "substantial harm to an enrollee has occurred as a result of" health plan non-compliance. To properly implement this statute, the DMHC must know what definition of "substantial harm..." the health plan utilizes when conducting its self-monitoring processes. Similarly, Health and Safety Code section 1367.03(g)(1) requires the DMHC to "focus more" on PON rather than isolated episodes of non-compliance. The term PON is vague, which is why the DMHC proposes to define the term in subsection (b)(11). However, subsection (h)(6)(C) clarifies that the DMHC's definition of PON is a minimum standard, and the health plan may choose to use a definition that is consistent with subsection (b)(11), but also has other components. This flexibility has the

⁶⁴ Section III.D of the Instruction Manual (p. 20) reiterates the requirements of subsection (h)(6)(C).

⁶⁵ See Civil Code section 3428, defining "substantial harm" as, "[...] loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss [...]"

benefit of allowing a health plan to utilize varying definitions of PON and “incidents of non-compliance...” that best serve the health plan’s operations, while remaining consistent with the definitions in the proposed Rule. This subsection also has the benefit of ensuring the DMHC has information necessary to evaluate the health plan’s quality assurance processes and compliance with timely access standards, and to “focus more” on PON, as required by Health and Safety Code section 1367.03.

Similar to existing Rule 1300.67.2.2(g)(2)(C), subsection (h)(6)(C)(ii) of Rule 1300.67.2.2 requires the health plan to report in the TAR whether it identified any PON or incidents of non-compliance resulting in substantial harm to an enrollee, but the amendments specify that that this report pertains to patterns and incidents that occurred *during the measurement year*. Specifying that health plans must report the occurrences from the applicable measurement year will have the benefit of allowing health plans to clearly understand the scope of information must be reported under this subsection. Additionally, the proposed Rule defines what constitutes a PON (see subsection (b)(11)), meaning the health plans’ reports of identified PONs under subsection (h)(6)(C)(ii) will be comparable. This provision therefore implements Health and Safety Code section 1367.03 by helping to ensure that health plan TARs are consistently reported according to the definitions in the Rule, and results in TARs that are comparable, as required by that statute. Additionally, this provision will have the benefit of helping health plans to understand how to fulfill the reporting obligation under this provision.

Subsection (h)(6)(C)(iii) of Rule 1300.67.2.2 amends existing subsection (g)(2)(C). The proposed amendments clarify the requirement for the health plan to report the health plan’s investigation efforts in response to an identified PON or “incident of non-compliance...” by adding a reference to proposed subsection (h)(6)(C)(ii) (regarding whether the health plan identified incidents or patterns of non-compliance). These clarifying amendments will have the benefit of helping health plans understand how to fulfill the reporting obligation under this provision to ensure compliance with the law.

Subsection (h)(6)(C)(iv) of Rule 1300.67.2.2 amends existing subsection (g)(2)(C) by further specifying required components of a health plan’s “corrective action plan” (CAP). Health plans must include in the CAP the health plan’s steps and follow-up actions to bring its network into compliance. This amended language will help health plans more clearly understand how to comply with the existing requirement to correct deficiencies that are identified. The amended language is necessary to implement and be consistent with existing laws, including requirements for health plans to make services readily available consistent with good professional practice, and monitor enrollee access to care and address access problems as they arise (see, e.g., Health and Safety Code section 1367, Rule 1300.67.2(f), etc.). This provision will result in the benefit of helping ensure health plans maintain appropriate self-monitoring and corrective processes and provide timely access to health care to enrollees.

Subsection (h)(6)(C)(v) of Rule 1300.67.2.2 specifies that if a health plan *later* identified *but did not report to the DMHC* a PON or incident of non-compliance resulting in substantial harm to an enrollee, then the health plan must include that information in the health plan’s next TAR submitted to the DMHC. This provision addresses the problem

that a TAR typically pertains to a single measurement year. If a health plan is unaware of a deficiency and therefore does not disclose a deficiency in the TAR, the DMHC will not be aware of the deficiency or the health plan's responsive action. Subsection (h)(6)(C)(v) addresses this problem by requiring the health plan to report the discovered information in the *next year's* TAR. This provision will result in the benefit helping ensure health plans maintain appropriate self-monitoring and corrective processes and provide timely access to health care to enrollees.

Subsection (h)(6)(D) of Rule 1300.67.2.2 describes the next item health plans must include in the TAR.⁶⁶ The amendments build on the existing requirement to report a list of all providers using advanced access appointment scheduling, adding health plans must include in the TAR their policies and procedures used for verifying network providers' advanced access programs. The Instruction Manual further clarifies health plans may report the list of providers using the Primary Care Provider Contact List Report Form (see Instruction Manual, p. 20). This will have the benefit of allowing health plans to clearly understand how to correctly submit the required information to the DMHC.

As noted earlier in this ISOR, the existing Rule 1300.67.2.2 defines "advanced access" (see subsection (b)(1)), and allows health plans to "demonstrate compliance with primary care time-elapsed standards through implementation of standards, processes and systems providing advanced access to primary care appointments" (see existing Rule 1300.67.2.2(c)(5)(I)). Further, under the existing Rule 1300.67.2.2 (d)(2)(E), health plans are also required to verify advanced access programs reported by providers and provider group to confirm that appointments are, in fact, scheduled consistent with the definition of advanced access. Proposed subsection (h)(6)(D) adds a requirement for a health plan to include in the TAR the advanced access verification policies and procedures. This will result in the benefit that the DMHC can review the policies and procedures to determine that they effectively verify the advanced access program as required under the existing Rule. It is particularly important to ensure a health plan's verification process is effective, because health plans may be "deemed compliant" with primary care time-elapsed standards, under the QAAP PAAS modality, discussed in regard to subsection (f)(1)(F). Since QAAP are deemed compliant and need not answer the PAAS, it is necessary to ensure the health plan's verification procedures for establishing a provider is a QAAP are effective. Otherwise, a health plan could be deemed compliant with time elapsed standards when the health plan is not truly compliant. Therefore, the DMHC review of policies and procedures under this subsection will help ensure enrollees receive timely access to care as required under Health and Safety Code section 1367.03. Finally, subsection (h)(6)(D) contains non-substantive amendments for consistency with defined terms in the Rule, such as "provider group" (which makes specific reference to medical groups and independent practice associations unnecessary). Consistent terminology is necessary to implement the reports required under Health and Safety Code sections 1367.03 by assisting health plans to complete report forms correctly before submission to the DMHC through the DMHC's web portal.

⁶⁶ Section III.E of the Instruction Manual (p. 23) reiterates the requirements of subsection (h)(6)(D).

Subsection (h)(6)(E) of Rule 1300.67.2.2 describes another item health plans must include in the TAR.⁶⁷ This subsection amends the existing requirement to include in the TAR a description of the implementation and use of triage, telemedicine, and health information technology; the amendments specify the required information includes applicable telehealth modalities. Telehealth modality is defined in the Instruction Manual (definition #30) as *the method by which an enrollee receives telehealth services*. The definition further clarifies telehealth modality may include direct patient care or provider-to-provider services, in a synchronous or asynchronous interaction, and states telehealth modalities may include live two-way video or audio interactions, e-consults, remote patient monitoring, store and forward interactions, remote clinician advice or triage services, or other methods of delivering treatment that meet the definition of “telehealth.”⁶⁸ The listed telehealth modalities encompass the methods for delivering telehealth known to the DMHC, and contain flexibility for new methods that may be developed in the future. Receiving information about the telehealth modalities used by health plans will allow the DMHC to better understand the ways health plans provide services via telehealth to identify trends that may warrant adjustment of standards, pursuant to Health and Safety Code section 1367.03(i). It is necessary to specify standardized ways to report this information, to ensure health plans use consistent terms and report a comparable TAR, as required by Health and Safety Code section 1367.03(f)(2).

Subsection (h)(6)(F) of Rule 1300.67.2.2 amends the existing requirements in existing Rule 1300.67.2.2(g)(2)(F) to include the results of the most recent annual enrollee and provider surveys and a comparison and discussion of the results to the results of the previous year’s survey.⁷⁰ The proposed subsection (h)(6)(F) adds a requirement for the plan to also report the health plan’s survey questions, methodology, and policies and procedures for administering the EES and PSS.⁶⁹

Related Instruction Manual Requirements for subsection (h)(6)(F):

The Instruction Manual (pp. 21-22) reiterates the requirements of subsection (h)(6)(F), and clarifies the PSS and EES documentation required to be submitted must include the health plan’s policies and procedures used to administer the PSS, including identification of page numbers in the relevant filings, a copy of the health plan’s PSS and EES survey tools, and the PSS and EES methodologies the health plan used to administer the survey and analyze the results. Additionally, the Instruction Manual clarifies the health plan must submit a narrative description

⁶⁷ Section III.F of the Instruction Manual (p. 23) reiterates the requirements of subsection (h)(6)(E).

⁶⁸ Telehealth is defined in the Business and Professions Code, section 2290.5, and that definition of telehealth is incorporated in the Instruction Manual (definition #29).

⁷⁰ Section III.G of the Instruction Manual (pp. 23-24) reiterate requirements under subsection (h)(6)(F).

⁶⁹ Note: Unlike the PAAS, health plans have flexibility to administer the PSS and ESS, consistent with Rule 1300.67.2.2(d)(2)(B)-(C). In contrast, health plans must adhere to the DMHC’s standardized methodology for the PAAS, as described in subsection (f) and the PAAS Manual.

comparing the current year's survey results with the survey results from the previous measurement year, as required by subsection (h)(6)(F). These instructions result in the benefit of ensuring health plans clearly understand what to submit to comply with subsection (h)(6)(F).

These requirements also help ensure the DMHC can easily identify relevant portions of the health plan submission and determine the health plan's compliance with relevant requirements, which will help ensure efficient regulatory review.

Subsections (d)(2)(B) and (d)(2)(C) of Rule 1300.67.2.2 require plans to administer the EES and PSS, but those subsections do not require adherence to a standardized script or methodology. However, Rule 1300.67.2.2(d)(2) requires health plans to file for DMHC approval the health plan's compliance monitoring policies and procedures designed to accurately measure the network accessibility, including the EES and PSS. Even though the DMHC does not dictate a health plan's methodology for the PSS/ESS, it will be valuable for the DMHC to receive the information about how health plans administer the EES and PSS. That information will provide valuable information regarding the context for the health plan's PSS/ESS results. Information about the health plan's EES/PSS processes will also allow the DMHC to ensure health plans are, in fact, administering the EES and PSS in accordance with their policies filed with and approved by the DMHC pursuant to Rule 1300.67.2.2(d)(2). Finally, subsection (h)(6)(F) contains amendments to use the terms EES and PSS, established in proposed Rule 1300.67.2.2(d), which are clearer than the old terms "enrollee and provider surveys." This will help health plans more clearly understand what must be included in the TAR pursuant to this subsection and ensure they submit the necessary information to the DMHC.

Subsection (h)(6)(G) of Rule 1300.67.2.2 describes the last item health plans must include in the TAR.⁷⁰ This subsection specifies health plans shall include the quality assurance report, which is required by subsection (f)(1)(J) and which is described in detail in paragraphs 81-85 of the PAAS Manual. This provision has the benefit of clarifying that health plans shall give the required report to the DMHC in the TAR, which will have the benefit of ensuring the health plan's PAAS received quality assurance review, as required by the Rule. As discussed in connection with subsection (f), the quality assurance report helps ensure the health plan's PAAS results and TAR are accurate. Accurate TARs will allow the DMHC to complete timely access compliance review pursuant to Health and Safety Code section 1367.03, and they will allow consumers to compare the performance of health plans in complying with timely access standards pursuant to Health and Safety Code section 1367.03(f)(2).

Related Instruction Manual Requirements for subsections (f) and (h)(6)(G):

The Instruction Manual (p. 22) reiterates the requirements of subsection (h)(6)(G) and further specifies the health plan must report the name of the external vendor used as required pursuant to subsection (f)(3) and the PAAS Manual. This will

⁷⁰ Section III.H of the Instruction Manual (p. 24) reiterates the requirements of subsection (h)(6)(G).

result in the benefit that the DMHC will be able to easily identify which vendor performed the required quality assurance review. This will help the DMHC ensure the vendor adhered to all requirements in subsection (f) and the PAAS Manual. It will also allow the DMHC to remain aware of external vendors providing this service, and identify any trends, such as certain vendors who fail to adhere to required standards.

ANR Requirements, beginning in Reporting Year 2022:

As described in section II.A of this ISOR, the Legislature enacted SB 964 to add network adequacy reporting and compliance review to existing laws regarding timely access to care. Accordingly, this rulemaking action adds network adequacy reporting (ANR) requirements implementing SB 964 in Rule 1300.67.2.2.

Subsection (h)(7) of Rule 1300.67.2.2 and the Instruction Manual specify the required contents of the ANR, including the ANR Report Forms incorporated by reference into the Rule.⁷¹ Subsection (h)(7) requires the ANR to confirm network status and enrollment, including the data categories required in Health and Safety Code section 1367.035(a) and 1367.035(g). Subsection (h)(7) and related provisions in the Instruction Manual are necessary to implement Health and Safety Code sections 1367 (requiring ready access to necessary care), 1367.035 (requiring annual submission specified network adequacy data (the ANR) with the TAR), and Health and Safety Code section 1367.03(f) (requiring the annual reports to be submitted in the manner specified by the DMHC). Similar to subsection (h)(6), subsection (h)(7) also requires the ANR to be submitted in accordance with the requirements in the Instruction Manual, which is incorporated by reference into the Rule, and which contains detailed instructions for how to fill out required report forms and submit the ANR through the DMHC's web portal. It is necessary to specify the required contents and format of the ANR so health plans understand what to file to comply with Health and Safety Code sections 1367.03(f) and 1367.035(a), and ensure standardization and comparability of resulting reports, as required by Health and Safety Code section 1367.03(f)(2). Accurate, complete, and comparable ANRs will allow consumers to shop for health coverage in an informed manner and choose health coverage with a network that is adequate and best fits the consumer's needs.

The specific purpose, necessity, and benefit of the provisions of subsection (h)(7) are further described in detail in the following paragraphs.

Subsection (h)(7)(A) of Rule 1300.67.2.2 specifies that the ANR must include listed information and data, such as the health plan's enrollment in each network and product line, and the service area of each network, all on a ZIP Code and county basis. Subsection (h)(7)(A) also requires the ANR to include a complete list of all network providers within each network, and information on all grievances regarding network adequacy and timely access compliance received for each network during the

⁷¹ Additional requirements for the annual TAR and ANR are set forth in subsection (h)(8) (Network Access Profile) and related provisions of the Instruction Manual, and are described later in this ISOR.

measurement year. The information required by subsection (h)(7)(A) is necessary to implement Health and Safety Code sections 1367 (requiring ready access to care) and 1367.035 (submission of network adequacy data for DMHC compliance review, including information regarding providers and grievances). This information is necessary because the DMHC must understand both the composition of a health plan's network, and who the network serves (the enrollment), in order to determine whether the network is adequate. This reporting requirement is also necessary to be consistent with other existing network adequacy laws that require accessible services within each service area (see, e.g., Rule 1300.67.2(a): "*Within each service area of a plan, [...] services shall be readily available and accessible to each of the plan's enrollees [...]*"). This information will allow the DMHC to understand how many and what type of providers participate in each network, which will result in the benefit of helping ensure the network has a comprehensive range of providers adequate to serve the enrollees. Receiving information about grievances will also allow the DMHC to identify any trends affecting enrollees' access to timely care, and result in corrective action to improve the accessibility of health services. Additionally, standardized ANR reporting will have the benefit of standardized reports, as required by Health and Safety Code section 1367.03(f)(2).

Subsection (h)(7)(B) of Rule 1300.67.2.2 specifies what report forms a health plan must complete and submit for its ANR: the Annual Network Report Forms, numbered 40-265 through 40-272 (ANR Report Forms).⁷² The ANR Report Forms, listed below, are incorporated by reference in the proposed Rule:

- (i) PCP and PCP Non-Physician Medical Practitioner Report Form, Form No. 40-265;
- (ii) Specialist and Specialist Non-Physician Medical Practitioner Report Form, Form No. 40-266;
- (iii) Hospital and Clinic Report Form, Form No. 40-267;
- (iv) Other Outpatient Provider Report Form, Form No. 40-268;
- (v) Mental Health Professional and Mental Health Facility Report Form, Form No. 40-269;
- (vi) Network Service Area and Enrollment Report Form, Form No. 40-270;
- (vii) Telehealth Report Form, Form No. 40-271; and
- (viii) Timely Access and Network Adequacy Grievance Report Form, Form No. 40-272.

Standardized ANR reporting is necessary to implement Health and Safety Code sections 1367.035(a) and 1367.03(f), and will have the benefit of resulting in comparable reports, as required by Health and Safety Code section 1367.03(f)(2).

Subsection (h)(7)(C) of Rule 1300.67.2.2 specifies that a reporting plan must submit the "Out-of-Network Payment Report Form," Form No. 40-273, with the health plan's ANR.⁷³

⁷² Sections I.A and V of the Instruction Manual reiterate the requirement to use only the report forms identified in Rule 1300.67.2.2 for the annual reports.

⁷³ Section I.A of the Instruction Manual reiterates the requirement to use only the report forms identified in Rule 1300.67.2.2 for the annual reports.

This provision is necessary to implement Health and Safety Code section 1371.31(a)(4), which requires health plans to include in the ANR, in the manner specified by the DMHC, the “number of payments made to noncontracting individual health professionals for services at a contracting health facility and subject to Health and Safety Code section 1371.9, as well as other data sufficient to determine the proportion of noncontracting individual health professionals to contracting individual health professionals at contracting health facilities.” Health and Safety Code section 1371.31 requires health plans to report this information in the manner specified by the DMHC, and the DMHC specifies the manner of the report in subsection (h)(7)(C) and related sections of the Instruction Manual.⁷⁴ The information required under subsection (h)(7)(C) will have the benefit of allowing health plans to understand how to comply with Health and Safety Code section 1371.31(a)(4), and will give the DMHC the information necessary to assess whether a health plan had enough in-network individual health professionals⁷⁵ at its in-network facilities (e.g., hospitals) to satisfy standards under the Knox-Keene Act, such as the requirement for a reasonable number of specialist providers, during the measurement year. This will ultimately lead to corrective action when necessary, which will result in health plan networks that better serve enrollees.

Subsection (h)(8) of Rule 1300.67.2.2 specifies how health plans must complete the Network Access Profile.⁷⁶ As stated previously, the Network Access Profile is part of the DMHC’s online web portal for the TAR and ANR. In the Network Access Profile, each health plan annually updates or completes its “profile” by entering high-level information about the health plan’s networks, network service area(s), product lines that use the network, and any plan-to-plan contracts. Therefore, the Network Access Profile is part of the annual report pursuant to Health and Safety Code sections 1367.03(f) and 1367.035(a). Entering the Network Access Profile information s

Overall, subsection (h)(8) is necessary to implement Health and Safety Code sections 1367.03 and 1367.035 by specifying how a health plan must enter foundational information into the DMHC’s web portal to allow the health plan to correctly submit its TAR and ANR and produce accurate and comparable reports, as required by Health and Safety Code section 1367.03(f)(2). Subsection (h)(8) will also help ensure that health plans update their profile information annually, resulting in reports that are up-to-date and accurate. More specifically, subsection (h)(8) specifies health plans must update or complete the Network Access Profile *before* submitting the TAR and ANR. This is necessary because the Network Access Profile houses information about the health plan and its networks, network service areas, plan-to-plan contracts, and other information that must be entered first. Entering the Network Access Profile information s

⁷⁴ See the following sections of the Instruction Manual: II (General Instructions Applicable to All Required Report Forms) and V.I (Out-of-Network Payment Report Form Instructions).

⁷⁵ The term “individual health professional” is defined in Health and Safety Code section 1371.9.

⁷⁶ Section I.B of the Instruction Manual reiterates requirements to complete or update the Network Access Profile.

the DMHC an overview of the health plans' networks, including any plan-to-plan contracts. Additionally, including network information in the Network Access Profile helps to ensure that the information submitted by the health plan in the TAR and ANR report forms is complete and accurate. The information entered into the Network Access Profile by the health plan is validated against the information in the health plan's report forms. For example, the health plan must enter the "network name" within the Network Access Profile, and the web portal validates that the same "network name" appears correctly throughout the health plan's report forms. Accordingly, subsection (h)(8) requires a health plan to 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 Instruction Manual. These requirements will result in the benefit of providing DMHC an overview of all health plan networks and help ensure that the health plans submit complete and accurate TAR and ANR. Subsection (h)(8) also reiterates a health plan must affirm the accuracy of the information and data, as required by subsection (h)(2), which will help hold the health plan accountable for maintaining appropriate protocols to report accurately to the DMHC.

Subsection (h)(8)(A)-(D) specify the required Network Access Profile data that a health plan must submit in the DMHC's web portal. Subsection (h)(8)(A) specifies the health plan shall update its Network Access Profile each year before submitting the reports to reflect any changes to the networks as of the network capture date. As noted regarding other provisions of subsection (h)(8), this will help ensure the submitted ANR reflects current information and result in an accurate TAR and ANR. It will also help ensure the resulting TAR and ANR are based on the relevant network capture date, and are comparable as required by Health and Safety Code section 1367.03(f)(2).

Subsection (h)(8)(B) requires a health plan to identify the network name and DMHC-assigned network identifier for each reported network, and identify relevant changes from the previous measurement year, including the appropriate amendment or notice of material modification and, any other information describing the network change.⁷⁷ This information in the Network Access Profile will allow the DMHC and the health plan to correctly complete and submit the TAR and ANR, and will allow the DMHC to easily track the reported information according to the network identifier. Additionally, the information about any relevant amendment or notice of material modification will help ensure the DMHC can easily find the filings associated with the network changes described by the health plan in its reports. This information will allow efficient review by the DMHC.

Related Instruction Manual Requirements for subsection (h)(8)(B):

The Instruction Manual (p.11) reiterates the requirements noted above and further clarifies that the DMHC will annually provide an updated list of networks and network identifiers within the web portal. This will benefit health plans by making required information easily accessible, reducing the burden on the health plans. The Instruction Manual also requires a health plan to identify whether the reported network had enrollment as of the network capture date and if not, the last date of

⁷⁷ Instruction Manual section I.B.1, p. 11.

enrollment within the network. This information is necessary to allow the DMHC to assess whether the health plan submitted all required network filings (which may be unnecessary if the network lacked enrollment). Information about the last date of enrollment also allows the DMHC to check the accuracy of the health plan's Enrollment Report Forms.

Subsection (h)(8)(C)(i)-(ii) further specify information the health plan must identify in the Network Access Profile for each network, including product lines and network service area. This information is necessary to allow health plans to understand how to correctly complete the Network Access Profile, be able to correctly submit the TAR and ANR, result in a comparable report, as required by Health and Safety Code section 1367.03(f)(2). Additionally, this information will allow the DMHC to assess the adequacy of each network, consistent with Health and Safety Code section 1367.035.

Related Instruction Manual Requirements for subsection (h)(8)(C):

The Instruction Manual (p.11) reiterates the requirements noted above and further clarifies that if the health plan identifies a produce line as large group, in-home supportive services, Healthy Kids, or employer, then the health plan must identify whether the Evidence of Coverage covers health services the health plan must offer to a group subscriber (including Alcohol and Other Drugs services,⁷⁸ applicable pharmacy services,⁷⁹ and orthotics/prosthetics⁸⁰). This information will allow the DMHC to ensure health plans comply with the Knox-Keene Act's coverage requirements. This has the benefit of helping to ensure enrollees of group health coverage receive health coverage that complies with the Knox-Keene Act standards. The Instruction Manual (p.11) also reiterates the requirement for health plans to report in the Network Access Profile the network service area, and clarifies to do so, the health plan must identify all counties or parts of counties within the network service area. This instruction will allow health plans to understand how to correctly complete this portion of the Network Access Profile and report their entire network service area. This will allow the DMHC to effectively conduct network adequacy review, and will help ensure the annual health plan reports are consistent and comparable, as required by Health and Safety Code section 1367.02(f).

Subsection (h)(8)(C)(iii) and related provisions of the Instruction Manual require the health plan to report the source of network providers. The sources must be reported as follows: 1) whether the health plan directly employs or contracts with some or all of its network providers pursuant to subsections (b)(9)(B)(i)-(iii); 2) whether the health plan is the primary plan or subcontracted plan for the network (based on whether any network provider are made available to the health plan's enrollees by a subcontracted plan, or to a primary plan); 3) (for primary plans) whether any subcontracted plan networks contribute providers through plan-to-plan contracts and there is any delegation of health plan

⁷⁸ See Health and Safety Code section 1367.2.

⁷⁹ See, e.g., Health and Safety Code section 1367.25.

⁸⁰ See Health and Safety Code section 1367.18.

functions; and 4) (for subcontracted plans) whether there are networks to which the health plan contributes network providers through a plan-to-plan contract.

Related Instruction Manual Requirements for subsection (h)(8)(C)(iii):

The Instruction Manual (pp.11-13) reiterates the requirements noted above regarding the reporting in the Network Access Profile the source of network providers. This portion of the Instruction Manual also further clarifies how to report the source of network providers, and what specific information is required. Specifically, when the health plan selects “Plan-to-Plan Contract – Network Serves as Primary Plan” (pursuant to Rule 1300.67.2.2(h)(8)(C)(iii)(c), the Instruction Manual specifies the information about the subcontracted plan and its networks, and duty delegation that the health plan must report in the Network Access Profile. Additionally, when the health plan selects “Plan-to-Plan Contract – Network Serves as Subcontracted Plan” (pursuant to Rule 1300.67.2.2(h)(8)(C)(iii)(d), the Instruction Manual specifies the information about the primary plan and its network providers, and duty delegation that the health plan must report in the Network Access Profile.

The information required by subsection (h)(8)(C) and related provisions of the Instruction Manual implements Health and Safety Code sections 1367.03 and 1367.035 by standardizing the TAR and ANRs to produce comparable reports, as required by Health and Safety Code section 1367.03(f)(2). Additionally, this information is necessary to implement Health and Safety Code section 1367 (holding a health plan ultimately responsible for compliance with the Knox-Keene Act, notwithstanding delegation of functions to other entities). As described previously in this ISOR, many health plans enter plan-to-plan contracts, which can cause confusion about whether the health plan is responsible for various functions. The DMHC must know about plan-to-plan contracts and delegation of duties in order to assess the health plan’s compliance with the Knox-Keene Act. The information required under subsection (h)(8)(iii) will allow the DMHC to understand the nature and composition of each reported health plan network and conduct appropriate compliance review. For example, primary plans must exercise appropriate oversight over subcontracted plans (see subsection (h)(6)(A)(iii)). This will have the benefit of allowing the DMHC to conduct effective compliance review for timely access and network adequacy, in the context of plan-to-plan contracts.

Subsection (h)(8)(D) of Rule 1300.67.2.2 specifies how the health plan must use standardized terminology for its TAR and ANR.⁸¹ This subsection addresses the problem that the required information in the TAR and ANR may be described using various terms, making comparison of reports from different health plans difficult. Accordingly, a health plan may either use the DMHC’s standard term or report what health plan term corresponds to the DMHC’s standard term using crosswalk tables (except as specified in the subsection). This provision has the benefit of allowing health plans to use their own terminology, if that terminology would best suit the health plan’s operations, while also

⁸¹ Sections I.B.7 (p. 13) and II.C (p.15) of the Instruction Manual reiterate the requirements in (h)(8)(D).

ensuring the DMHC is able to accurately compare information from different health plans. This provision is necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2). The specific areas for which standard terms must be used or identified are described in the following paragraphs.

Subsection (h)(8)(D)(i)-(x) specify the areas of standardized terminology. Subsection (h)(8)(D)(i) specifies the standard hospital names are those from the California Office of Statewide Health Planning and Development (OSHPD), available at <https://oshpd.ca.gov>, as of the network capture date. This provision has the benefit of identifying a reliable source of hospital name information applicable to the measurement year. This provision also specifies the DMHC shall make the list of standard hospital names available in the DMHC's web portal, which will have the benefit of reducing the burden on health plans to locate the information elsewhere. This provision is necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable as required by Health and Safety Code section 1367.03(f)(2).

Subsection (h)(8)(D)(ii) specifies the standard product line categories a health plan must use in their reports or identify in crosswalk tables (e.g., "HMO Small Group Market"). As defined in subsection (b)(13), product line means the combination of the health plan's product and the type of market segment (e.g., small group) in which the product is offered. It is necessary to define "product line" to implement the purpose of Health and Safety Code section 1367.035(b)-(c), which require separate submission of network adequacy data by product line. Similarly, subsection (h)(8)(D)(ii) specifies the health plan will report product lines with standardized terminology; this provision is necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable as required by Health and Safety Code section 1367.03(f)(2). Standardized terminology will also have the benefit of ensuring efficient regulatory review by the DMHC.

Subsection (h)(8)(D)(iii) specifies the standard provider types a health plan must use or identify, including physician specialty and sub-specialty type (based on American Board of Medical Specialties and the Knox-Keene Act), non-physician medical practitioner specialty type (based on appropriate licensing boards), mental health professional specialty type, other outpatient provider type, hospital and other inpatient provider type, clinic type, and mental health facility type. This provision is necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable as required by Health and Safety Code section 1367.03(f)(2). Regarding specialties, this provision also has the benefit of basing standard terms on terms used consistently in the health care industry. This will have the benefit of standard terms that are understandable and identifiable by reporting health plans.

Subsection (h)(8)(D)(iv) specifies the standard provider languages a health plan must use in their reports or identify in crosswalk tables. Several required report forms require the health plan to indicate any languages other than English spoken by the network provider. Health and Safety Code section 1367 requires ready access to necessary health care services, in accordance with language assistance program requirements. Information

regarding network provider languages is necessary to allow the DMHC to understand the network's capacity to serve the enrollee population. This provision in subsection (h)(8)(D)(iv) is necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports use comparable terminology, as required by Health and Safety Code section 1367.03(f)(2). This will have the benefit of standardized terms that are understandable and identifiable by reporting health plans.

Subsection (h)(8)(D)(v) specifies the standard provider group names a health plan must use in their reports. This subsection specifies the standard provider group names are those filed with the Secretary of State, the name on file with the Department for capitated provider groups, or the name on file with the DMHC for risk-bearing organizations that file information pursuant to section 1300.75.4.2, as applicable. This provision is necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2). This provision also specifies the DMHC shall make the list of standard provider group available on the DMHC's web portal, which will have the benefit of reducing the burden for health plans.

Subsection (h)(8)(D)(vi) specifies the standard type of license or permit a health plan must use or identify. This subsection specifies the standard type of license or permit is based on 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 the California Health and Human Services Agency, including the Department of Health Care Services (DHCS). This provision has the benefit of basing standardized terms on relevant, reliable sources. This provision is necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2) and identifies sources the health plans may utilize to reduce the burden of identifying the source.

Subsection (h)(8)(D)(vii) specifies the standard ZIP Code and county a health plan must use for its TAR and ANR. This provision specifies the DMHC will make the list of standard zip codes and counties available on the DMHC's web portal, which will have the benefit of reducing the burden on health plans and helping to ensure health plans know where to find the standard terms. This provision is necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2).

Subsection (h)(8)(D)(viii) specifies the standard California license number and National Provider Identifier (NPI), and requires a health plan to identify license and NPI information for each network provider (including providers from out-of-state). This will allow the DMHC to identify each network provider and ensure they are appropriately licensed, and the health plan network is adequate. This subsection also specifies the DMHC will annually publish on the DMHC's web portal a current list of active NPIs, derived from the National Plan and Provider Enumeration System (NPPES), NPI registry (npiregistry.cms.hhs.gov). The DMHC will also annually publish on its web portal a list of California license numbers

for physicians, derived from the Department of Consumer Affairs (www.dca.ca.gov). This provision will reduce the burden on health plans by making the required standard information readily available in the DMHC's web portal. This subsection is necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2).

Subsection (h)(8)(D)(ix) specifies the standard grievance field values the health plan must report related to timely access and network adequacy grievances. This provision is necessary to implement Health and Safety Code section 1367.035(a)(6), which requires the ANR to include this grievance data. However, like other data, without standardized terms, health plans would describe grievances using varying terms, making comparison of reports cumbersome for the DMHC and consumers. This subsection is necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2).

Subsection (h)(8)(D)(x) specifies the requirement for standard telehealth location and modality terminology, which is further specified in Appendix E of the Instruction Manual. This provision is necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable as required by Health and Safety Code section 1367.03(f)(2). Standardized terminology will also have the benefit of ensuring efficient regulatory review by the DMHC.

Related Instruction Manual Requirements for subsection (h)(8)(D):

The Instruction Manual reiterates the requirements of subsection (h)(8)(D),⁸² and clarifies that the DMHC's standardized terminology is contained in appendices A-F of the Instruction Manual:

- **Appendix A** (p. 131): Product Line Categories. The standardized list of product line categories reflects the types of product lines the DMHC knows to be common in California's health care marketplace, and also include an "other" category to include any novel product lines. These standardized terms also reflect the way health plans typically categorize their product lines in DMHC licensing filings. These product line terms have the benefit of being familiar to health plans, meaning it will not be burdensome for health plans to use these terms.
- **Appendix B** (p. 133): Provider Types. The standardized provider types in appendix B derive from existing law or other widely-recognized and credible sources including the American Board of Medical Specialties of Medical Specialties (for specialists); Rule 1300.45(m) for Primary Care Providers; areas of specialization recognized by the Board of Registered Nursing and National Commission on Certification of Physician Assistants for Non-

⁸² See sections I.B.7 (p. 13) and II.C (beginning p. 16) of the Instruction Manual.

Physician Medical Practitioners; Areas of specialty identified by consumer advocates (e.g., Qualified Autism Service Provider), and facility terms consistent with those used by OSHPD or the Centers for Medicare and Medicaid Services (CMS). These standardized terms are widely recognized and used by health plans, and will not be burdensome for health plans to locate and utilize.

- **Appendix C** (p. 142): Provider Languages. The listed languages are those Covered California (California's Health Benefits Exchange) requires health plans to use when reporting languages spoken by providers in a Covered California product. This list will therefore be familiar and non-burdensome to health plans that offer Covered California products. Additionally, this list is an appropriate resource for all health plans because it is reasonably comprehensive.
- **Appendix D** (p. 151): Type of License and Certificate. The standardized terminology in this appendix is 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. These Departments and Boards are familiar to health plans and so their terms will be easy to use and understand.
- **Appendix E** (p. 152): Telehealth Terminology. This terminology was developed in coordination with representatives from the Center for Connected Health Policy and a group of health plan and provider stakeholders that met regularly with the DMHC to advise the DMHC on the integration of telehealth innovation into the health plan regulatory scheme. These standardized terms reflect common locations where patients receive telehealth service and common telehealth delivery modalities. Appendix E also includes "other" categories to accommodate other information health plans report that does not fall under one of the standardized terms.
- **Appendix F** (p. 153): Grievance Field Values. These are the terms typically used by health plans based on the DMHC's experience in auditing health plan grievance files and grievance logs through the health plan survey process under Health and Safety Code section 1380. Additionally, where relevant, these terms track to terminology set forth in section 1368 and Rules 1300.68, et seq., in the Knox-Keene Act. The standardized terms for complaint category, provider category, and resolution method are familiar to health plans and will be easy to use and understand.

These appendices will have the benefit of helping health plans easily find the standardized terminology and comply with subsection (h)(8)(D).

Subsection (h)(9) clarifies the DMHC may review the reported information and data for completeness and accuracy, and halt submission of incomplete or nonconforming data. For example, if the health plan indicated in the DMHC's web portal that the health plan would be submitting certain report forms, but then the health plan did not upload those report forms, the TAR and ANR submission portal will prevent submission of that report. The health plan must either correct its list of included forms, or include all forms the health plan said it would submit to finish the report. This ability is necessary to ensure the DMHC receives the required information and does not receive incomplete or inaccurate forms.

Related Instruction Manual Requirements for subsection (h)(9): Validation

Instruction Manual section I.A.1 (pp.9-10) further clarifies the provisions of subsection (h)(9). The Instruction Manual states before submission of information through the DMHC's web portal, the uploaded report forms must pass the DMHC's automated validation process for completeness and accuracy. The Instruction Manual clarifies that the process does not guarantee that the health plan submission is completely correct, nor does it protect the health plan from DMHC enforcement action for inaccurate or incomplete reports. However, the validation process helps ensure the health plan submits all required documents, and that the health plan's submission matches what the health plan indicated it would submit. For example, in the DMHC's web portal, a health plan indicates which report forms it will submit, and the validation process under subsection (h)(9) checks whether the final submission actually included all of the indicated report forms.

The Instruction Manual clarifies the circumstances when a health plan's report form may not pass validation and may prevent submission through the DMHC's web portal: 1) the report form fields contain information or data conflicting with requirements in Rule 1300.67.2.2 of the Field Instructions (located in the Instruction Manual); 2) the report form is missing required information or data; 3) the report form contains information conflicting with standardized terminology requirements under Rule 1300.67.2.2(h)(8)(D); 4) the report form contains information or data conflicting with other information or data reported by the health plan through the DMHC's web portal (including information in the Network Access Profile regarding health plan networks, an incomplete crosswalk, or inconsistent information regarding network service areas); 5) the report form contains information conflicting with sources of required information such as the NPI Registry (required under Rule 1300.67.2.2(h)(8)(D)(viii), California Department of Consumer Affairs (required under Rule 1300.67.2.2(h)(8)(D)(vi)), U.S. Postal system (required under Rule 1300.67.2.2(h)(8)(D)(vii); 6) the health plan did not include required Enrollment Report Form information; or 7) the health plan's submission does not contain a Network Service Area Report Form and all other forms the health plan indicated it would submit.

These provisions describing the web portal's automated validation process will help the health plan correctly and completely submit required information, and will help the health plan clearly understand how to correct validation errors. The validation

process is necessary to implement Health and Safety Code sections 1367.03 and 1367.035 by ensuring health plans submit complete and accurate annual reports to the DMHC. This will have the benefit of helping health plans identify and correct basic problems within their annual reports, and achieve compliance with TAR and ANR requirements under the Knox-Keene Act. It will also ensure the DMHC's compliance review is efficient because the DMHC will not have to spend time performing or explaining to health plans this type of validation or what further information must be provided.

Additionally, subsection (h)(9) clarifies the DMHC may omit from its review information or data that is erroneous or contrary to the health plan's representations to the DMHC within the health plan's submission, other approved or pending filings, assessments, or actions with the DMHC. Historically, the DMHC has found TAR and ANR reports to contain significant and extensive data errors. This subsection will have the benefit of allowing health plans to understand that only valid data and information will be considered when the DMHC conducts compliance review. This will help ensure health plans maintain appropriate processes to submit complete and accurate reports to the DMHC.

Finally, subsection (h)(9) specifies the plan is responsible for ensuring the accuracy of its reported information and data, as set forth and required by subsections (a)(3) (*obligation to comply with section not waived when health plan delegates functions to another entity*), (a)(5) (*reports must be timely, accurate, and complete*), (h)(2) (*designated health plan compliance officer must review reports and verify pursuant to section 1004 the information is true and correct and contains no material misstatements*), (i) (*determining compliance and non-compliance*), and (j) (*review and enforcement*). The purpose of this subsection is to implement the reporting requirement under Health and Safety Code sections 1367.03 and 1367.035 in a manner that makes health plans accountable for providing correct information to the DMHC by the required deadlines. Accurate, timely, and complete information is necessary to allow the DMHC to conduct its compliance review pursuant to Health and Safety Code sections 1367.03(g) and 1367.035(d). This provision of subsection (h)(9) is also necessary to implement Health and Safety Code section 1367, which holds a health plan ultimately responsible for compliance with the Knox-Keene Act, notwithstanding delegation of functions to other entities. This subsection will help health plans understand they are responsible for complying with the law, and will result in more timely, accurate, and complete health plan reports submitted to the DMHC.

Subsection (i) of Rule 1300.67.2.2 specifies the standards the DMHC will use to determine compliance or non-compliance with the Rule. The purpose of this subsection is to ensure health plans understand the circumstances when the health plan will be found non-compliant and potentially subject to corrective or enforcement action by the DMHC. This subsection is necessary to implement Health and Safety Code sections 1367 (requiring ready access to health care services), 1367.03 (requiring timely access to care and the TAR), and 1367.035 (regarding network adequacy and the ANR). This subsection will result in the benefit of allowing health plans to clearly understand they are accountable for demonstrating compliance with the Rule so they can structure their operations and networks accordingly. This will help ensure enrollees have timely access to care through adequate networks.

Subsection (i)(1) specifies when a health plan network is non-compliant with Rule 1300.67.2.2 and the Knox-Keene Act's timely access and network adequacy requirements. This provision will have the benefit of allowing health plans to clearly understand the circumstances under which the DMHC will find a network to be non-compliant and subject the health plan to corrective or enforcement action. First, this subsection specifies a network is non-compliant when the health plan fails to demonstrate it met network adequacy for a network service area. This provision will help clarify the health plan is responsible for showing that its network is adequate, and will ensure health plans structure their operations to be able to make that demonstration in the annual reports (e.g., the health plan will ensure it can accurately report on its network). This provision will also ensure compliance determinations under the Rule are consistent with the way the DMHC currently assesses network adequacy, under existing law (see, e.g., Rule 1300.67.2(a): "*Within each service area of a plan, [...] services shall be readily available and accessible to each of the plan's enrollees [...]*").

Second, subsection (i)(1)(B) specifies a network is non-compliant when the health plan failed to provide timely access to care to an enrollee. This provision has the benefit of clarifying that, although the DMHC "focuses more" on PON during timely access compliance reviews,⁸³ a health plan remains responsible for complying with timely access laws under the Knox-Keene Act. This will allow health plans to understand what is required to comply with Rule 1300.67.2.2(c).

Third, subsection (i)(1)(C) specifies a network is non-compliant when the results of the health plan's PAAS indicate a PON as defined in subsection (b)(11)(A). This provision has the benefit of clarifying that a PON shown by a PAAS with a low rate of compliance is an actionable deficiency under the Knox-Keene Act. This will help health plans understand what will be considered a violation of Rule 1300.67.2.2(f)(1) (which requires a PAAS rate of compliance exceeding the PON standard in subsection (b)(11)(A)).

Fourth, subsection (i)(1)(D) specifies a network is non-compliant when the health plan fails to report sufficient or accurate information and data demonstrating network adequacy or timely access for a network service area. This provision is necessary to address the historic problem that health plan TAR and ANR reports have contained data errors so significant and extensive that the DMHC has found it impossible to assess the health plan's compliance with timely access and network adequacy requirements. This problem created an untenable situation where the most deficient health plan reporters were subject to the least regulatory review by the DMHC. To address this problem, subsection (i)(1)(D) clarifies that the health plan is responsible for demonstrating compliance using information and data in the annual reports. Subsection (i)(2) further clarifies subsection (i)(1) by specifying the DMHC may consider a health plan's failure to provide timely, complete, or accurate reports under subsection (h) as a presumptive failure to satisfy network adequacy requirements and a failure to demonstrate compliance with time-elapsd standards. Similar to subsection (i)(1)(D), subsection (i)(2) addresses the problem that the DMHC cannot assess compliance with timely access and network adequacy requirements when health plan reports contain extremely deficient data. Therefore,

⁸³ Health and Safety Code section 1367.03(g).

subsections (i)(1)(D) and (i)(2) will result in the benefit that health plans understand their responsibility to report completely and accurately. It will also result in the benefit of clarifying the DMHC's authority to take appropriate enforcement action when health plans fail to demonstrate compliance. However, subsection (i)(2) also clarifies that when the DMHC presumes the health plan is non-compliant, the health plan may submit information and data demonstrating the health plan's network is adequate. This provision will ensure health plans who initially submit untimely, incomplete, or inaccurate reports have the opportunity to correct the problem and demonstrate compliance. This will result in the benefit that timely access and network adequacy requirements, and related reporting requirements, are enforceable by the DMHC.

Subsection (i)(3) amends existing Rule 1300.67.2.2(g)(3). The amendments relocate the provision to subsection (i)(3) to accommodate the reorganization of the proposed Rule. This provision is necessary to implement Health and Safety Code section 1367.03(g), which requires the DMHC to focus more on PON when evaluating compliance. As amended, subsection (i)(3) specifies the DMHC will focus more on PON rather than isolated episodes of non-compliance, when evaluating a health plan's compliance with the standards in Rule 1300.67.2.2(c) (timely access standards). This amendment is necessary because the existing Rule 1300.67.2.2 addresses only timely access, so it was unnecessary to specify the DMHC will focus more on PON with timely-access standards. In contrast, the amended Rule also addresses compliance review under Health and Safety Code section 1367.035 (network adequacy), which is not subject to the requirement in Health and Safety Code section 1367.03(g) to focus more on PON. Subsection (i)(3) will result in the benefit that health plans will better understand the requirements for the DMHC to focus on PON under timely access requirements.

Subsection (i)(4) of Rule 1300.67.2.2 amends existing Rule 1300.67.2.2(g)(3) and specifies the factors the DMHC may consider when evaluating compliance, so the amendments specify that is the purpose of the listed factors. This will help health plans more clearly understand the bases for DMHC compliance determinations. The amendments also relocate the provision to subsection (i)(4) to accommodate the reorganization of the proposed Rule. The amendments also strike the phrase "*but not limited to,*" because that phrase is redundant. It is necessary to strike the phrase "but not limited to" because it is not necessary; the word "including" means that the noted processes are not an exhaustive list. This repeal will result in the benefit of reduced redundancy, which will improve the clarity of the Rule.

Subsection (i)(4)(A) contains amendments specifying: 1) a health plan's failure to maintain an adequate number or variety of network providers necessary to deliver timely care, or 2) inappropriately characterizing network providers who are available to deliver covered services, are both factors the DMHC may consider when evaluating compliance under the law. Similarly, subsection (i)(4)(B) contains amendments specifying that the factors include network adequacy deficiencies. These amendments are necessary to add the topic of network adequacy to the compliance factors already contained in Rule 1300.67.2.2. The existing Rule 1300.67.2.2 predated SB 964, and addressed only timely access compliance. However, SB 964 enacted Health and Safety Code section 1367.035, which added network adequacy requirements to the existing timely access

reporting laws. Therefore, the amendments to subsection (i)(4)(A)-(B) are necessary to add network adequacy-related factors to the factors the DMHC will consider when evaluating compliance. This will have the benefit of clarifying the DMHC's authority to evaluate compliance with network adequacy requirements, and allow health plans to understand what may constitute actionable violations for timely access and network adequacy deficiencies.

Subsection (i)(4)(C) specifies a health plan's failure to follow the requirements of the Rule when submitting the TAR and ANR is a factor the DMHC may consider when making compliance determinations. This provision is necessary to implement Health and Safety Code sections 1367.03 and 13673.035, including the requirement for comparable TARs and ANRs. The DMHC's experience has shown health plan reports often include significant errors that make compliance review difficult or impossible. Subsection (i)(4) helps ensure the DMHC's standardized reporting requirements are enforceable. This will ultimately result in more accurate reports that consumers can use to shop for health care coverage in an informed manner.

Subsection (i)(4)(D)-(E) of Rule 1300.67.2.2 amends the existing Rule by re-numbering the factors to account for the reorganization of the proposed Rule. This non-substantive edit will result in clear formatting that allows health plans to easily navigate and understand the Rule.

The existing subsection (g)(3)(E) of Rule 1300.67.2.2 is repealed because the factor is unnecessary and may be considered unclear. This repealed provision stated the DMHC may consider other factors in relevant provisions of law, and other factors deemed appropriate, as specified. However, the Rule's provision specifying the factors the DMHC may consider is non-exhaustive, so it is redundant to include this kind of catch-all provision. This repeal has the benefit of clarifying the Rule, and allowing health plans to better understand the DMHC's compliance review process.

Subsection (i)(4)(F) specifies the DMHC, when making compliance determinations, may consider the nature and extent to which a single instance of non-compliance results from the health plan's failure to monitor or make health care services readily available and accessible for the network service area. This factor is necessary because it pertains to a systemic failure on the part of the health plan, which has the potential to impact many enrollees beyond the single known instance of non-compliance. This provision is also necessary to implement Health and Safety Code sections 1367 (ready access to care), 1367.03 (timely access), and 1367.035 (network adequacy), and related rules such as Rule 1300.67.2(a) ("*[w]ithin each service area of a plan, [...] services shall be readily available and accessible to each of the plan's enrollees [...]*"). Finally, this provision in subsection (i)(4)(F) is also necessary to allow health plans to understand how a deficiency under certain provisions of the proposed Rule, such as failure to monitor using quality assurances processes required by subsection (d), may factor into the DMHC's compliance review and findings. Clear understanding of the DMHC's compliance processes will allow health plans to ensure their networks and processes meet compliance standards, resulting in better access to health care services for the health plan enrollees.

Subsection (i)(5) of Rule 1300.67.2.2 clarifies the DMHC may take enforcement action against a health plan for any finding of non-compliance. This is necessary to clarify the scope of Health and Safety Code section 1367.03(g), which requires the DMHC to “focus more” on PON when evaluating timely access compliance. The provision can be misunderstood to mean only PON are subject to enforcement action. Subsection (i)(5) clarifies that Health and Safety Code section 1367.03(g) does not limit the health plan’s responsibility for complying with all relevant laws. This provision will allow health plans to more clearly understand their responsibilities under the Rule. Additionally, subsection (i)(5) specifies the DMHC will provide the health plan an opportunity to respond to DMHC findings of non-compliance, and present a corrective action plan, before the DMHC pursues enforcement action. This provision has the benefit of allowing health plans to correct deficiencies without having to undergo an enforcement action. This will save health plans and the DMHC time and resources, and may allow the health plan to take the initiative and become compliant sooner than they might under an enforcement action. Finally, subsection (i)(5) specifies the DMHC may take enforcement action if the health plan’s responsive information or corrective action plan is insufficient, which ensures the DMHC retains appropriate enforcement authority when a health plan does not fix problems identified in the DMHC’s findings of non-compliance. This will ensure the DMHC is able to respond to health plan deficiencies with enforcement action to bring the health plan into compliance with the Rule.

Subsection (j) of Rule 1300.67.2.2 specifies provisions related to the DMHC’s review and enforcement of the Rule. This subsection specifies the health plan’s failure to comply with the Rule, including deficiencies in reporting and failure to correct such deficiencies, may result in disciplinary action against the health plan. As described elsewhere in this ISOR, the DMHC’s experience has shown health plan reports often contained extensive data errors that made accurate compliance review impossible for the DMHC. Subsection (j) will clarify that such failures are actionable, and will result in health plans submitting reports that are more accurate.

Subsection (j) also specifies the DMHC may request additional information from the health plan necessary to complete the DMHC’s review of required reports or information or to carry out and complete any enforcement action. The reporting health plan shall be responsible for demonstrating compliance with this section of the Rule and the Knox-Keene Act. This provision addresses the problem that it is often the case that only the health plan has information necessary for the DMHC to assess compliance with the Rule. This provision is necessary to implement Health and Safety Code sections 1367.03 and 1367.035 by clarifying the DMHC’s ability to ask the health plan follow-up questions when the health plan report under subsection (h) lacks information necessary for the DMHC to complete its review, or take subsequent regulatory action. This provision will have the benefit of avoiding unnecessary enforcement actions by clarifying the DMHC’s ability to request information. It will also result in the benefit that all DMHC actions (compliance review and enforcement action) are based on complete information about the health plan. This provision allowing the DMHC to request additional information will ultimately improve the quality of the resulting reports and enforcement actions, because they will be based on complete information from the health plan. Finally, subsection (j) specifies the DMHC Director has all civil, criminal, and administrative remedies available under the Knox-

Keene Act. This implements Health and Safety Code section 1386, regarding the DMHC's enforcement mechanisms, and helps clarify that the DMHC retains all regulatory authority granted under the Knox-Keene Act.

Subsection (k) clarifies that nothing in Rule 1300.67.2.2 alters the legal and contractual obligations for Medi-Cal managed care (MCMC) plan reporting requirements to the DHCS. The DMHC developed this language with input from DHCS. This provision is necessary to ensure consistency, and avoid any potential or perceived conflicts, between the Rule and MCMC plan requirements stemming from DHCS's administration of the California's state Medicaid program (Medi-Cal).

ii. Report Form Instructions (necessity):

As described in this ISOR, proposed Rule 1300.67.2.2(h) specifies that health plans must use the DMHC's standard report forms to submit the TAR and ANR. The Instruction Manual contains detailed instructions for how to use the required report forms, including both general instructions applicable to all required report forms, and field-by-field instructions for each report form. These instructions are necessary to implement Health and Safety Code sections 1367.03(f) and 1367.035(a), and result in comparable health plan reports as required by Health and Safety Code section 1367.03(f)(2).

Section II of the Instruction Manual (pp. 15-17) specifies the general instructions applicable to all required report forms, and advises health plans to review the instructions before completing any TAR or ANR report forms. This will help ensure health plans understand how to correctly complete report forms, and submit complete and accurate TAR and ANR forms. The general requirements for all report forms are necessary for the reasons described in the following sections:

- A. **Reporting Data from Subcontracted Plans:** The Instruction Manual reiterates the requirements of subsections (h)(1)(A) and (h)(1)(B), stating the primary plan is responsible for submitting all required reports, and subcontracted plans are responsible for completing the Network Access Profile. This does not impose any requirements apart from those in Rule 1300.67.2.2, but including this instruction in the Instruction Manual will help ensure health plans understand these requirements as they complete the required report forms. This will help ensure health plan reports are accurate, and will allow the DMHC to hold the health plan responsible for compliance with the Knox-Keene Act, pursuant to Health and Safety Code section 1367.
- B. **Reporting Multiple Entries for the Same Data Field:** The Instruction Manual specifies that for ANR Report Forms and Contact List Report Forms, the health plan must report all data for the network provider, including a complete separate rows in the report form to show all information (e.g., multiple practice addresses, multiple specialties, multiple provider groups) for the network provider (or relevant data field). The Instruction Manual also provides examples of fields that may require multiple entries. The instructions clarify that the additional rows must not report duplicate data entries for enrollment counts, which helps ensure accurate enrollment data being submitted to the DMHC. These instructions will help ensure

health plans clearly understand how to report complete information and will help ensure health plans use the report forms in a consistent manner, as required by Health and Safety Code section 1367.03(f)(2).

- C. **Reporting with Standardized Terminology:** The Instruction Manual reiterates the requirements under subsection (h)(8)(D) to report data according to the DMHC's standardized terminology, either by using the standardized terms or by associating the health plan's terminology, using the crosswalk tables in the DMHC's web portal. Reiterating these requirements will help ensure the Instruction Manual is a useful tool for health plans who are submitting the TAR and ANR, by making these requirements easy to find and read. This will help ensure health plans clearly understand how to comply with subsection (h)(8)(D) and submit reports to the DMHC in a consistent manner.

PAAS Report Forms

Rule 1300.67.2.2(h)(6)(B)(i) proposes to adopt the PAAS report forms for health plans to use to submit data and information it gathers from conducting the PAAS for each of the provider types set forth in the PAAS Manual. A plan must submit all PAAS report forms as specified in the PAAS Manual and Instruction Manual. The PAAS Report Forms include the following 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), which includes the following:
 - 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.

ANR Report Forms:

Rule 1300.67.2.2(h)(7)(B)(i)-(viii) requires health plans to complete and submit ANR report forms with data and information concerning network adequacy as required by Health and safety Code section 1367.035, subdivision (a). The ANR report forms include:

1. PCP and PCP Non-Physician Medical Practitioner Report Form, Form No. 40-265;
2. Specialist and Specialist Non-Physician Medical Practitioner Report Form, Form No. 40-266;
3. Hospital and Clinic Report Form, Form No. 40-267;
4. Other Outpatient Provider Report Form, Form No. 40-268;
5. Mental Health Professional and Mental Health Facility Report Form, Form No. 40-269;
6. Network Service Area and Enrollment 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.

Proposed Rule 1300.67.2.2(h)(7)(C,) requires health plans that submit data in accordance with Health and Safety Code section 1371.31(a)(4), to submit the Out-of-Network Payment Report Form, Form No. 40-273. Health plans must submit this data in accordance with the DMHC Instruction Manual and in accordance with the Measurement Year described in proposed Rule 1300.67.2.2(b)(3)(A). Health and Safety Code section 1371.31 requires this data to be submitted as part of the annual reports regarding network adequacy submitted pursuant to Health and Safety Code section 1367.035(a). The ANR Report Forms benefit consumers, health plans, network providers and the DMHC by providing data that can be evaluated to ensure networks are adequate to meet consumer health care needs.

It is necessary that health plans complete the report forms using comparable data and information. The purpose of the data and information is to provide the DMHC with a way to measure and compare ANR data required to be reported annually pursuant to Health and Safety Code section 1367.035 and TAR data required to be reported annually pursuant to Health and Safety Code section 1367.03(f). The following paragraphs describe -- by field name -- the specific purpose and necessity of each field in each report form.

REPORT FORM FIELDS (Necessity)

Accepting New Patients field (Instruction Manual p. 101)

This field appears in the following ANR forms:

- Hospitals and Clinics report form;
- The PCP and PCP Non-Physician Medical Practitioner Report Form; and
- The Other Outpatient Provider Report Form.

The instructions tell a health plan to indicate whether a network provider is accepting new patients (as defined on Instruction Manual, p. 3) at the reported practice address.

This field implements statutory requirements that health plans shall include as part of the

ANR “providers with open practices” pursuant to Health and Safety Code section 1367.035(a)(4). This field is added to assist the DMHC in implementing statutory authority requiring health plans to demonstrate they have an adequate network. It also implements the requirements in Health and Safety Code section 1367.03(f) for reports of timely access and network adequacy data to be comparable so consumers can assess the performance by network providers and health plans. Uniform and comparable data also helps the DMHC assess compliance data across health plans, networks and product lines. This field benefits health plans and stakeholders by clarifying the data that must be filed for DMHC review, clarifying terms use by the DMHC, and ensuring consistent and comparable health plan reports. It also benefits consumers by ensuring adequate networks for timely access to health care services.

In the Other Outpatient Provider Report Form, in the Other Outpatient Provider tab, the Instruction Manual instructs a health plan to indicate whether a network provider is accepting new patients) at the practice location. If no individual provider is accepting new patients at the practice address, this field permits the health plan to record whether the entity provider is accepting new patients at the practice address. This field implements statutory requirements that health plans shall include as part of the ANR “providers with open practices” pursuant to Health and Safety Code section 1367.035(a)(4). This field is necessary to implement statutory authority requiring health plans to demonstrate they have an adequate network pursuant to Health and Safety Code section 1367.035. This field benefits health plans and stakeholders by clarifying the data that must be filed for DMHC review, clarifying terms used by DMHC, and ensuring consistent and comparable health plan reports. This field also benefits consumers by ensuring adequate networks for timely access to health care services.

Accepting New Patients or Referrals field (Instruction Manual p. 104)

This field appears in the following ANR forms:

- Mental Health Professional and Mental Health Facility Report Form;
- PCP and PCP Non-Physician Medical Practitioner Report Form; and,
- Specialist and Specialist Non-Physician Medical Practitioner Report Form

The instructions tell the plan to identify whether the network provider is accepting new patients, at the reported practice address. This field implements statutory requirements that health plans shall include as part of the ANR “information that demonstrates the capacity of primary care providers to be accessible and available to enrollees” pursuant to Health and Safety Code section 1367.035(a)(5), and “providers with open practices” pursuant to Health and Safety Code section 1367.035(a)(4). This field is added to assist the DMHC in implementing statutory authority requiring health plans to demonstrate they have an adequate network by evaluating which providers are accepting new patients and referrals. This field benefits health plans and stakeholders by clarifying the data that must be filed for DMHC review, clarifying terms use by DMHC, and ensuring consistent and comparable health plan reports.

Advanced Access Provider field (Instruction Manual p. 29)

This field appears in the following PAAS form:

- The Primary Care Providers Contact List Report Form

The Instruction Manual instructs the plan to identify whether the network provider is an Advanced Access Provider. This field is necessary to implement Health and Safety Code section 1367.03(f)(2), because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. This field implements Rule 1300.67.2.2(h)(6)(B)(i)a., which benefits consumers, the DMHC, network providers and health plans by requiring data be reported to the DMHC and ensures that uniform data regarding timely access to health care services is gathered and reported for evaluation and resolution, if applicable.

Board Certified / Eligible field (Instruction Manual p. 27)

This field appears in the following ANR forms:

- PCP and PCP Non-Physician Medical Practitioner Report Form;
- Specialist and Specialist Non-Physician Medical Practitioner Report Form; and
- Telehealth Report Form.

This field appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form; and
- Psychiatrists Raw Data Report Form.

The health plan is instructed to indicate for each specialty or subspecialty whether the network provider is board certified or board eligible (Rule 1300.67.2.2(h)(8)(D)(iii)).

This field is necessary to implement Health and Safety Code section 1367.035(a)(4), which requires the health plan to report to the DMHC area of specialty for providers. This data assists the DMHC to evaluate types of providers available by specialty. It also implements Rule 1300.67.2.2(h)(7)(B)(i), (ii) and (vii), which require the health plan to submit data to the DMHC using the provided report forms. This rule benefits DMHC, consumers and health plans by providing clear requirements for reporting, and by providing uniform data to the DMHC to review and evaluate network adequacy.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. This field implements Rule 1300.67.2.2(h)(6)(B)(i)a., c., d., f., h. and k., which benefit consumers, the DMHC, network providers and health plans by

providing a standardized methodology to develop contact lists, determine the number of network providers from which the plan must obtain survey responses to meet a required sample size and select the network providers to be surveyed. It also assists health plans, consumers, network providers and the DMHC by requiring data be reported to the DMHC. The rule benefits consumers, health plans and the DMHC by ensuring that uniform data regarding timely access to health care services is calculated and reported for evaluation and resolution, if applicable.

CA License field (Instruction Manual p. 27)

This field appears in the following ANR forms:

- Hospital and Clinic Report Form;
- Mental Health Professional and Mental Health Facility Report Form;
- Other Outpatient Provider Report Form;
- PCP and PCP Non-Physician Medical Practitioner Report Form; and
- Specialist and Specialist Non-Physician Medical Practitioner Report Form.

It appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form; and,
- Psychiatrists Raw Data Report Form.

The instructions tell the health plan to provide the California license number of the provider active on the network capture date. If no individual provider is reported, the plan is directed to report the entity's California license number if applicable.

This field is necessary to implement Health and Safety Code section 1367.035(a), which requires the health plan to report specified data to the DMHC. This data assists the DMHC to identify providers by California license number. It also implements Rule 1300.67.2.2(h)(7)(B)(i)-(v), which require the health plan to submit data to the DMHC using the provided report forms. This rule benefits DMHC, consumers and health plans by providing clear requirements for reporting, and by providing uniform data to the DMHC to review and evaluate network adequacy.

This field is also necessary to implement Health and Safety Code section 1367.03(f)(2), because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. This field implements Rule 1300.67.2.2(h)(6)(B)(i)a., c., d., f., h. and k., which benefit consumers, the DMHC, network providers and health plans by providing a standardized methodology to develop contact lists, determine the number of network providers from which the plan must obtain survey responses to meet a required sample size and select the network providers to be surveyed. It also assists health plans, consumers, network providers and the DMHC by requiring data be reported to the DMHC

and ensures that uniform data regarding timely access to health care services is calculated and reported for evaluation and resolution, if applicable.

CA License / Certificate field (Instruction Manual p. 30).

This field appears in the following ANR forms:

- Mental Health Professional and Mental Health Facility Report Form, and
- Telehealth Report Form

It appears in the following PAAS forms:

- Non-Physician Mental Health Care Providers Contact List Report Form, and
- Non-Physician Mental Health Care Providers Raw Data Report Form

The instructions tell the health plan to provide the California license or certificate identifier active on the Network Capture date.

This field is necessary to implement Health and Safety Code section 1367.035(a), which requires the health plan to provide data specified by the DMHC. This data assists the DMHC to evaluate types of providers available by license or certificate number. It benefits consumers, health plans, and the DMHC to be able to identify a provider by a license or certificate number. It also implements Rule 1300.67.2.2(h)(7)(B)(v) and (vii), which require the health plan to submit data to the DMHC using the provided report forms. This rule benefits DMHC, consumers and health plans by providing clear requirements for reporting, and by providing uniform data to the DMHC to review and evaluate network adequacy.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2), because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. This field implements Rule 1300.67.2.2(h)(6)(i)b. and g., which benefit consumers, the DMHC, network providers and health plans by requiring uniform data be reported to the DMHC and ensures that data regarding timely access to health care services is calculated and reported by health plans for evaluation and resolution, if applicable.

Calculation 1 and 2* Yes, there is an available appointment within [applicable time-elapsed standard]. No, there is no available appointment within [applicable time-elapsed standard] field (Instruction Manual p. 46)

This field is contained in the following PAAS forms:

- Primary Care Providers Raw Data Report Form
- Non-Physician Mental Health Care Providers Raw Data Report Form
- Specialist Physicians Raw Data Report Form
- Psychiatrists Raw Data Report Form

The instructions tell the health plan to indicate whether the network providers next available urgent appointment or non-urgent appointment falls within the applicable urgent or non-urgent standard as required by Rule 1300.67.2.2(c)(5)(A)-(I).

In the Primary Care Providers Raw Data Report Form, the Instruction Manual instructs the health plan to indicate whether the network providers next available urgent appointment or non-urgent appointment falls within the applicable urgent or non-urgent standard as required by Rule 1300.67.2.2(c)(5)(A)-(I). If the health plan has identified the network provider as a Qualified Advanced Access Provider (Rule 1300.67.2.2(f)(1)(F)). The health plan is instructed to indicate if there is an available appointment within the applicable standards. Health plans must verify that primary care providers participating in an Advanced Access Program are scheduling appointments consistent with the definition of Advanced Access in Rule 1300.67.2.2(d)(2)(E). This field is important because it provides data necessary for calculating timely access to urgent and non-urgent appointments.

It also refers the health plan to Step 8 in the PAAS Manual and Appendix 2 in the PAAS Manual for instructions concerning calculation of the appointment wait times and results as required by Rule 1300.67.2.2(f)(1)(H). Appendix 2 provides instructions for the survey methodology. The instructions ensure the calculations and survey data yield accurate data that can be compared by DMHC across health plans, networks and product lines.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2), because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. This field implements Rule 1300.67.2.2(f)(1)(H)-(D) and (h)(6)(i)f.-i., which benefit consumers, the DMHC, network providers and health plans by providing a standardized methodology to calculate data based on data entered into the Raw Data report Forms and by requiring data be reported to the DMHC. The rule benefits consumers, health plans and the DMHC by ensuring that uniform data regarding timely access to health care services is calculated and reported for evaluation and resolution, if applicable.

Calculation 1* Yes, there is an available appointment within 15 Business Days. No, there is no available appointment within 15 Business Days field (Instruction Manual p. 68)

This field appears in the following PAAS form:

- The Ancillary Service Providers Raw Data Report Form

The instructions tell the health plan to indicate whether a network provider's next available non-urgent appointment is available within 15 business days. This field includes data required as part of the PAAS (Rule 1300.67.2.2, subsection (f)). It also instructs the health plan to Step 8 in the PAAS Manual (p. 20), and Appendix 2 in the PAAS Manual (p. 38) for instructions concerning calculation of the appointment wait times and results as required by Rule 1300.67.2.2(f)(1)(G) and (H). Appendix 2 provides instructions for the survey methodology. The instructions ensure the calculations and survey data yield accurate data that can be compared by DMHC across health plans, networks and product lines. It

reminds the health plan that urgent care appointments questions are not applicable to Ancillary Service Providers in the PAAS Manual.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. This field implements Rule 1300.67.2.2(h)(6)(i)j., which benefits consumers, the DMHC, network providers and health plans by providing a standardized methodology to record calculate and report data to the DMHC. The rule benefits consumers, health plans and the DMHC by ensuring that uniform data regarding timely access to health care services is calculated and reported for evaluation and resolution, if applicable.

City field (Instruction Manual p. 28)

This field appears in the following ANR forms:

- Hospital and Clinic Report Form;
- Mental Health Professional and Mental Health Facility Report Form;
- Other Outpatient Provider Report Form;
- PCP and PCP Non-Physician Medical Practitioner Report Form; and
- Specialist and Specialist Non-Physician Medical Practitioner Report Form.

This field appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;
- Ancillary Service Providers Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

The instructions tell the health plan to provide the city in which the practice address is located.

This field implements Health and Safety Code section 1367.035(a), which requires health plans to report the location of provider offices. This data assists the DMHC to evaluate types of providers available by location. It also implements Rule 1300.67.2.2(h)(7)(B)(i)-(v), which require the health plan to submit data to the DMHC using the provided report forms. This information benefits DMHC, consumers and health plans by providing clear requirements for reporting, and by providing uniform data to the DMHC to review and evaluate network adequacy.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2), because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. This field implements Rule 1300.67.2.2(f)(1)(A)-(D) and (h)(6)(i)a.-j., which benefit consumers, the DMHC, network providers and health plans by providing a standardized methodology to select the networks to be surveyed, develop contact lists, determine the number of network providers from which the plan must obtain survey responses to meet a required sample size and select the network providers to be surveyed. This information will assist health plans, consumers, network providers and the DMHC by requiring data be reported to the DMHC and ensures that uniform data regarding timely access to health care services is calculated and reported for evaluation and resolution, if applicable.

Clinic Name field (Instruction Manual p. 101)

This field appears in the following ANR forms:

- Hospital and Clinic Report Form;
- PCP and PCP Non-Physician Medical Practitioner Report Form;
- Specialist and Specialist Non-Physician Medical Practitioner Report Form.

The instructions tell the health plans to provide the name of the primary care clinic at which the network provider delivers part-time or full-time services. In the Hospital and Clinics report form, in the Clinics area, the form instructs the health plan to provide the legal clinic name.

This field is necessary to implement Health and Safety Code section 1367.035(a) and (g), which require the health plan to provide data requested by the DMHC. This data along with other data assists the DMHC to identify available providers. It also implements Rule 1300.67.2.2(h)(7)(B)(i)-(iii), which require the health plan to submit data to the DMHC using the provided report forms. This rule benefits the DMHC, consumers and health plans by providing clear requirements for reporting, and by providing uniform data to the DMHC to review and evaluate network adequacy.

Clinic Type field (Instruction Manual p. 122)

This field appears in the following ANR form:

- Hospitals and Clinics Report Form

The instructions tell the health plan to identify the type of clinic as set forth in Appendix B.

This field is necessary to implement Health and Safety Code section 1367.035(a) and (g), which require the health plan to provide data requested by the DMHC. This data assists the DMHC in evaluating types of clinics available in a health plan network. It also implements Rule 1300.67.2.2(h)(7)(B)(iii), which require the health plan to submit data to

the DMHC using the provided report forms. This rule benefits the DMHC, consumers and health plans by providing clear requirements for reporting, and by providing uniform data to the DMHC to review and evaluate network adequacy.

Comments 1 field (Instruction Manual p.29)

This field appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;
- Ancillary Service Providers Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

The instructions tell the health plans to provide any notes or explanations to the DMHC regarding information being reported. (Instruction Manual p. 29) This field provides an opportunity for health plans to provide any information that impacts the information they submit on the PAAS forms.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. This field implements Rule 1300.67.2.2(h)(6)(i)a.-j., which benefits consumers, the DMHC, network providers and health plans by requiring the health plan to provide specified report forms to the DMHC. This field benefits consumers, health plans, network providers and the DMHC by having a place to provide any comments relevant to data required on the report forms. The information benefits consumers, health plans and the DMHC by ensuring that uniform data regarding timely access to health care services is calculated and reported for evaluation and resolution, if applicable.

Comments 2 field (Instruction Manual p. 29)

This field appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;
- Ancillary Service Providers Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;

- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

The field permits health plans to provide any notes or explanations to the DMHC regarding information being reported. This field provides an opportunity for health plans to provide any information that impacts the information they submit on the PAAS forms. This field is necessary to implement Health and Safety Code section 1367.03(f)(2), because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. This field implements Rule 1300.67.2.2(h)(6)(i)a.-j., which benefit consumers, the DMHC, network providers and health plans by requiring the health plan to provide specified report forms to the DMHC. This field benefits consumers, health plans, network providers and the DMHC by having a place to provide any comments relevant to data required on the report forms. The rule benefits consumers, health plans and the DMHC by ensuring that uniform data regarding timely access to health care services is calculated and reported for evaluation and resolution, if applicable.

Comments 3 field (Instruction Manual p. 46)

This field appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;
- Ancillary Service Providers Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

This field permits health plans to provide any notes or explanations to DMHC regarding information being reported. This field provides an opportunity for health plans to provide any information that impacts the information they submit on the PAAS forms.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. This field implements Rule 1300.67.2.2(h)(6)(i)a.-j., which benefit consumers, the DMHC, network providers and health plans by requiring the health plan to provide specified report forms to the DMHC. This field benefits consumers, health plans, network providers and the DMHC by having a place to provide any comments relevant to data required on the report forms. The rule benefits consumers, health plans and the DMHC by ensuring that uniform data regarding timely access to health care services is calculated and reported for evaluation and resolution, if applicable.

Complaint Category field (Instruction Manual p.127)

This field appears in the following ANR form:

- Timely Access and Network Adequacy Grievance Report Form

The instructions tell the health plan to identify the category of TA or ANR grievance as provided and defined in Appendix F Instruction Manual (pp. 127 and 153). This field is added to implement Health and Safety Code section 1367.035(a)(6), which requires health plans to annually provide timely access and network adequacy grievances that the health care service plan received during the preceding calendar year. Grievances regarding timely access and network adequacy help DMHC to identify problems with health plans and provided health care services. Reporting grievances by category helps grievances to be organized and evaluated in a uniform manner. The DMHC can use the information to work with health plans to make changes to benefit consumers. The field information may be used to assess timely access and network adequacy concerns leading to grievances or complaints.

Complaint ID field (Instruction Manual p.127)

This field appears in the following ANR form:

- Timely Access and Network Adequacy Grievance Report Form

The instructions tell the health plan to provide the identifier that identifies the grievance reported by the health plan (Instruction Manual, p. 127). If a grievance was filed with a subcontracted plan, the health plan is instructed to provide the identifier assigned by the subcontracted plan.

This field is added to implement Health and Safety Code section 1367.035(a)(6), which requires health plans to annually provide timely access and network adequacy grievances that the health care service plan received during the preceding calendar year. Grievances regarding timely access and network adequacy help DMHC to identify problems with health plans and provided health care services. Reporting grievances by category helps grievances to be organized and evaluated in a uniform manner. The DMHC can use the information to work with health plans to make changes to benefit consumers. This field ensures that data gathered is uniform and comparable. It benefits consumers, stakeholders and DMHC by providing data that can be used to ensure accurate assessment of timely access to health care services and network adequacy.

Contracting Facility Name field (Instruction Manual p. 129)

This field appears in the following form:

- Out-of-Network Payment Report Form

The instructions tell the health plan to provide the name of the contracting facility where the noncontracted provider delivered services to an enrollee (Instruction Manual, p. 129). This field is added to implement Health and Safety Code section 1371.31(a)(4), which requires health plans to submit to the DMHC as part of its reports submitted under Health and Safety Code section 1367.035(a), the number of payments paid to noncontracting individual health professionals for services at a contracting health facility. The health plan must also submit other data sufficient to determine the proportion of noncontracting individual health professionals to individual contracting health professionals at contracting health facilities.

This field also appears in the ANR Out-of-Network Payment Report Form, in the Proportion Report tab. It instructs the health plan to provide the name of the facility contracted with the health plan as of the date the health plan must report the ANR to the DMHC (Instruction Manual, p. 130). This field is added to implement Health and Safety Code section 1371.31(a)(4), which requires health plans to submit to the DMHC as part of its reports submitted under Health and Safety Code section 1367.035(a), the number of payments paid to noncontracting individual health professionals for services at a contracting health facility. The health plan must also submit other data sufficient to determine the proportion of noncontracting individual health professionals to individual contracting health professionals at contracting health facilities.

This field benefits consumers, stakeholders and DMHC by providing data that can be used to ensure accurate assessment of network adequacy. The field provides information concerning patients who received care from out-of-network providers. The DMHC can review provided out-of-network information to evaluate whether it indicates network adequacy concerns. This field also implements Rule 1300.67.2.2(h)(7)(C), which requires the health plan to report out-of-network data on the Out-Of-Network Payment Report Form.

County field (Instruction Manual p. 28)

This field appears in the following ANR forms:

- Telehealth Report Form;
- Hospital and Clinic Report Form;
- Mental Health Professional and Mental Health Facility Report Form;
- Other Outpatient Provider Report Form;
- PCP and PCP Nonphysician Medical Practitioner Report Form;
- Specialist and Specialist Non-Physician Medical Practitioner Report Form;
- Network Service Area and Enrollment Report Form; and
- Timely Access and Network Adequacy Grievance Report Form.

This field appears in the following PAAS forms:

- Results Report Form;
- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;

- Specialist Physicians Contact List Report Form;
- Psychiatrist Contact List Report Form;
- Ancillary Service Providers Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physician Raw Data Report Form;
- Psychiatrist Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

There are six variations of the county field. In the PAAS Contact List Report Forms, the Raw Data Report Forms, the ANR Hospital and Clinic Report Form, the Mental Health Professional and Mental Health Facility Report Form, the Other Outpatient Provider Report Form, the PCP and PCP Nonphysician Medical Practitioner Report Form, and the Specialist and Specialist Non-Physician Medical Practitioner Report Form, the Instruction Manual instructs the health plan to identify and input the County in which the practice address is located. This implements Health and Safety Code section 1367.035(a)(1) because the health plan is reporting data regarding office location on an annual basis for analysis of timely access to health plan enrollees. The field also implements Health and Safety Code section 1367.03(f)(2), because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. This data benefits consumers, health plans, and the DMHC by providing data that can be evaluated to determine network adequacy by county and comparable data that can be used to calculate and evaluate timely access to care for health plan enrollees.

In the Telehealth Report Form, the health plan is instructed to provide the county in which the network provider's distant site is located (Instruction Manual p. 123). The Instruction Manual describes the network provider's distant site as the site where the network provider is located when delivering telehealth services (Instruction Manual p. 123). This information is beneficial to consumers, health plans, and the DMHC because it helps to clarify available health care services for consumers. This field implements Health and Safety Code section 1367.035(a) and (g), which requires health plans to submit requested network adequacy data to the DMHC on an annual basis to indicate timely access to health care services for health plan enrollees.

In the Network Service Area and Enrollment Report Form, service area tab, the health plan is instructed to provide the county or partial county in the network's service area for the reported network. This helps the DMHC evaluate available networks in geographic areas. It implements Health and Safety Code section 1367.035(a) and (g) which requires health plans to submit requested network adequacy data to the DMHC on an annual basis to indicate timely access to health care services for health plan enrollees.

The Network Service Area and Enrollment Report Form, enrollment area tab, instructs health plans to identify the county where the enrollee resides or works and to report the county that qualifies the enrollee for a network and product line. This data helps the DMHC evaluate network adequacy by product line, network and health plan. This

implements Health and Safety Code section 1367.035(a), which requires health plans to submit data requested by the DMHC to be reported on an annual basis to indicate timely access to health care services for health plan enrollees.

The Timely Access and Annual Network Adequacy Grievance Report instructs the health plan to provide the county where identified enrollees reside or work. This field implements Health and Safety Code section 1367.035(a)(6), which requires health plans to report grievance data to the DMHC annually as part of the report submitted pursuant to Health and Safety Code section 1367.03(f). This data is beneficial because it helps the DMHC evaluate grievance by health plan, network, product line and location.

In the PAAS Results Forms, the health plan is instructed to identify the county in which the health plan is reporting results. When the PAAS survey is conducted, the health plan must include the county to use in calculations concerning timely access. This field ensures that data gathered by health plans is uniform and comparable. It benefits consumers, stakeholders and the DMHC, by providing data from the PAAS that can be used in calculations to ensure accurate assessment of timely access to health care services.

Generally, this field is necessary to implement Health and Safety Code section 1367.035(a), and (g), which requires a health plan to include the location of providers' offices, and data requested by the DMHC, as part of its annual network report. Health plans must identify and report the county where providers' offices are located as part of the Timely Access Reports and Annual Network Reports. in accordance with proposed Rule 1300.67.2.2(h)(6)(B)(i)a.-k.1.-5., (h)(7)(B)(i)-(viii), and (h)(7)(A)(i) and (ii). This field ensures that data gathered is uniform and comparable. It benefits consumers, stakeholders and the DMHC by providing data used to ensure accurate assessment of timely access to health care services and network adequacy.

Date Received field (Instruction Manual p. 127)

This field appears in the following ANR form:

- Timely Access and Network Adequacy Grievance Report Form.

The instructions tell the health plan to provide the date the health plan received the grievance. This field implements Health and Safety Code section 1367.035(a)(6), which requires health plans to report grievance data to DMHC annually as part of the report submitted pursuant to Health and Safety Code section 1367.03(f). This data is beneficial to consumers, health plans and the DMHC by providing grievances concerning network adequacy to be evaluated by the DMHC. The Date Received is helpful to the DMHC to indicate when the health plan receives the grievance and ensure grievances are timely processed and responded to by the health plan. This field ensures that data gathered is uniform and comparable. It benefits consumers, stakeholders and the DMHC by providing data that can be used to ensure accurate assessment of timely access to health care services and network adequacy.

Date Resolved field (Instruction Manual p. 127)

This field appears in the following ANR form:

- Timely Access and Network Adequacy Grievance Report Form.

The instructions tell instructs the health plan to provide the date the health plan resolved the grievance (Instruction Manual, p. 127).

This field implements Health and Safety Code section 1367.035(a)(6), which requires health plans to report grievance data to the DMHC annually as part of the report submitted under Health and Safety Code section 1367.03, subdivision (f). The Date Resolved is helpful to the DMHC to indicate when the health plan processed and responded to the grievance. This data benefits consumers, health plans and the DMHC by providing a way for the DMHC to evaluate network adequacy. This field also ensures that data gathered is uniform and comparable. It benefits consumers, stakeholders and DMHC by providing data that is useful in ensuring accurate assessment of timely access to health care services.

Date Survey Completed* (Instruction Manual p. 44)

This field appears in the following PAAS forms:

- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

The instructions tell the health plan to provide the date the response was completed or the date the appointment data was extracted. This implements Health and Safety Code section 1367.03, which requires the DMHC to develop and implement standards for timely access to care, and health plans to report data in compliance with those standards. This field also implements proposed Rule 1300.67.2.2(h)(6)(B)(i)f.-j., which requires health plans to complete the PAAS for each of the Provider Survey Types set forth in the PAAS Manual, and submit the PAAS Report Forms provided by the DMHC. This field is important in calculating whether network providers responded to surveys within required time frames. This field ensures that data gathered is uniform and comparable. It benefits consumers, stakeholders and DMHC by providing data that can be used to ensure accurate assessment of timely access to health care services.

Date Survey Initiated* (Instruction Manual p. 44)

This field appears in the following PAAS forms:

- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;

- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

The instructions tell the health plan to provide the date the survey was initiated by email, electronic communication, fax, or extraction (Instruction Manual, p. 44). If the survey was initiated by phone, the health plan is instructed to provide the date the first telephone call was made in attempting to initiate the survey.

This implements Health and Safety Code section 1367.03, which requires the DMHC to develop and implement standards for timely access to care, and health plans to report data in compliance with those standards. This field also implements proposed Rule 1300.67.2.2(h)(6)(B)(i)f.-j., which requires health plans to complete the PAAS for each of the Provider Survey Types set forth in the PAAS Manual, and submit the PAAS Report Forms provided by the DMHC. This field is important in calculating whether network providers responded to surveys within required time frames. This field ensures that data gathered is uniform and comparable. The information benefits consumers, stakeholders and the DMHC by providing data used to ensure accurate assessment of timely access to health care services.

DBA field (Instruction Manual p. 38)

This field appears in ANR forms:

- Hospital and Clinic Report Form; and
- Mental Health Professional and Mental Health Facility Report Form.

This field appears in PAAS forms:

- Ancillary Service Providers Contact List Report Form; and
- Ancillary Service Providers Raw Data Report Form

The instructions tell the health plan to provide the doing-business-as (DBA) name of the network provider, if applicable.

This field is necessary to implement Health and Safety Code section 1367.035(a) and (g), which require a health plan to provide data specified by the DMHC as part of its annual report submitted pursuant to Health and Safety Code section 1367.03(f). This field also implements proposed Rule 1300.67.2.2(h)(6)(A)(i)e. and j., and (h)(7)(iii) and (v), the Timely Access Compliance Reports and Annual Network Reports, by providing data requested in the report forms. This field is beneficial because it helps the DMHC identify and locate network providers by their DBA names. This field ensures that data gathered is uniform and comparable. It benefits consumers, stakeholders and the DMHC by providing data that can be used to ensure accurate assessment of timely access to health care services and network adequacy.

Displayed in Provider Directory field (Instruction Manual p. 29)

This field appears in the following ANR forms:

- Hospital and Clinic Report Form;
- Mental Health Professional and Mental Health Facility Report Form;
- Other Outpatient Provider Report Form;
- PCP and PCP Non-Physician Medical Practitioner Report Form;
- Specialist and Specialist Non-Physician Medical Practitioner Report Form; and
- Telehealth Report Form.

This field appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form; and
- Ancillary Service Providers Contact List Report Form.

The field instructs health plans to indicate whether, on the network capture date, the network provider was displayed in the health plan's online provider directory maintained pursuant to Health and Safety Code section 1367.27. The health plan is instructed to only identify the network provider as listed in the provider directory if the network provider was displayed in the provider directory for identified, specified fields that correspond to

identified, specified fields in the applicable ANR or PAAS Report Form (see, e.g., Instruction Manual, p. 29).

This field is necessary to implement Health and Safety Code section 1367.035(a) and (g), which require a health plan to provide data specified by DMHC as part of its annual report filed under Health and Safety Code section 1367.03(f). This field also implements proposed Rule 1300.67.2.2(h)(6)(B)(i)a.-e. and (h)(7)(i)-(v) and (vii), the Timely Access Compliance Reports and Annual Network Reports, by providing data requested by the report forms. This field benefits consumers, health plans and the DMHC by ensuring network providers considered for network adequacy are listed in the plan's provider directory. This field ensures that data gathered is uniform and comparable. This information benefits consumers, stakeholders and the DMHC by providing data that can be used to ensure accurate assessment of timely access to health care services and network adequacy.

E-mail Address field (Instruction Manual p. 102)

This field appears in the following ANR forms:

- Mental Health Professional and Mental Health Facility Report Form;
- Other Outpatient Provider Report Form;

- PCP and PCP Non-Physician Medical Practitioner Report Form; and
- Specialist and Specialist Non-Physician Medical Practitioner Report Form.

The instructions tell the health plan to provide the network provider's office email address, if applicable, as provided in Health and Safety Code section 1367.27(i)(6), which requires specified information be contained in a health plan's provider directory. This field is added to implement Health and Safety Code section 1367.035(a) and (g), which require a health plan to provide data specified by the DMHC as part of its annual report submitted under Health and Safety Code section 1367.03(f). This field also implements Rule 1300.67.2.2(h)(7)(B)(i), (ii), (iv) and (v), Annual Network Reports, by providing data requested by the ANR forms. This field links health plan network providers assessed for network adequacy to network providers in a health plan's provider directory. This field ensures that data gathered is uniform and comparable. It benefits consumers, stakeholders and the DMHC by providing data that can be used to ensure accurate assessment of a health plan's network adequacy.

Email Address 1 field (Instruction Manual p. 28)

This field appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form
- Non-Physician Mental Health Care Providers Contact List Report Form
- Specialist Physicians Contact List Report Form
- Psychiatrists Contact List Report Form
- Ancillary Service Providers Contact List Report Form
- Primary Care Providers Raw Data Report Form
- Non-Physician Mental Health Care Providers Raw Data Report Form
- Specialist Physicians Raw Data Report Form
- Psychiatrists Raw Data Report Form
- Ancillary Service Providers Raw Data Report Form

The field instructs the health plan that this field is included for the health plan's use in conducting the PAAS only and the information shall not be submitted to DMHC in the report form (Instruction Manual, p. 28).

This field is added to implement Health and Safety Code section 1367.03 (f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. The PAAS Contact Lists and Raw Data Report Forms are submitted pursuant to Rule 1300.67.2.2(h)(6)(B)(i)a.-j. The purpose of this field is to provide an email address for the use of health plans to conduct the PAAS. This field benefit consumers, health plans and the DMHC by ensuring that uniform data regarding timely access to health care services is calculated and reported for evaluation and resolution, if applicable.

E-mail Address 2 (Instruction Manual p. 28)

This field appears in the following PAAS Report Forms:

- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;
- Ancillary Service Providers Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

The field instructs the health plan that this field is included for the health plan's use in conducting the PAAS only and the information shall not be submitted to DMHC in the report form (Instruction Manual, p.28).

This field is added to implement Health and Safety Code section 1367.03 (f)(2), because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. The PAAS Contact Lists and Raw Data Report Forms are submitted pursuant to Rule 1300.67.2.2, subsection (h)(6)(B)(i)a.-j.. The purpose of this field is to provide an email address for the use of health plans to conduct the PAAS. It benefit consumers, health plans and the DMHC by ensuring that uniform data regarding timely access to health care services is calculated and reported for evaluation and resolution, if applicable.

E-mail Address 3 field (Instruction Manual p. 28)

This field appears in the following PAAS Report Forms:

- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;
- Ancillary Service Providers Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

The instructions tell the health plan that this field is included for the health plan's use in conducting the PAAS only and the information shall not be submitted to DMHC in the report form (Instruction Manual, p. 28).

This field is necessary to implement Health and Safety Code section 1367.03(f)(2), because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. The PAAS Contact Lists and Raw Data Report Forms are submitted pursuant to Rule 1300.67.2.2(h)(6)(B)(i)a.-j. The purpose of this field is to provide an email address for use by health plans to conduct the PAAS. The field benefits consumers, health plans and the DMHC by ensuring that uniform data regarding timely access to health care services is calculated and reported for evaluation and resolution, if applicable.

Entity DBA field (Instruction Manual p. 117)

This field appears in the following ANR form:

- Other Outpatient Provider Report Form.

The field instructs the health plan to provide the name of the doing-business-as (DBA) network provider entity, if applicable. This field is added to implement Health and Safety Code section 1367.035(a) and (g), which requires a health plan to provide data specified by DMHC as part of its annual report submitted under Health and Safety Code section 1367.03(f). This field also implements Rule 1300.67.2.2(h)(7)(B)(iv), by providing data required in the Annual Network Reports. This field assists the DMHC to clearly identify a DBA network provider entity for purposes of determining network adequacy. This field information benefits the DMHC, consumers and health plans by providing clear requirements for reporting, and by providing uniform data to the DMHC to review and evaluate network adequacy.

Entity Name field (Instruction Manual p. 117)

This field appears in the following ANR forms:

- Other Outpatient Provider Report Form; and
- Telehealth Report Form.

In the Other Outpatient Provider Report Form, the Instruction Manual instructs the health plan to provide the legal name of the entity if the network provider is an entity. In the Telehealth Report Form, the Instruction Manual instructs the health plan to provide the entity name in this field if the network provider is an entity.

This field is necessary to implement Health and Safety Code section 1367.035(a) and (g), which require a health plan to provide data specified by the DMHC as part of its annual report submitted under Health and Safety Code section 1367.03(f). This field implements proposed Rule 1300.67.2.2(h)(7)(B)(vii), which requires the Telehealth Report Form to be provided as part of the Annual Network Reports submitted to the DMHC. This field also implements Proposed Rule 1300.67.2.2(h)(7)(B)(iv), which requires the Other Outpatient Provider Report Form to be provided as part of the Annual Network Reports. This field

information benefits the DMHC, consumers and health plans by providing clear requirements for reporting, and by providing uniform data to the DMHC to review and evaluate network adequacy.

Entity NPI field (Instruction Manual p. 117)

This field appears in the following ANR form:

- Other Outpatient Provider Report Form.

The health plan is instructed to provide the unique National Provider Identifier (NPI) assigned to the network provider (Instruction Manual, p. 117). If an entity NPI is provided, the health plan is instructed to provide the NPI of the entity active on the network capture date (Instruction Manual, p. 117).

This field is added to implement Health and Safety Code section 1367.035(a) and (g), which require a health plan to provide data specified by the DMHC as part of its annual report submitted pursuant to Health and Safety Code section 1367.03, subdivision (f). This field also implements Proposed Rule 1300.67.2.2(h)(7)(B)(iv,) which requires the Other Outpatient Provider Report Form to be provided as part of the Annual Network Reports submitted to the DMHC. The purpose of this field is to provide a clear way to identify network providers with a standardized NPI. It benefits consumers, stakeholders and the DMHC by clarifying the data in the report. This field assists the DMHC in implementing statutory authority to develop and implement requirements for health plans to demonstrate they have an adequate network pursuant to Health and Safety Code section 1367.035.

Entity or Facility Name field (Instruction Manual p. 38)

This field appears in the following PAAS form:

- Ancillary Service Providers Contact List Report Form; and
- Ancillary Service Providers Raw Data Report Form.

The field instructs the health plan to provide the name of the entity or facility providing the ancillary service (Instruction Manual, p. 38).

This field is necessary to implement Health and Safety Code section 1367.03, which requires the health plans to report data concerning timely access to care pursuant to standards developed by DMHC. The PAAS Contact Lists and Raw Data Report Forms are submitted pursuant to proposed Rule 1300.67.2.2(h)(6)(B)(i)e. and j. The purpose of this field is to provide for the health plan to provide the name of the facility or entity providing ancillary services to network enrollees. The data in these forms will help the DMHC select network providers for the purpose of conducting the PAAS. It will also help health plans record the data from the PAAS. This field benefits consumers, health plans and the DMHC by gathering comparable data. Uniform and comparable data helps the

DMHC assess data across health plans, networks and product lines so it can identify and resolve problem areas.

Expected Number of Providers with an Available Non-Urgent Appointment field (Instruction Manual p. 93)

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual instructs the health plan that this field auto-calculates the percentage of network providers that had non-urgent appointments and the number of network providers for each county by product, summed across all counties for each Provider Survey Type in each network (Instruction Manual, p. 91). It also explains how the calculation could be performed manually using data from other fields.

This field is added to implement Health and Safety Code section 1367.03, which requires the health plans to report data concerning timely access to care pursuant to standards developed by DMHC. The PAAS Results Report Form is submitted pursuant to proposed Rule 1300.67.2.2(h)(6)(B)(i)k.7. The purpose of this field is to provide a number used to calculate the percentage of providers with timely appointments for non-urgent appointments (weighted). This field assists the DMHC in implementing statutory authority to develop and implement requirements for health plans to report data pursuant to Health and Safety Code section 1367.03(f). Health and Safety Code section 1367.03(f), requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans. Uniform and comparable data also helps the DMHC assess data across health plans, networks and product lines so it can identify and resolve problem areas. This field benefits health plans and stakeholders by clarifying the data that filed for DMHC review, clarifies terms use by the DMHC, and ensuring consistent and comparable health plan reports. The DMHC benefits by having uniform, comparable data to evaluate timely access to health care services and network adequacy. The DMHC can evaluate data and work with health plans to resolve compliance issues after evaluating this information.

Expected Number of Providers with an Available Urgent Care Appointment field (Instruction Manual p. 91)

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual tells the health plan that for each Provider Survey Type in each network, this field auto-calculates the percent of network providers that had an available urgent care appointment in a county and the number of network providers for each county, summed across all counties (Instruction Manual, p. 88). The instructions also explain how to perform the calculation manually using data from other fields.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2), because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. The purpose of this field is to provide a number used to calculate the field percentage of providers with timely appointments for urgent care appointments (weighted). This field calculates information for the rate of compliance reported to the DMHC. The expected number of providers with an available urgent care appointment field assists the DMHC in implementing statutory authority to develop and implement requirements for health plans to report data pursuant to Health and Safety Code section 1367.03(f). Health and Safety Code section 1367.03(f), requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans. Uniform and comparable data also helps the DMHC assess data across health plans, networks and product lines so it can identify and resolve timely access compliance concerns.

Facility field (Instruction Manual p. 101)

This field appears in the following ANR forms:

- Mental Health Professional and Mental Health Facility Report Form;
- Other Outpatient Provider Report Form;
- PCP and PCP Non-Physician Medical Practitioner Report Form; and
- Specialist and Specialist Non-Physician Medical Practitioner Report Form.

The Instruction Manual tells the health plan to provide the name of the hospital or facility where the provider gives services, or the name of each hospital or facility where the network provider holds privileges. The health plan is also instructed to indicate if the provider uses a hospitalist or other physician arrangement to admit patients to the hospital, or the name of the hospital where the network provider provides services if the provider treats patients within a facility (Instruction Manual, p. 101). If the individual network provider delivers health care services in a facility setting, the health plan is instructed to report the name of the facility. If no individual provider is reported in this area, the health plan is instructed to report the name of the facility where the entity network provider delivers health care services, if the entity provider delivers health care services within a facility.

This field implements Health and Safety Code section 1367.035(a)(1) and (3), which requires health plans to report annually to DMHC the provider office location and hospital where providers have admitting privileges, if any. This field also implements Health and Safety Code section 1367.035(g), which requires health plans to submit data as specified by the DMHC. The purpose of this field is to provide the name of the hospital or facility where the network provider practices or has privileges, as described in the instructions above. This information helps the DMHC assess network adequacy by including data where health care services are provided to health plan enrollees. This field benefits the DMHC, consumers and health plans by providing clear requirements for reporting, and by providing uniform data to the DMHC to review and evaluate the health plan's network adequacy.

Facility NPI field (Instruction Manual p. 101)

This field appears in the following ANR forms:

- Mental Health Professional and Mental Health Facility Report Form,
- Other Outpatient Provider Report Form,
- PCP and PCP Non-Physician Medical Practitioner Report Form,
- Specialist and Specialist Non-Physician Medical Practitioner Report Form.

This field is necessary to implement Health and Safety Code section 1367.035(a) and (g), which require a health plan to provide data specified by DMHC as part of its annual report submitted under Health and Safety Code section 1367.03(f). This field also implements proposed Rule 1300.67.2.2(h)(7)(B)(iv), which requires the Other Outpatient Provider Report Form to be provided as part of the Annual Network Reports submitted to the DMHC. The purpose of this field is to provide a clear way to identify network providers with a standardized NPI. In particular, this field connects a NPI value to the facility named by the health plan. This information benefits consumers, stakeholders and the DMHC by providing a standardized way to identify facilities so that the same facility will not be identified more than once during reporting. It benefits by clarifying the data to be provided to the DMHC for evaluation.

This field assists the DMHC in implementing statutory authority to develop and implement requirements for health plans to report data pursuant to Health and Safety Code section 1367.03(f). Health and Safety Code section 1367.03(f), requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans. Uniform and comparable data also helps the DMHC assess health plans, networks and product lines so it can identify and resolve compliance issues.

Fax Number 1 field (Instruction Manual p. 28)

This field appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;
- Ancillary Service Providers Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

This field is included for the health plan's use in conducting the PAAS and the information is not submitted to the DMHC in the ANR report form.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2), because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. The PAAS Contact Lists and Raw Data Report Forms are submitted pursuant to Rule 1300.67.2.2(h)(6)(B)(i)a.-j. The purpose of this field is to provide a fax number for use by health plans to conduct the PAAS in order to gather data regarding timely access to care. Health and Safety Code section 1367.03(f), requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans. This field provides contact information so the health plan can gather data. Uniform and comparable data helps the DMHC assess data across health plans, networks and product lines so the DMHC can work with the health plan to identify and resolve problem areas.

Fax Number 2 field (Instruction Manual p. 28)

This field appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;
- Ancillary Service Providers Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

This field is included for the health plan's use in conducting the PAAS and the information is not submitted to the DMHC in the ANR report form.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2), because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. The PAAS Contact Lists and Raw Data Report Forms are submitted pursuant to Rule 1300.67.2.2(h)(6)(B)(i)a.-j. The purpose of this field is to provide a fax number for use by health plans to conduct the PAAS in order to gather data regarding timely access to care. Health and Safety Code section 1367.03(f), requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans. This field provides contact information so the health plan can gather data. Uniform and comparable data helps the DMHC assess data across health plans, networks and product lines so the DMHC can work with the health plan to identify and resolve problem areas. plans, networks and product lines so it can identify and resolve problem areas.

Fax Number 3 field (Instruction Manual p. 28)

This field appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;
- Ancillary Service Providers Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

This field is included for the health plan's use in conducting the PAAS and the information is not submitted to the DMHC in the ANR report form.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2), because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. The PAAS Contact Lists and Raw Data Report Forms are submitted pursuant to Rule 1300.67.2.2(h)(6)(B)(i)a.-j. The purpose of this field is to provide a fax number for use by health plans to conduct the PAAS in order to gather data regarding timely access to care. Health and Safety Code section 1367.03(f), requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans. This field provides contact information so the health plan can gather data. Uniform and comparable data helps the DMHC assess data across health plans, networks and product lines so the DMHC can work with the health plan to identify and resolve problem areas.

First Name field (Instruction Manual p. 27)

This field appears in the following ANR forms:

- Mental Health Professional and Mental Health Facility Report Form;
- Other Outpatient Provider Report Form;
- PCP and PCP Non-Physician Medical Practitioner Report Form;
- PCP and PCP Non-Physician Medical Practitioner Report Form;
- Specialist and Specialist Non-Physician Medical Practitioner Report Form; and
- Telehealth Report Form.

This field appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;

- Psychiatrists Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form; and
- Psychiatrists Raw Data Report Form.

The instructions tell the health plan to provide the first name of the network provider (Instruction Manual, p. 27).

This field is necessary to implement Health and Safety Code section 1367.035(a) and (g), which require a health plan to provide data specified by DMHC as part of its annual report submitted pursuant to Health and Safety Code section 1367.03(f). This field also implements Proposed Rule 1300.67.2.2(h)(6)(B)(i)a.-d. and f.-j., which requires the PAAS Report forms to be provided as part of the Timely Access Compliance Report. It also implements proposed Rule 1300.67.2.2(h)(7)(B)(i), (ii), (iv) (v), and (vii), which requires health plans to submit specified report forms as part of the ANR. Proposed Rule 1300.67.2.2(h)(7)(a)(iii), requires a complete list of all network providers within each network.

The purpose of this field is to provide and update a complete list of network providers to assist the DMHC in evaluating health plan's network adequacy. Its purpose is also to maintain a list of network providers that the health plan may use in the PAAS, and to assist the health plan in gathering and recording data after conducting the PAAS. This field assists DMHC in implementing statutory authority to develop and implement requirements for health plans to report data pursuant to Health and Safety Code section 1367.03(f). Health and Safety Code section 1367.03(f), requires health plans to submit annual reports concerning timely access and network adequacy and for the reports to be comparable so consumers can assess the performance by network providers and health plans.

Uniform and comparable data also helps the DMHC assess data across health plans, networks and product lines so the DMHC can work with the health plan to identify and resolve problem areas.

FQHC/RHC Name field (Instruction Manual p. 27)

This field appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;
- Ancillary Service Providers Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form;

- Psychiatrists Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

The Instruction Manual informs the health plan to provide the name of the FQHC/RHC network provider (Instruction Manual, p. 27).

This field is necessary to implement Health and Safety Code section 1367.035(a) and (g), which require a health plan to provide data as part of its annual report submitted to the DMHC pursuant to Health and Safety Code section 1367.03(f). This field also implements proposed Rule 1300.67.2.2(h)(6)(B)(i)a.-j., which requires the PAAS Report forms to be provided as part of the Timely Access Compliance Report. Proposed Rule 1300.67.2.2(h)(6)(B)(II)a. and b., requires network providers to be included in the PAAS Raw Data and Contact List. The data helps the DMHC evaluate timely access to care for consumers. This field also assists the DMHC in implementing statutory authority to develop and implement requirements for health plans to report data pursuant to Health and Safety Code section 1367.03(f). Health and Safety Code section 1367.03(f), requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans. Uniform and comparable data assists the DMHC in assessing information for health plans, networks and product lines so the DMHC can identify and resolve problem areas.

Full Time / Part Time field (Instruction Manual p. 101)

This field appears in the following ANR forms:

- Mental Health Professional and Mental Health Facility Report Form;
- PCP and PCP Non-Physician Medical Practitioner Report Form; and
- Specialist and Specialist Non-Physician Medical Practitioner Report Form.

The Instruction Manual tells the health plan to identify whether, as of the network capture date, the network provider is full-time or part-time as these terms are defined in the “Definitions” section of the Instruction Manual (Instruction Manual p. 101).

This field is added to implement Health and Safety Code section 1367.035(a) and (g), which require a health plan to provide data specified by DMHC as part of its annual report submitted pursuant to Health and Safety Code section 1367.03(f). This field assists the DMHC in determining the hours network providers are available to provide health care services to enrollees. This rule benefits the DMHC, consumers and health plans by providing clear requirements for reporting and by providing uniform data to DMHC to review and evaluate a health plan’s network adequacy.

Grievance Type field (Instruction Manual p. 127)

This field appears in the following ANR form:

- Timely Access and Network Adequacy Grievance Report Form.

The Instruction Manual instructs the health plan to report the type of grievance based on the notice and resolution timeframes required under the Knox-Keene Act (Instruction Manual, p. 127). The grievances shall be categorized as "Expedited," "Exempt" or "Standard," as set forth in Rule 1300.68(d) and Rule 1300.68.01.

This field implements Health and Safety Code section 1367.035(a)(6), which requires the health plan to submit grievances as part of data submitted annually to DMHC. It implements proposed Rule 1300.67.2.2(h)(7)(A)(iv), which requires grievances concerning timely access and network adequacy received for each network during the measurement year to be submitted as part of the ANR Report. The purpose of this field is to track grievance data. The DMHC uses grievance data to evaluate network adequacy and timely access issues. This field assists the DMHC in implementing statutory authority to develop and implement requirements for health plans to report pursuant to Health and Safety Code section 1367.03(f). Health and Safety Code section 1367.03(f), requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans. Uniform and comparable data also helps the DMHC assess data across health plans, networks and product lines so it can identify and resolve compliance issues.

Hospital Name field (Instruction Manual p. 120)

This field appears in the following ANR form:

- Hospital and Clinic Report Form.

The Instruction Manual tells the health plan to provide the legal name of the hospital network provider (Instruction Manual, p.120).

This field implements Health and Safety Code section 1367.035(a) and (g), which requires health plans to submit requested network adequacy data to the DMHC annually. It implements proposed Rule 1300.67.2.2(h)(7)(A)(iii), which requires the health plan to report all hospitals as of the network capture date for each reported network. This information benefits the DMHC, consumers and health plans by identifying a hospital by its legal name so it can be distinguished from other hospitals for purposes of determining hospital network adequacy. This field also benefits health plans and stakeholders by clarifying the data that must be filed for DMHC review, clarifying terms use by the DMHC, and ensuring consistent and comparable health plan reports. The DMHC can then evaluate data and work with health plans to resolve network adequacy issues.

Hospital System field (Instruction Manual p. 121)

This field appears in the following ANR form:

- Hospital and Clinic Report Form.

The Instruction Manual tells the health plan to provide the name of the hospital system to which the network provider belongs, if applicable (Instruction Manual, p. 118).

This field implements Health and Safety Code section 1367.035(a) and (g), which requires health plans to submit requested network adequacy data to the DMHC annually. It implements proposed Rule 1300.67.2.2(h)(7)(A)(iii), which requires the health plan to report all hospitals as of the network capture date for each reported network. This information benefits the DMHC, consumers and health plans by identifying a hospital system by its legal name so it can be distinguished from other hospital systems for purposes of determining hospital network adequacy. This field also benefits health plans and stakeholders by clarifying the data that must be filed for DMHC review, clarifying terms use by the DMHC, and ensuring consistent and comparable health plan reports. The DMHC can then evaluate data and work with health plans to resolve network adequacy issues.

Hospital Type field (Instruction Manual p. 121)

This field appears in the following ANR form:

- Hospital and Clinic Report Form.

The Instruction Manual tells the health plan to provide the type of hospital or inpatient facility, as set forth in Appendix B (Instruction Manual, p. 133). Appendix B lists types of hospitals and other inpatient provider types.

This field implements Health and Safety Code section 1367.035(a) and (g), which provide that health plans shall annually provide data to the DMHC as specified by the DMHC. This field also implements proposed Rule 1300.67.2.2(h)(7)(B)(iii), which requires the Hospital and Clinic Report Form to be submitted as one of the ANR reports. This benefits the DMHC, consumers and health plans by identifying the type of services available at a hospital or inpatient facility. This information is important for evaluating network adequacy. This field assists the DMHC in implementing statutory authority to develop and implement requirements for health plans to report data pursuant to Health and Safety Code section 1367.03(f). Health and Safety Code section 1367.03(f), requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans. Uniform and comparable data also helps the DMHC assess data across health plans, networks and product lines so it can identify and resolve problem areas.

Hospitalist field (Instruction Manual p. 107)

This field appears in the following ANR form:

- Specialist and Specialist Non-Physician Medical Practitioner Report Form.

The instructions tell the health plan to state the network provider's method of admitting patients (Instruction Manual, p. 104). The health plan is told to identify whether the network provider admits patients to the hospital or other facility identified in the corresponding "Facility" field directly, or by using a hospitalist or some other physician arrangement.

This field implements Health and Safety Code section 1367.035(a) and (g), which provide that health plans shall annually provide data as specified by the DMHC. This field also implements proposed Rule 1300.67.2.2(h)(7)(B)(ii), which requires the Specialist and Specialist Non-Physician Medical Practitioner Report Form with identified data be submitted as one of the ANR reports. This field benefits the DMHC, consumers and health plans by identifying how enrollees are admitted to a facility or hospital. This information also benefits the DMHC, consumers and health plans by providing clear requirements for reporting, and by providing uniform data to the DMHC to review and evaluate a health plan's network adequacy.

Individual NPI field (Instruction Manual p. 116)

This field appears in the following ANR form:

- Other Outpatient Provider Report Form.

The Instruction Manual tells the health plan to provide the unique NPI assigned to the individual network provider, active on the network capture date (Instruction Manual, p. 116). NPI means the number(s) associated with a network provider, as registered through the National Plan and Provider Enumeration System (Instruction Manual, p. 6).

This field implements Health and Safety Code section 1367.035(a) and (g), which requires health plans to submit requested network adequacy data to the DMHC annually. This field implements Rule 1300.67.2.2(h)(7)(A)(iii), which requires the health plan to provide a complete list of all the network providers within each network and Rule 1300.67.2.2(h)(7)(B)(iv), which requires the health plan to complete and submit the Other Outpatient Report Form as part of the ANR. The purpose of this field is to report a complete list of the health plan's outpatient providers as of the network capture date. It benefits the DMHC, consumers and health plans by identifying providers available in the health plan's network. This information benefits the DMHC, consumers and health plans by providing clear requirements for reporting, and by providing uniform data to the DMHC to review and evaluate network adequacy.

In-Person Appointments field (Instruction Manual p. 102).

This field appears in the following ANR forms:

- Mental Health Professional and Mental Health Facility Report Form;
- Other Outpatient Provider Report Form;
- PCP and PCP Non-Physician Medical Practitioner;
- Specialist and Specialist Non-Physician Medical Practitioner Report Form; and
- Telehealth Report Form.

The Instruction Manual tells the health plan to identify whether the network provider is available to offer either in-person appointments or “walk-in” appointments at the reported practice address (Instruction Manual, p. 102). For purposes of the Telehealth Report Form, the field instructs the health plan to identify whether the network provider also treats patients in-person, or only treats patients via a telehealth modality (Instruction Manual, p. 125).

This field implements Health and Safety Code section 1367.035(a) and (g), which requires health plans to submit on an annual basis requested network adequacy data to the DMHC. This field implements Rule 1300.67.2.2(h)(7)(B)(i)-(v) and (vii), which requires the health plan to submit the specified ANR report forms. The purpose of this field is to provide information concerning the availability of network providers to provide health care services and which modality the network provider uses. This field benefits the DMHC, consumers and health plans by providing clear requirements for reporting, and by providing uniform data to the DMHC to review and evaluate network adequacy.

Inside / Outside Approved Service Area field (Instruction Manual p. 99)

This field appears in the following ANR form:

- Network Service Area and Enrollment Report Form.

The instructions tell the health plan to identify the location of the enrollee relative to the approved network service area (Instruction Manual, p. 99). The health plan shall provide whether the reported enrollment by county and ZIP Code is within, or outside, of the network service area for the identified network name.

This field implements Health and Safety Code section 1367.035(a) and (g), which requires health plans to submit on an annual basis requested network adequacy data to the DMHC. This field implements Rule 1300.67.2.2(h)(7)(B)(vi), which requires the health plan to submit the specified report form as part of the ANR. It also implements Rule 1300.67.2.2(h)(7)(A)(i), which requires the health plan to report the number of enrollees within each ZIP Code, county and product line as of the network capture date for each reported network. The purpose of this field is to identify the location of the enrollee in relation to the approved service area of the health plan. This information benefits the DMHC, consumers and health plans by providing clear requirements for reporting, and by providing uniform data to the DMHC to review and evaluate network adequacy.

Last Name field (Instruction Manual p. 27)

This field appears in the following ANR forms:

- Mental Health Professional and Mental Health Facility Report Form;
- Other Outpatient Provider Report Form;
- PCP and PCP Non-Physician Medical Practitioner Report Form;
- Specialist and Specialist Non-Physician Medical Practitioner Report Form; and Telehealth Report Form.

This field appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form; and
- Psychiatrists Raw Data Report Form.

The instructions tell the health plan to provide the last name of the network provider (Instruction Manual, p. 27).

This field is necessary to implement Health and Safety Code section 1367.035(a) and (g), which require a health plan to provide data specified by the DMHC as part of its annual report submitted pursuant to Health and Safety Code section 1367.03(f). This field also implements proposed Rule 1300.67.2.2, subsection (h)(6)(B)(i)a.-d. and f.-j., which requires the PAAS Report forms to be provided as part of the Timely Access Compliance Report. This field also implements proposed Rule 1300.67.2.2, subsections (h)(7)(B)(i), (ii), (iv), (v), and (vii), which requires health plans to submit specified report forms as part of the ANR and proposed Rule 1300.67.2.2(h)(7)(a)(iii), which requires a complete list of all network providers within each network. The purpose of this field is to provide and update a complete list of a health plan's network providers to assist the DMHC in evaluating network adequacy. This information assists the DMHC in implementing statutory authority to develop and implement requirements for health plans to report data pursuant to Health and Safety Code section 1367.03(f), which requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans. Uniform and comparable data also helps the DMHC assess data across health plans, networks and product lines so the DMHC can identify and resolve problem areas.

License Type field (Instruction Manual p. 27)

This field appears in the following ANR forms:

- PCP and PCP Non-Physician Medical Practitioner; and
- Specialist and Specialist Non-Physician Medical Practitioner Report Form.

This field appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form; and
- Psychiatrists Raw Data Report Form.

The instructions tell the health plan to provide the network provider's type of license, as set forth in Appendix D (see, e.g., Instruction Manual, p. 100).

This field is necessary to implement Health and Safety Code section 1367.035(a) and (g), which require a health plan to provide data specified by the DMHC as part of its annual report submitted pursuant to Health and Safety Code section 1367.03 (f), which requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. This field also implements proposed Rule 1300.67.2.2(h)(6)(B)(i)a., c., d., f., h., and i., which require the PAAS Report forms be provided as part of the Timely Access Compliance Report. This information helps implement proposed Rule 1300.67.2.2(h)(6)(B)(i) and (ii), which requires health plans to submit specified report forms as part of the ANR. The purpose of this field is to provide the network provider's license in a standardized format as provided by Appendix B of the Instruction Manual.

Uniform and comparable data also helps the DMHC assess data across health plans, networks and product lines so the DMHC can identify and resolve problem areas. This information benefits health plans and stakeholders by clarifying the data that must be filed for DMHC review, clarifies terms use by the DMHC, and ensures consistent and comparable health plan reports. The DMHC can evaluate data and work with health plans to resolve problems identified in the reports.

Mental Health Facility Name field (Instruction Manual p. 114)

This field appears in the following ANR form:

- Mental Health Professional and Mental Health Facility Report Form.

The instructions tell the health plan to provide the legal name of the network provider (Instruction Manual p. 114).

This field is necessary to implement Health and Safety Code section 1367.035(a) and (g), which require a health plan to provide data specified by the DMHC as part of its annual report. This field implements proposed Rule 1300.67.2.2(h)(7)(B)(v), which requires the health plan to submit the specified ANR report form and proposed Rule 1300.67.2.2(h)(7)(a)(iii), which requires a complete list of all network providers within each network. The purpose of this field is to ensure a list of network providers for the DMHC to use to evaluate network adequacy. This information benefits the DMHC, consumers and health plans by providing clear requirements for reporting, and by providing uniform data to the DMHC to review and evaluate a health plan's network adequacy.

Mental Health Facility Type field (Instruction Manual p. 114)

This field appears in the following ANR form:

- Mental Health Professional and Mental Health Facility Report Form.

The instructions tell the health plan to provide the type of mental health facility, as set forth in Appendix B (Instruction Manual, p. 114).

This field is necessary to implement Health and Safety Code section 1367.035(a) and (g), which require a health plan to provide data specified by the DMHC as part of its annual report. This field implements proposed Rule 1300.67.2.2(h)(7)(B)(v), which requires the health plan to submit the specified ANR report form and proposed Rule 1300.67.2.2(h)(7)(a)(iii), which requires a complete list of all network providers within each network. The purpose of this field is to ensure a list of network providers for the DMHC to use to evaluate network adequacy. This information benefits the DMHC, consumers and health plans by providing clear requirements for reporting, and by providing uniform data to the DMHC to review and evaluate a health plan's network adequacy.

Name of Individual Conducting the Survey* field (Instruction Manual p. 45)

This field appears in the following PAAS forms:

- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

The instructions tell the health plan to provide the first name and first initial of the surveyor's last name (the person who made the call on behalf of the health plan) if conducting the PAAS using a telephone call, (Instruction Manual, p. 45). A unique ID may be used to identify the surveyor if the name of the surveyor is unavailable to the health plan. The health plan does not have to provide a name if the survey was not completed by telephone.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2), because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. This field implements proposed Rule 1300.67.2.2, subsections (h)(6)(B)(i)f.-j., which requires the health plan to submit the specified PAAS forms as part of the Timely Access Compliance Report. This field implements the requirement that the health plan administer the PAAS pursuant to proposed Rule 1300.67.2.2(f)(1)(F), using one of the three modalities set forth in the PAAS Manual. The purpose of this field is to identify the person who administered the PAAS if it was administered by telephone call. This information assists the DMHC in implementing its statutory authority to develop requirements for health plans to report data pursuant to Health and Safety Code section 1367.03(f), which requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans. Uniform and comparable data helps the DMHC assess data across health plans, networks and product lines so it can identify and resolve problem areas. This field benefits health plans and stakeholders by clarifying the data to be filed for DMHC review, clarifies terms use by the DMHC, and ensures consistent and comparable health plan reports. The DMHC can evaluate data and work with health plans to resolve identified problems.

Nature of Resolution field (Instruction Manual p. 127)

This field appears in the following TAR form:

- Timely Access and Network Adequacy Grievance Report Form.

The instructions tell the health plan to provide the nature of the resolution for this grievance, as defined in the “Definitions” section of the Instruction Manual (see pp. 5-6). Appendix F provides a list of resolutions (Instruction manual, p. 153).

This field is necessary to implement Health and Safety Code section 1367.035(a)(6), which requires the health plan to provide the DMHC information about grievances related to timely access and network adequacy that the plan received during the preceding year. This field implements Health and Safety Code section 1367.03(g)(2), which requires the Director to periodically evaluate health plan grievances to determine if any audit, investigative, or enforcement actions should be undertaken by the DMHC. It information also helps implement Health and Safety Code section 1367.035(a) and (g), which require health plans to submit to the DMHC on an annual basis requested network adequacy data. The purpose of this field is to indicate the type of resolution a health plan provided to a grievance. This information benefits the DMHC, consumers and health plans by providing data that the DMHC can use to look at types of grievances and resolutions concerning network adequacy. This information benefits the DMHC, consumers and health plans by providing clear requirements for reporting, and by providing uniform data to the DMHC to review and evaluate network adequacy.

Network ID field (Instruction Manual p. 27)

This field appears in the following ANR forms:

- Hospital and Clinic Report Form;
- Network Service Area and Enrollment Report Form;
- Timely Access and Network Adequacy Grievance Report Form;
- Hospital and Clinic Report Form;
- Mental Health Professional and Mental Health Facility Report Form;
- Network Service Area and Enrollment Report Form;
- Other Outpatient Provider;
- Out-Of-Network Payment Report Form;
- PCP and PCP Non-Physician Medical Practitioner Report Form;
- Specialist and Specialist Non-Physician Medical Practitioner Report Form; and
- Telehealth Report Form.

This field appears in the following PAAS forms:

- Results Report Form;
- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;
- Ancillary Service Providers Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

This information is also required in the following:

- Out-of-Network Payment Report Form.

The instructions tell the health plan to provide the network identifier for the reported network name (Instruction Manual, p. 27). Network identifiers are assigned by the DMHC and made available to health plans in the web portal.

This field implements Health and Safety Code section 1367.035(a) and (g), which requires health plans to submit to the DMHC on an annual basis requested network adequacy data. This field also helps implement Health and Safety Code section 1367.03(f)(2), because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. This information is necessary under proposed Rule 1300.67.2.2(h)(6)(B)(i)a.-j., which requires the health plan to submit the specified PAAS report forms and proposed Rule 1300.67.2.2(h)(7)(B)(i)-(vii), which requires the health plan to submit the specified ANR report forms. This information is also necessary

pursuant to Rule 1300.67.2.2(h)(7)(C), which requires the health plan to submit the Out-of-Network Payment Report Form. The purpose of this field is to provide a uniform network identifier so the DMHC can identify and evaluate the adequacy of networks and Timely access to health care services. Health and Safety Code section 1367.03(f), requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans.

This field benefits health plans and stakeholders by clarifying the data that must be filed for DMHC review, clarifies terms use by the DMHC, and ensures consistent and comparable health plan reports. The DMHC benefits by using uniform, comparable data to evaluate timely access to health care services and network adequacy.

Network Name field (Instruction Manual p. 26)

This field appears in the following ANR forms:

- Hospital and Clinic Report form;
- Network Service Area and Enrollment Report Form;
- Timely Access and Network Adequacy Grievance Report Form;
- Hospital and Clinic Report Form;
- Mental Health Professional and Mental Health Facility Report Form;
- Network Service Area and Enrollment Report Form;
- Other Outpatient Provider;
- Out-Of-Network Payment Report Form;
- PCP and PCP Non-Physician Medical Practitioner Report Form
- Specialist and Specialist Non-Physician Medical Practitioner Report Form; and
- Telehealth Report Form.

It appears in the following PAAS forms:

- Results Report Form;
- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;
- Ancillary Service Providers Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

In the PAAS Raw Data and Contact List forms, the health plan is instructed to provide the network name within which the reported provider serves as a network provider. (Instruction Manual p. 26)

In the PAAS Results Report Form, this field auto-populates each network name reported by the health plan. In the PAAS Results Form, in the Network by Provider Survey Type Tab, for each Provider Survey Type, this field auto-populates each network name that reported data in the Results Tab associated with the Provider Survey Type. (Instruction Manual p. 90)

In the ANR Hospital and Clinic Report Form, and the Mental Health Professional and Mental Health Facility Report Form, the health plan is instructed to provide the network name within which the reported hospital or clinic, as applicable, serves as a network provider. (See, e.g., Instruction Manual p. 120)

In the ANR Network Service Area and Enrollment Report Form, under Enrollment, the health plan is instructed to provide the network name corresponding to the identified enrollment. Under Service Area, the health plan is instructed to provide the network name for the reported network service area. (See, e.g., Instruction Manual p. 98).

In the ANR Timely Access and Network Adequacy Grievance Report Form, the health plan is instructed to provide the network name within which the enrollee was enrolled on the date of the grievance. (Instruction Manual p. 126).

In the ANR Mental Health Professional and Mental Health Facility Report Form, PCP and PCP Non-Physician Medical Practitioner Report Form, Specialist and Specialist Non-Physician Medical Practitioner Report Form, Telehealth Report Form, and Other Outpatient Provider Report Form, the health plan is instructed to provide the network name within which the reported provider serves as a network provider. (See, e.g., Instruction Manual p. 111).

In the Out-Of-Network Payment Report Form, the health plan is instructed to provide the network name within which the reported contracting facility participates. (Instruction Manual p. 129).

This field implements Health and Safety Code section 1367.035(a) and (g), which require data is submitted by health plans regarding network adequacy as specified by the DMHC. This field is necessary to implement Health and Safety Code section 1367.03(f)(2), because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. This field implements the requirement to submit PAAS Report Forms pursuant to proposed Rule 1300.67.2.2(h)(6)(B)(i)a.-j. and k.1.-7., and ANR Report Forms pursuant to proposed Rule 1300.67.2.2(h)(7)(B)(i)-(vii). This field also implements Proposed Rule 1300.67.2.2(h)(7)(C), which requires submission of the Out-of-Network Payment Report Form. The purpose of this field is to gather information to complete the PAAS, select providers to be surveyed for the PAAS, complete the survey and record the results in the applicable reporting forms. This field helps the health plan calculate the PAAS results and record and submit them to the DMHC. It also assists the health plan to track providers, facilities, grievances, and enrollees by network for purposes of network adequacy.

Network Tally field (Instruction Manual p. 83)

This field appears in the following PAAS form:

- Results Report Form.

This field is used to calculate how many unique networks were reported in the data submitted by the health plan. (Instruction Manual p. 83).

This field helps implement Health and Safety Code section 1367.03(f)(2), because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. This field implements the requirements to submit PAAS Report Forms to the DMHC pursuant to proposed Rule 1300.67.2.2(h)(6)(B)(i)k.1.-5. The purpose of this field is to provide the number of unique networks reported by the health plan. The value in this field will be used to calculate PAAS values in other fields. The data gathered will help to determine the rate of compliance for health plans.

This field assists the DMHC in implementing statutory authority to develop and implement requirements for health plans to report data pursuant to Health and Safety Code section 1367.03(f). Health and Safety Code section 1367.03(f), requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans. Uniform and comparable data also helps the DMHC assess data across health plans, networks and product lines so it can identify and resolve identified problems. This field benefits health plans and stakeholders by clarifying the data that must be filed for DMHC review, the terms used by the DMHC, and ensuring consistent and comparable health plan reports. The DMHC benefits by using uniform, comparable data to evaluate timely access to health care services and network adequacy. Consumers benefit from having adequate networks for timely access to health care services. Health plans benefit from having clear standards for information they need to report to DMHC. The DMHC can evaluate data and work with plans to resolve identified problems.

Network Tier ID field (Instruction Manual p. 100)

This field appears in the following ANR forms:

- Hospital and Clinic Report Form;
- Mental Health Professional and Mental Health Facility Report Form;
- Other Outpatient Provider Report Form;
- PCP and PCP Non-Physician Medical Practitioner Report Form; and
- Specialist and Specialist Non-Physician Medical Practitioner Report Form.

The instructions tell the health plan to provide the network tier, as the term is defined in the “Definitions” section of the Instruction Manual, if the network is a tiered network (Instruction Manual, p. 100).

This field implements Health and Safety Code section 1367.035(a) and (g), which requires

health plans to submit requested network adequacy data to the DMHC. This field helps implement proposed Rule 1300.67.2.2(h)(7)(B)(i)-(v), which require the health plan to submit specified ANR report forms. The purpose of this field is to identify network tiers available to enrollees within tiered health plan networks. This field is used by the DMHC to evaluate the adequacy of networks. This rule benefits the DMHC, consumers and health plans by providing clear requirements for reporting, and by providing uniform data to the DMHC to review and evaluate network adequacy.

Non-CA License field (Instruction Manual p. 27)

This field appears in the following ANR forms:

- Hospital and Clinic Report Form;
- Mental Health Professional and Mental Health Facility Report Form;
- Other Outpatient Provider Report Form;
- PCP and PCP Non-Physician Medical Practitioner Report Form; and
- Specialist and Specialist Non-Physician Medical Practitioner Report Form.

This field appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form; and
- Psychiatrists Raw Data Report Form.

The instructions tell the health plan to provide the license number issued outside of the state of California, active on the network capture date. (Instruction Manual p. 27)

This field helps implement Health and Safety Code section 1367.035(a) and (g), which require identified data regarding network adequacy be submitted to the DMHC. This field implements Health and Safety Code section 1367.03(f)(2), which requires the health plan to provide data to the DMHC in compliance with standards developed by the DMHC. This field implements proposed Rule 1300.67.2.2(h)(6)(B)(i)a., c., d., f., h., and i., which requires the health plan to submit the specified PAAS report forms, and proposed Rule 1300.67.2.2(h)(7)(B)(i)-(v), which requires the health plan to submit the specified ANR report forms.

Health and Safety Code section 1367.03(f) requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans. The purpose of this field is to record non-California licenses used by providers in a health plan network. Some enrollees may use health care services by providers outside of California. Those services may be part of the calculation of timely access data and evaluation of network adequacy. Uniform and comparable data also helps the DMHC assess data across health plans, networks and product lines so it can identify and resolve identified problems.

Non-CA License / Certificate field (Instruction Manual p. 30)

This field appears in the following ANR Report Forms:

- Mental Health Professional and Mental Health Facility Report Form; and
- Telehealth Report Form.

It appears in the following PAAS Report Forms:

- Non-Physician Mental Health Care Providers Contact List Report Form; and
- Non-Physician Mental Health Care Providers Raw Data Report Form.

The instructions tell the health plan to provide the license number or certificate identifier issued outside of the state of California, active on the network capture date. (Instruction Manual p. 30).

This field implements Health and Safety Code section 1367.035(a) and (g), which require data regarding network adequacy be submitted by health plans to the DMHC. This field implements Health and Safety Code section 1367.03(f)(2), which requires the health plan to provide data to the DMHC in compliance with standards developed by the DMHC. This field implements proposed Rule 1300.67.2.2(h)(6)(B)(i)b. and g., which requires the health plan to submit the specified PAAS Report Forms, and proposed Rule 1300.67.2.2(h)(7)(B)(v) and (vii), which requires the health plan to submit the specified ANR report forms. The purpose of this field is to record non-California licenses or certificates of providers who may be used by enrollees to access health care services outside of California. This data is collected for purposes of calculating timely access and evaluating the network adequacy of a health plan. This field assists the DMHC in implementing statutory authority to develop and implement requirements for health plans to report data pursuant to Health and Safety Code section 1367.03(f), which requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans. Uniform and comparable data also helps the DMHC assess data across health plans, networks and product lines so it can identify and resolve identified problems.

Non-CA License / Certificate State field (Instruction Manual p. 30)

This field appears in the following ANR forms:

- Mental Health Professional and Mental Health Facility Report Form; and
- Telehealth Report Form.

It appears in the following PAAS forms:

- Non-Physician Mental Health Care Providers Contact List Report Form; and
- Non-Physician Mental Health Care Providers Raw Data Report Form.

The instructions tell the health plan to provide the state in which the non-California license or certificate was issued. (Instruction Manual p. 30).

This field implements Health and Safety Code section 1367.035(a) and (g), which require data regarding network adequacy be submitted by the health plans to the DMHC. This field implements Health and Safety Code section 1367.03(f)(2), which requires the health plan to provide data to the DMHC in compliance with standards developed by the DMHC. This field helps implements proposed Rule 1300.67.2.2(h)(6)(B)(i)b. and g., which requires the health plan to submit the specified PAAS report forms, and proposed Rule 1300.67.2.2(h)(7)(B)(v) and (vii), which requires the health plan to submit the specified ANR report forms. The purpose of this field is to record information about non-California licenses or certificates issued to network providers. Some enrollees may use health care services by providers outside of California. This data is collected for purposes of calculating timely access and evaluating network adequacy. This field assists the DMHC in implementing statutory authority to develop and implement requirements for health plans to report data pursuant to Health and Safety Code section 1367.03(f), which requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans. Uniform and comparable data also helps the DMHC assess data across health plans, networks and product lines so it can identify and resolve identified problems.

Non-CA License State field (Instruction Manual p. 27)

This field appears in the following ANR forms:

- Hospital and Clinic Report Form;
- Mental Health Professional and Mental Health Facility Report Form;
- Other Outpatient Provider Report Form;
- PCP and PCP Non-Physician Medical Practitioner Report Form; and
- Specialist and Specialist Non-Physician Medical Practitioner Report Form.

This field appears in the following PAAS Report Forms:

- Primary Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form; and
- Psychiatrists Raw Data Report Form.

The instructions tell the health plan to provide the state in which the non-California license was issued. (Instruction Manual p. 27).

This field implements Health and Safety Code section 1367.035(a) and (g), which require data regarding network adequacy be submitted by the health plans to the DMHC. This field implements Health and Safety Code section 1367.03(f)(2), which requires the health plan to provide data to the DMHC in compliance with standards developed by the DMHC.

This field helps implement proposed Rule 1300.67.2.2(h)(6)(B)(i)b. and g., which requires the health plan to submit the specified PAAS report forms, and proposed Rule 1300.67.2.2(h)(7)(B)(v) and (vii), which requires the health plan to submit the specified ANR report forms. The purpose of this field is to record the state in which non-California licenses or certificates were issued. Some enrollees may use health care services by providers outside of California. This data is collected for purposes of calculating timely access and evaluating network adequacy. This field assists the DMHC in implementing statutory authority to develop and implement requirements for health plans to report data pursuant to Health and Safety Code section 1367.03(f), which requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans. Uniform and comparable data also helps the DMHC assess data across health plans, networks and product lines so it can identify and resolve identified problems.

Non-Contracted Provider First Name field (Instruction Manual p. 129)

This field appears in the following form:

- Out-of-Network Payment Report Form.

The instructions tell the health plan to provide the first name of the non-contracted provider paid for delivering services to an enrollee at the contracting facility. (Instruction Manual p. 129)

This field implements Health and Safety Code section 1367.035(a) and (g), which require data regarding network adequacy be submitted by health plans to the DMHC. This field implements proposed Rule 1300.67.2.2(h)(7)(C), which requires health plans to submit Out-of-Network Payment Report Form to the DMHC. The purpose of this field is to provide the first name of the non-contracted provider who was paid for delivering services to an enrollee at a contracting facility. This field assists the DMHC in determining what types of services patients receive from out-of-network providers to determine whether it was necessary for a patient to receive services from an out-of-network provider. The need for out-of-network services may relate to network adequacy issues within the health plan network. This information benefits consumers and health plans because the DMHC may be able to identify network adequacy issues that the health plan may need to resolve. This field benefits the DMHC, consumers and health plans by providing clear requirements for reporting, and by providing uniform data to the DMHC to review and evaluate network adequacy.

Non-Contracted Provider Last Name field (Instruction Manual p. 129)

This field appears in the following:

- Out-of-Network Payment Report Form.

The instructions tell the health plan to provide the last name of the non-contracted provider paid for delivering services to an enrollee at the contracting facility. (Instruction Manual p. 129)

This field implements Health and Safety Code section 1367.035(a) and (g), which require data regarding network adequacy be submitted by the health plan to the DMHC. This field implements proposed Rule 1300.67.2.2(h)(7)(C), which requires health plans to submit Out-of-Network Payment Reports to the DMHC. The purpose of this field is to provide the last name of the non-contracted provider who was paid for delivering services to an enrollee at a contracting facility. This field provides information to the DMHC about the types of services health plan enrollees receive from out-of-network providers to determine whether it was necessary for the enrollee to receive services from an out-of-network provider. The need for out-of-network services may relate to network adequacy issues within the health plan network. This information benefits consumers and health plans because the DMHC may be able to identify network adequacy issues that the health plan may need to resolve. This field benefits the DMHC, consumers and health plans by providing clear requirements for reporting, and by providing uniform data to the DMHC to review and evaluate network adequacy.

Non-Contracted Provider NPI field (Instruction Manual p. 129)

This field appears in the following:

- Out-of-Network Payment Report Form.

The instructions tell the health plan to provide the unique NPI assigned to the non-contracted provider paid for delivering services to an enrollee at the contracting facility (Instruction Manual, p. 129).

This field implements Health and Safety Code section 1367.035(a) and (g), which require data regarding network adequacy be submitted by the health plan to the DMHC. This field implements proposed Rule 1300.67.2.2(h)(7)(C), which requires health plans to submit Out-of-Network Payment Report Forms to the DMHC. The purpose of this field is to provide the unique NPI of the non-contracted provider who was paid for delivering services to an enrollee at a contracting facility. This field provides a way to identify a non-contracted provider by a standardized number. This field provides information to the DMHC regarding services patients receive from out-of-network providers to determine whether it was necessary for a patient to receive services from an out-of-network provider. The need for an out-of-network provider may relate to network adequacy issues. This information benefits consumers and health plans because the DMHC may be able to identify network adequacy issues that the health plan may need to resolve. This field benefits the DMHC, consumers and health plans by providing clear requirements for reporting, and by providing uniform data to the DMHC to review and evaluate network adequacy.

NPI field (Instruction Manual p. 120)

This field appears in the following ANR forms:

- Hospital and Clinic Report Form;
- Mental Health Professional and Mental Health Facility Report Form;
- PCP and PCP Non-Physician Medical Practitioner Report Form;
- Specialist and Specialist Non-Physician Medical Practitioner Report Form; and
- Telehealth Report Form.

This field appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;
- Ancillary Service Providers Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

The instructions tell the health plan to provide the unique NPI assigned to the network provider and active on the network capture date (Instruction Manual, p. 120).

This field implements Health and Safety Code section 1367.035(a) and (g), which require data regarding network adequacy be submitted by the health plan to the DMHC. This field implements Health and Safety Code section 1367.03(f)(2), which requires the health plan to provide data to the DMHC in compliance with standards developed by the DMHC. This field implements proposed Rule 1300.67.2.2(h)(6)(B)(i)a.-j., which requires the health plan to submit the specified PAAS report forms, and proposed Rule 1300.67.2.2(h)(7)(B)(i)-(iii), (v), and (vii), which requires the health plan to submit the specified ANR report forms.

The purpose of this field is to provide the unique NPI of network providers in each of the specified forms so that network providers are identifiable by a standardized value. This field assists the DMHC in implementing statutory authority to develop and implement requirements for health plans to report data pursuant to Health and Safety Code section 1367.03(f), which requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans. Uniform and comparable data also helps the DMHC assess data across health plans, networks and product lines so it can identify and resolve network adequacy or timely access concerns.

NPI of Supervising PCP field (Instruction Manual p. 27)

This field appears in the following ANR form:

- PCP and PCP Non-Physician Medical Practitioner Report Form.

This field appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form;
- Primary Care Providers Raw Data Report Form.

The instructions tell the health plan to provide the unique NPI of the reported primary care physician who supervises the non-physician medical practitioner. (Instruction Manual p. 27).

This field implements Health and Safety Code section 1367.035(a) and (g), which require data regarding network adequacy be submitted by the health plan to the DMHC. This field implements Health and Safety Code section 1367.03 (f)(2), which requires the health plan to provide data to the DMHC in compliance with standards developed by the DMHC. This field implements proposed Rule 1300.67.2.2(h)(6)(B)(i)a. and f., which requires the health plan to submit the specified PAAS report forms, and proposed Rule 1300.67.2.2(h)(7)(B)(i), which requires the health plan to submit the specified ANR report forms. The purpose of this field is to provide the unique NPI of the primary care providers who supervise non-physician medical practitioners in each of the specified forms so that the supervising primary care provider is identifiable by a standardized value. This field assists the DMHC in implementing statutory authority to develop and implement requirements for health plans to report data pursuant to Health and Safety Code section 1367.03(f), which requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans. Uniform and comparable data also helps the DMHC assess data across health plans, networks and product lines so it can identify and resolve network adequacy and timely access issues.

NPI of Supervising Specialist field (Instruction Manual p. 109)

This field appears in the following ANR form:

- Specialist and Specialist Non-Physician Medical Practitioner Report Form.

The instructions tell the health plan to provide the unique NPI of the reported physician who supervises the non-physician medical practitioner. (Instruction Manual p. 109).

This field implements Health and Safety Code section 1367.035(a) and (g), which require data regarding network adequacy be submitted by the health plan to the DMHC. This field implements Health and Safety Code section 1367.03(f)(2), which requires the health plan to provide data to the DMHC in compliance with standards developed by the DMHC. This field implements proposed Rule 1300.67.2.2(h)(7)(B)(ii), which requires the health plan to

submit the specified ANR report forms. The purpose of this field is to provide the unique NPI of the reported physician who supervises the non-physician medical practitioner so that the supervising physician is identifiable by a standardized value. This field assists the DMHC in implementing statutory authority to develop and implement requirements for health plans to report data pursuant to Health and Safety Code section 1367.03(f), which requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans. Uniform and comparable data also helps the DMHC assess data across health plans, networks and product lines so it can identify timely access and network adequacy issues.

Number of Contracted Providers at Facility field (Instruction Manual p. 130)

This field appears in the following report forms:

- Out-Of-Network Payment Report Form.

The instructions tell the health plan to provide the number of unique contracted providers that were available to deliver services as in-network or "participating" providers at the contracting facility at any point during the measurement year (Instruction Manual, p. 130). If the reporting plan (as defined in proposed Rule 1300.67.2.2(b)(16)) obtains network providers through a plan-to-plan contract (as defined in proposed Rule 1300.67.2.2(b)(12)), the health plan is instructed to include all network providers made available to the reporting plan's enrollees via the subcontracted plan (as defined in proposed Rule 1300.67.2.2(b)(12)(B)).

This field implements Health and Safety Code section 1367.035(a) and (g), which require data regarding network adequacy be submitted by the health plan to the DMHC. This field implements proposed Rule 1300.67.2.2(h)(7)(C), which requires health plans to submit Out-of-Network Payment Reports to the DMHC. The purpose of this field is to help the DMHC track the proportion of contracted to non-contracted providers at the health plan's contracting facilities for each reported network pursuant to Health and Safety Code section 1371.31(a)(4). This field assists the DMHC, consumers and health plans by evaluating the network providers available to provide health care services to enrollees. This field benefits the DMHC, consumers and health plans by providing clear requirements for reporting, and by providing uniform data to the DMHC to review and evaluate network adequacy.

Number of Enrollees field (Instruction Manual p. 98)

This field appears in the following ANR form:

- Network Service Area and Enrollment Report Form.

The health plan is instructed to provide the total number of health plan enrollees in the reported county and ZIP Code, for the identified network and product line (Instruction Manual, p. 94). The total number of enrollees includes both the enrollees for whom the

reporting plan arranges care and the enrollees that the reporting plan has delegated to one or more subcontracted plans, if applicable. The Instruction Manual instructs the health plan that the number reported in this field shall reflect the complete enrollment in the reported network for the identified county, ZIP Code, and product line (Instruction Manual, p. 98).

This field implements Health and Safety Code section 1367.035(a) and (g), which require data regarding network adequacy be submitted by the health plans to the DMHC. This information benefits the DMHC, consumers, and health plans by implementing proposed Rule 1300.67.2.2(h)(7)(A)(i), which requires the health plan to report the health plan's enrollment in each network and product line, by county and ZIP code. This data is important in evaluating network adequacy by area, product line and county. This field benefits the DMHC, consumers and health plans by providing clear requirements for reporting, and by providing uniform data to the DMHC to review and evaluate network adequacy.

Number of Enrollees Assigned to Provider field (Instruction manual p. 100)

This field appears in the following ANR forms:

- Hospital and Clinic Report Form; and
- PCP and PCP Non-Physician Medical Practitioner Report Form.

For the Hospital and Clinic Report Form, and the PCP and PCP Non-Physician Medical Practitioner Report Form in the primary care area, the instructions tell the health plan to provide the total number of enrollees within the network assigned to a network provider. If enrollees are not assigned, the health plan is instructed to provide the enrollees for whom the network provider delivers primary care, as defined in Health and Safety Code section 1367.69(b). (Instruction Manual, p. 100).

For purposes of the PCP and PCP Non-Physician Medical Practitioner Report Form, in the PCP NPMP area, if the non-physician medical practitioner serves as a primary care provider or independently provides direct care to enrollees, the health plan is instructed to provide the total number of enrollees within the network assigned to the network provider. If the enrollees are not assigned, the health plan is instructed to provide the number of enrollees for whom the network provider delivers primary care, as defined in section 1367.69(b). (Instruction Manual, p. 103).

This field implements Health and Safety Code section 1367.035(a) and (g), which require data regarding network adequacy be submitted by the health plans to the DMHC. This field implements proposed Rule 1300.67.2.2(h)(7)(B)(i) and (iii), which requires the health plan to report the data required data on the specified ANR Report Forms. The purpose of this field is to provide the number of enrollees receiving care from specified providers whether the enrollees are assigned or not assigned. This field is important to evaluate a health plan's network adequacy. This field benefits the DMHC, consumers and health plans by providing clear requirements for reporting, and by providing uniform data to the DMHC to review and evaluate network adequacy.

Number of Ineligible Providers field (Instruction Manual, p. 76).

This field appears in the following PAAS Report Form:

- Results Report Form.

The instructions tell the health plan to provide the number of network providers who were identified as being ineligible for the Provider Survey Type in each county in each network (Instruction Manual, p. 76). The "Number of Ineligible Providers" is identified by calculating the number of network providers identified in the "Outcome" field of the Raw Data Report Form as "Ineligible."

This field is necessary to implement Health and Safety Code section 1367.03(f)(2), which requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. The purpose of this field is to provide the number of network providers who were ineligible for the provider survey type in each county/network. The purpose of this field is to record a number that will be auto-calculated by the Results Report Form to calculate the number of nonresponding and ineligible providers (PAAS Manual, p. 28). The field also provides the method for calculating the value for the Number of Ineligible Providers. This value is also used for updating the PAAS Contact List Report Forms. This field implements proposed Rule 1300.67.2.2(f)(1)(F) and (G), which requires the health plan to administer the PAAS and record the outcomes on the Raw Data Report Forms. It implements Rule 1300.67.2.2(h)(6)(B)(i)k.1.-5., which assists health plans, consumers, network providers and the DMHC by requiring data be reported to the DMHC on specified PAAS Report Forms. This field assists the DMHC in implementing statutory authority to develop and implement requirements for health plans to report data pursuant to Health and Safety Code section 1367.03(f), which requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans. Uniform and comparable data also helps the DMHC assess data across health plans, networks and product lines.

Number of Non-Contracted Providers at Facility field (Instruction Manual, p. 130).

This field appears in the following:

- Out-Of-Network Payment Report Form.

The instructions tell the health plan to provide the number of unique non-contracted providers paid by the health plan for rendering services at the contracting facility during the reporting period (Instruction Manual, p. 130).

This field implements Health and Safety Code section 1367.035(a) and (g), which require data regarding network adequacy be submitted by the health plan to the DMHC. This field implements Rule 1300.67.2.2(h)(7)(C), which requires a health plan to submit the Out-Of-Network Payment Report Form. The purpose of this field is to identify and record the

number of unique non-contracted providers paid by the health plan for services at the contracting facility during the reporting period. This value helps the DMHC evaluate the services being provided by non-contracted providers that may not be covered by contracted providers. It benefits consumers and health plans by demonstrating a need for contracted providers if the network is deficient. This field benefits health plans and stakeholders by clarifying the data that must be filed for DMHC review, clarifies terms used by the DMHC, and ensures consistent and comparable health plan reports. The DMHC benefits by using uniform, comparable data to evaluate timely access to health care services and network adequacy. Health plans benefit from having clear standards for information they need to report to the DMHC. Plans also benefit from evaluation of their data. The DMHC can evaluate data and work with plans to resolve identified network adequacy issues.

Number of Non-Responding Providers field (Instruction Manual p. 76)

This field appears in the following PAAS form:

- Results Report Form, including:

The Instruction Manual instructs the health plan to enter the number of network providers who did not respond to one or more applicable survey questions or declined to participate in the survey for the provider survey type in the in each county in each network. The health plan must identify the "Number of Non-Responding Providers" by calculating the number of network providers identified in the "Outcome" field of the Raw Data Report Form as "Refused." The instructions also reference paragraph 58 of the PAAS Manual, which contains related information about non-responding providers. This reference will have the benefit of ensuring a health plan can easily locate all instructions necessary to correctly complete the "number of non-responding providers" field.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the DMHC's standardized methodology. This field implements proposed Rule 1300.67.2.2(f)(1)(F) and (G), which require the health plan to administer the PAAS and record the outcomes on the Raw Data Report Form. The purpose of this field is to record a number that will be used by the Results Report Form to automatically calculate the percentage of non-responding and ineligible providers (PAAS Manual, p. 29).

This field assists the DMHC in implementing statutory authority to develop and implement standardized methodologies health plans must use to report data pursuant to Health and Safety Code section 1367.03(f). Health and Safety Code section 1367.03(f) requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans. Uniform and comparable data also helps the DMHC assess data across health plans, networks, and product lines so the DMHC can identify and resolve problem areas.

Number of Payments Made at Contracting Facility field (Instruction Manual p. 130)

This field appears in the following:

- Out-Of-Network Payment Report Form, in the Out-of-Network Report tab.

The instructions tell the health plan to provide the number of payments made to the noncontracted provider for delivering services to an enrollee in the specified network at the contracting facility during the reporting period.

This field is necessary to implement Health and Safety Code section 1371.31(a)(4), which requires data regarding payments to noncontracting individuals at contracting facilities to be included in a health plan's annual reports pursuant to Health and Safety Code section 1367.035. Proposed Rule 1300.67.2.2(h)(7)(C) requires health plans to submit the required data on the Out-of-Network Payment Report Form. Health plans must submit this data in accordance with the Instruction Manual and in accordance with the measurement year defined in proposed Rule 1300.67.2.2(b)(3)(A). The Number of Payments Made at Contracting Facility field benefits consumers, health plans, and the DMHC by recording the number of payments made to noncontracting providers at contracting facilities. The information in this field provides an indicator of whether the health plan networks are adequate for enrollee health care needs because a very high number of payments to noncontracted providers at contracting facilities may suggest the health plan has an insufficient number of contracting providers at that facility. This information will allow the DMHC and health plans to assess this factor and make necessary adjustments to help ensure enrollees have appropriate access to network providers.

This field also assists the DMHC in implementing statutory authority to develop and implement requirements for health plans to report data pursuant to Health and Safety Code section 1367.03(f). Health and Safety Code section 1367.03(f)(2) requires annual health plan reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans. Uniform and comparable data also helps the DMHC assess data across health plans, networks, and product lines so the DMHC can identify and resolve network adequacy concerns.

Number of Providers at Entity field (Instruction Manual p. 125)

This field appears in the following ANR form:

- Telehealth Report Form.

Rule 1300.67.2.2(h)(7)(A)(iii) requires the Telehealth Report Form to be reported as part of the ANR. The Instruction Manual instructs the health plan that, if the plan reported provider information by "Entity Name," the plan must provide the number of network providers within the entity who provide telehealth services, for each specialty type reported.

The information from this field is necessary to implement Health and Safety Code section 1367.035(a) and (g), which require health plans to report network data specified by the DMHC, because this field requires health plans to report network providers by specialty type, if they provide telehealth services. Telehealth is one way a health plan may arrange for health care services, and should be considered when assessing network adequacy. This field ensures information about the number and specialties of network providers who give telehealth services is available to the DMHC for consideration when determining network adequacy. This field benefits health plans and stakeholders by clarifying the data that must be filed for DMHC review, clarifying terms use by the DMHC, and ensuring consistent and comparable health plan reports. The DMHC benefits by receiving uniform, comparable data to evaluate timely access to health care services and network adequacy, which will promote efficient regulatory review. Consumers benefit from having adequate networks to fulfill their health care needs. Health plans benefit from having clear standards for information they need to report to the DMHC. The DMHC can evaluate health plan data and work with plans to resolve identified compliance issues.

Number of Providers Attempted to be Surveyed field (Instruction Manual p. 73)

This field appears in the following PAAS form, including:

- Results Report Form.

The Instruction Manual instructs the health plan to provide the total number of network providers the health plan attempted to survey via the Three Step Protocol, Extraction, and QAAP (Qualified Advanced Access Provider) for the provider survey type in the County/Network. The instructions clarify that a survey attempt includes those network providers that responded, were ineligible, and non-responders for the applicable County/Network. The Instruction Manual also provides instructions for calculating "Number of Providers Attempted to be Surveyed." The health plan identifies that by calculating the number of network providers in the "Outcome" field of the Raw Data Report Form as "Eligible," "Refused," and "Ineligible."

This field is part of Rule 1300.67.2.2(f)(1)(H), requiring health plans to calculate and record the results of the PAAS on the Results Report Form, and Rule 1300.67.2.2(h)(6)(B)(i)k., which requires health plans to file the Results Report Form (for all provider survey types) with the DMHC. The value from this field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the DMHC's standardized methodology. Information about the number of providers attempted to be surveyed will help the DMHC assess the health plan's compliance with the PAAS Manual and subsection (f). Additionally, the numbers in this field are part of a calculation of survey results to determine the availability of timely health care appointments. The information benefits consumers by providing measurable data the DMHC can use to ensure health plan compliance with timely access requirements. It benefits consumers and plans by providing clear instructions for completing the PAAS. Clear instructions for the methodology ensure the plans gather and report accurate, uniform data.

Number of Providers Responded as a Qualified Advanced Access Provider field (Instruction Manual p. 75)

This field appears in the following ANR form:

- Results Report Form.

The instructions tell a health plan to report: 1) the total number of primary care providers *who were selected to be surveyed* and deemed compliant as QAAP in the County/Network, if the plan is using random sampling, or 2) the total number of primary care providers deemed compliant as QAAP in the County/Network if the plan is using census. The instructions reference paragraphs 54-57 of the PAAS Manual, which contain related information the QAAP survey modality. This reference will have the benefit of ensuring a health plan can easily locate all instructions necessary to correctly complete the “Number of Providers Responded as a [QAAP]” field. Finally, the instructions specify how a health plan can filter the Raw Data Report Form’s “Outcome” field to show QAAP survey responders. The number recorded in this field will also be used in the calculation of the number recorded in the Total Number of Providers Responded to Survey field (Instruction Manual, p. 77).

This field implements proposed Rule 1300.67.2.2(f)(1)(H) [*Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form*] and Rule 1300.67.2.2(h)(6)(B)(i)k.1. [*Primary Care Providers Results Tab*]. The purpose of these provisions is to calculate and record results of the PAAS in a consistent manner. This field and the related provisions of the Rule benefit consumers and health plans by providing clear instructions for calculating and recording PAAS results on the Results Report Form. Clear instructions for the methodology ensure the health plans gather and report accurate, uniform data to the DMHC. The information from the “Number of Providers Responded as a [QAAP]” field is also necessary to implement Health and Safety Code section 1367.03 (f) which requires health plans to report timely access data to the DMHC in the manner specified by the DMHC. This field provides the number of providers who were surveyed and responded as QAAP. The numbers in this field are part of a calculation of survey results to determine the availability of timely health care appointments. The data benefits consumers by providing measurable data the DMHC can use to ensure health plan compliance with timely access to care for consumers. More specifically, the information in this field allows the DMHC to see how many network providers surveyed in the PAAS were deemed compliant with timely access standards, pursuant to the QAAP modality (see PAAS Manual paragraph 65), and Rule 1300.67.2.2(c)(5)(I). Information about the number of QAAP survey responders is necessary for the DMHC to be able to determine a health plan’s compliance with QAAP requirements and timely access standards, which will help ensure the PAAS results accurately reflect the network’s ability to provide timely appointments to enrollees.

Number of Providers Responded via Extraction field (Instruction Manual p. 74)

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual instructs the health plan to provide the total number of network providers who responded to the applicable survey questions via the Extraction PAAS modality for the Provider Survey Type in the County/Network. The Instruction Manual clarifies which network providers are relevant and must be included in this field. Relevant responding network providers include providers that provided extracted data with appointment dates and times or indicated an appointment type (e.g., urgent care appointments) was not applicable to his/her practice. Relevant responding network providers do not include the non-responding providers, ineligible providers, or network providers that responded via the other PAAS modalities: the Three Step Protocol or QAAP. The Instruction Manual also explains that the "Number of Providers Responded via Extraction" is identified by calculating from Raw Data Report Form the number of network providers identified in the "Outcome" field as "Eligible – Completed Survey" and the "Survey Completed via" field as "Extraction." These instructions will have the benefit of allowing health plans to clearly understand how to correctly complete this field.

This field implements proposed Rule 1300.67.2.2(f)(1)(H) [*Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form*] and Rule 1300.67.2.2(h)(6)(B)(i)k.1.-5. [*Results Tabs for each provider survey type*]. The purpose of these provisions is to calculate and record results of the PAAS in a consistent manner. This field and the related provisions of the Rule benefit consumers and health plans by providing clear instructions for calculating and recording PAAS results on the Results Report Form. Clear instructions for the methodology ensure the health plans gather and report accurate, uniform data to the DMHC. The Number of Providers Responded via Extraction field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. This field provides the number of providers who were surveyed and responded via the Extraction survey modality. The numbers in this field are part of a calculation of survey results to determine the availability of timely health care appointments. The information benefits consumers by providing measurable data the DMHC can use to ensure compliance by health plans with timely access to care for consumers. This field benefits consumers and health plans by providing clear instructions for completing the PAAS. Clear instructions for the methodology ensure the health plans gather and report accurate, uniform data to the DMHC. The data benefits consumers by providing measurable data the DMHC can use to ensure health plan compliance with timely access to care for consumers. Additionally, information about the number of providers who responded to the PAAS using various modalities will help the DMHC ensure the health plans follow all requirements related to the modalities in the PAAS Manual, and will help the DMHC understand whether certain modalities are problematic for providers and should be adjusted by the DMHC, to reduce provider burden.

Number of Providers Responded via Three Step Protocol field (Instruction Manual p. 74)

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual for the Instruction Manual instructs the health plan to provide the total number of network providers who responded to the applicable survey questions via the Three Step Protocol for the provider survey type in the County/Network. The Instruction Manual clarifies which network providers are relevant and must be included in this field. Relevant responding network providers include network providers that responded to the survey questions with appointment dates and times or indicated an appointment type (e.g., urgent care appointments) was not applicable to his/her practice. Relevant responding network providers do not include non-responding providers, ineligible providers, or network providers who responded via one of the other PAAS modalities: Extraction or QAAP. The Instruction Manual explains that Responding network providers are identified in the Raw Data Report Form by filtering the "Outcome" field for "Eligible – Completed Survey" and the "Survey Completed via" field for "Phone," "Fax," and "Email/Online."

This field implements proposed Rule 1300.67.2.2(f)(1)(H) [*Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form*] and Rule 1300.67.2.2(h)(6)(B)(i)k.1.-5. [*Results Tabs for each provider survey type*]. The purpose of these provisions is to calculate and record results of the PAAS in a consistent manner. This field and the related provisions of the Rule benefit consumers and health plans by providing clear instructions for calculating and recording PAAS results on the Results Report Form. Clear instructions for the methodology ensure the health plans gather and report accurate, uniform data to the DMHC. This Number of Providers Responded via Three Step Protocol field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. This field provides the number of network providers who the health plan surveyed and who responded via the Three Step Protocol modality. The numbers in this field are part of a calculation of survey results to determine the availability of timely health care appointments. The information benefits consumers by providing measurable data the DMHC can use to ensure compliance by health plans with timely access standards. Additionally, information about the number of providers who responded to the PAAS using various modalities will help the DMHC ensure the health plans follow all requirements related to the modalities in the PAAS Manual, and will help the DMHC understand whether certain modalities are problematic for providers and should be adjusted by the DMHC to reduce provider burden. This field benefits the consumers, health plans, and the DMHC by providing clear instructions for the methodology which will ensure the health plans gather and report accurate, uniform data to the DMHC.

Number of Providers Who Responded to the Question Regarding the Availability of a Non-Urgent Appointment Across All Counties field (Instruction Manual p. 94)

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual states, for each Provider Survey Type in each network, this field auto-calculates the number of network providers who responded to the question regarding the availability of a non-urgent appointment across all counties. The Instruction Manual explains that in the Results Tab for each provider Survey type, for each applicable county, the report form auto-calculates the sum of the "Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent Appointment" field for all counties included in the network.

This field implements proposed Rule 1300.67.2.2(f)(1)(H) [*Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form*] and Rule 1300.67.2.2(h)(6)(B)(i)k.7. [*Network by Provider Survey Type Tab*]. The purpose of these provisions is to calculate and record results of the PAAS in a consistent manner. This field and the related provisions of the Rule benefit consumers and health plans by providing clear explanations for calculating and recording PAAS results on the Results Report Form. Clear instructions for the methodology ensure the health plans gather and report accurate, uniform data to the DMHC. This Number of Providers Who Responded to the Question Regarding the Availability of a Non-Urgent Appointment Across All Counties field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. This field provides the number of network providers who the health plan surveyed and who responded to the survey question regarding the availability of a non-urgent appointment across all counties. The numbers in this field are part of a calculation of survey results to determine the availability of timely health care appointments. The information benefits consumers by providing measurable data the DMHC can use to ensure compliance by health plans with timely access standards. This information also helps the DMHC understand how many of each provider survey type responded to the health plan's PAAS, which will provide valuable context for the health plan's PAAS results.

Number of Providers Who Responded to the Question Regarding the Availability of an Urgent Care Appointment Across All Counties field (Instruction Manual p. 92)

This field appears in the following PAAS form:

- Results Report Form.

The instructions for this field states, for each provider survey type in each network, this field auto-calculates the sum of network providers who responded to the question regarding the availability of an urgent care appointment across all counties. The Instruction Manual provides that, in the Results Tab for each provider survey type, for

each county a network is in, the auto-calculation will sum "Number of Providers Who Responded to the Question Regarding the Availability of an Urgent Care Appointment" field for all counties included in the network.

This field implements proposed Rule 1300.67.2.2(f)(1)(H) [*Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form*] and Rule 1300.67.2.2(h)(6)(B)(i)k.7. [*Network by Provider Survey Type Tab*]. The purpose of these provisions is to calculate and record results of the PAAS in a consistent manner. This field and the related provisions of the Rule benefit consumers and health plans by providing clear explanations for calculating and recording PAAS results on the Results Report Form. Clear instructions for the methodology ensure the health plans gather and report accurate, uniform data to the DMHC. This Number of Providers Who Responded to the Question Regarding the Availability of a Urgent Care Appointment Across All Counties field is necessary to implement Health and Safety Code section 1367.03(f)(2), because it requires data to be gathered and reported to the DMHC in compliance with the DMHC's standardized methodology. This field provides the number of providers who were surveyed and responded to the survey question regarding the availability of an urgent appointment across all counties. The numbers in this field are part of a calculation of survey results to determine the availability of timely health care appointments. The information benefits consumers by providing measurable data the DMHC can use to ensure compliance by health plans with timely access standards. This information also helps the DMHC understand how many of each provider survey type responded to the health plan's PAAS, which will provide valuable context for the health plan's PAAS results.

Number of Providers Weight Used for Calculating Aggregate Percentage of Providers with Timely Appointments for Non-Urgent Appointments in Auto-Calculation Tabs field (Instruction Manual p. 83)

This field appears in the following PAAS form:

- Results Report Form.

The instructions tell the health plan to verify the auto-calculated fields are accurately reflected in the Results Report Form based on the numbers entered in specified fields for the provider survey type in the County/Network. Specifically, the Instruction Manual explains this field is used for the total number of network providers in the County/Network for the provider survey type when calculating the aggregate weighted "Percentage of Providers with Timely Appointments for Non-Urgent Appointments (Weighted)" field in the Network by provider survey type tab. If no network providers in the County/Network responded to a non-urgent appointment request, this field must equal 0. If at least one network provider responded to the non-urgent appointment request, this field is equal to the "Number of Providers within County/Network" field. These instructions will have the benefit of allowing health plans to clearly understand how to correctly verify this field and ensure the accuracy of their TAR.

This field implements proposed Rule 1300.67.2.2(f)(1)(H) [*Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form*] and

Rule 1300.67.2.2(h)(6)(B)(i)k.1.-5. *[Results Tabs for each provider survey type]*. The purpose of these provisions is to calculate and record results of the PAAS in a consistent manner. This field and the related provisions of the Rule benefit consumers and health plans by providing clear instructions for calculating and recording PAAS results on the Results Report Form. Clear instructions for the methodology ensure the health plans gather and report accurate, uniform data to the DMHC. The information from this field is necessary to implement Health and Safety Code section 1367.03(f) which requires health plans to report timely access data to the DMHC in a consistent manner, resulting in comparable TARs. This field provides values for verifying auto-calculated fields, and the numbers in this field are part of a calculation of survey results to determine the availability of timely health care appointments. The information benefits consumers by providing measurable data the DMHC can use to ensure compliance by health plans with timely access standards.

Number of Providers Weight Used for Calculating Aggregate Percentage of Providers with Timely Appointments for Urgent Care Appointments Rates of Compliance in Auto-Calculation Tabs (All Provider Survey Types Except Ancillary Providers) field (Instruction Manual pp.82-83)

This field appears in the following PAAS form:

- Results Report Form.

The instructions tell the health plan to verify the auto-calculated fields are accurately reflected in the Results Report Form based on the numbers in the specified fields for the provider survey type in the County/Network. The Instruction Manual explains that this field is used for the total number of network providers in the County/Network for the provider survey type when calculating aggregate weighted "Percentage of Providers with Timely Appointments for Urgent Care Appointments (Weighted)" field in the Network by Provider Survey Type Tab. If no network providers in the County/Network responded to an urgent care appointment request, this field must equal 0. If at least one network provider responded to an urgent care appointment request, this field is equal to the "Number of Providers within County/Network" field. Finally, the Instruction Manual explains that Ancillary Service Providers are not surveyed for urgent care appointments, so this field is not applicable for Ancillary Service Providers. These instructions will have the benefit of allowing health plans to clearly understand how to correctly verify this field and ensure the accuracy of their TAR.

This field implements proposed Rule 1300.67.2.2(f)(1)(H) *[Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form]* and Rule 1300.67.2.2(h)(6)(B)(i)k.1.-4. *[Results Tabs for each provider survey type except ancillary providers]*. The purpose of these provisions is to calculate and record results of the PAAS in a consistent manner. This field and the related provisions of the Rule benefit consumers and health plans by providing clear instructions for calculating and recording PAAS results on the Results Report Form. Clear instructions for the methodology ensure the health plans gather and report accurate, uniform data to the DMHC. This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires

data to be gathered and reported to the DMHC in compliance with the DMHC's standardized methodology. This field provides information that will help health plans verify auto-calculated fields, which will help ensure the health plan TAR is accurate. The numbers in this field are part of a calculation of survey results to determine the availability of timely health care appointments. The information benefits consumers by providing measurable data the DMHC can use to ensure compliance by health plans with timely access standards.

Number of Providers Who Responded to the Question Regarding a Non-Urgent Appointment within [10 Business Days or 15 Business Days] field (Instruction Manual p. 78)

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual instructs the health plan to enter the number of network providers who responded to the non-urgent appointment question for the provider survey type in the County/Network. The Instruction Manual explains that network providers who responded to the non-urgent appointment question do not include ineligible providers, non-responding providers, or network providers that responded that non-urgent appointments are not applicable. The Instruction Manual further explains how to identify the "Number of Providers Who Responded to the Question Regarding the Availability of a Non-Urgent Appointment within [10 Business Days or 15 Business Days]" by using values from specified fields in the Raw Data Report Forms for each provider survey type. Finally, the Instruction Manual explains that the number from this field is the denominator used to calculate the "Percentage of Providers with a Non-Urgent Appointment Available within [10 Business Days or 15 Business Days] (Unweighted)." The Instruction Manual also references paragraphs 70-72 of the PAAS Manual, which contain related information for compliance determinations. This reference will have the benefit of ensuring a health plan can easily locate all instructions necessary to correctly complete the "Number of Providers with a Non-Urgent Appointment Available within [10 Business Days or 15 Business Days]" field.

This field implements proposed Rule 1300.67.2.2(f)(1)(H) [*Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form*] and Rule 1300.67.2.2(h)(6)(B)(i)k.1.-5. [*Results Tabs for each provider survey type*]. The purpose of these provisions is to calculate and record results of the PAAS in a consistent manner. This field and the related provisions of the Rule benefit consumers and health plans by providing clear instructions for calculating and recording PAAS results on the Results Report Form. Clear instructions for the methodology ensure the health plans gather and report accurate, uniform data to the DMHC. This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the DMHC's standardized methodology. This field provides the number of providers who responded to the question concerning availability of a non-urgent appointment within ten or fifteen business days. This field also provides the number used in other calculations for the survey results. The

numbers in this field are part of a calculation of survey results to determine the availability of health care appointments within specific timeframes required by Rule 1300.67.2.2(c)(5). The information benefits consumers by providing measurable data the DMHC can use to ensure compliance with timely access standards by health plans.

Number of Providers Who Responded to the Question Regarding an Urgent Care Appointment within [48 Hours or 96 Hours] (All Provider Survey Types Except Ancillary Providers) field (Instruction Manual, p. 76)

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual instructs the health plan to enter the number of network providers who responded to the urgent care appointment question for the provider Survey type in the County/Network. The Instruction Manual explains that network providers that responded to the urgent care appointment question do not include ineligible providers, non-responding providers, or network providers that responded that urgent care appointments are not applicable. The Instruction Manual explains how to identify the “Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care Appointment within [48 Hours or 96 Hours]” by using values from specified fields in the Raw Data Report Form. The “Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care Appointment within [48 Hours or 96 Hours]” is the denominator used to calculate the “Percentage of Providers with an Urgent Care Appointment Available within [48 Hours or 96 Hours].” The Instruction Manual references paragraphs 70-72 of the PAAS Manual, which contain related information for compliance determinations. This reference will have the benefit of ensuring a health plan can easily locate all instructions necessary to correctly complete this field. Finally, the Instruction Manual reminds the health plan that Ancillary Service Providers are not surveyed for urgent care appointments, so this field is not applicable for Ancillary Service Providers.

This field implements proposed Rule 1300.67.2.2(f)(1)(H) [*Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form*] and Rule 1300.67.2.2(h)(6)(B)(i)k.1.-4. [*Results Tabs for each provider survey type except ancillary providers*]. The purpose of these provisions is to calculate and record results of the PAAS in a consistent manner. This field and the related provisions of the Rule benefit consumers and health plans by providing clear instructions for calculating and recording PAAS results on the Results Report Form. Clear instructions for the methodology ensure the health plans gather and report accurate, uniform data to the DMHC. This field is necessary to implement Health and Safety Code section 1367.03 (f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the DMHC’s standardized methodology. This field provides the number of providers who responded to the question concerning availability of non-urgent appointment within 48 or 96 hours (minimum standards under Rule 1300.67.2.2(c)(5)). This field also provides the number used in other calculations in the survey. The numbers in this field are part of a calculation of survey results that determine the availability of health care appointments within specific

timeframes. The information benefits consumers by providing measurable data the DMHC can use to ensure compliance with timely access standards by health plans

Number of Providers with a Non-Urgent Appointment Available within [10 Business Days or 15 Business Days] field (Instruction Manual p. 78)

This field appears in the following PAAS form:

- Results Report Form.

The instruction Manual instructs health plans to enter the number of network providers who indicated a non-urgent appointment was available within the applicable standard under Rule 1300.67.2.2(c)(5) (i.e., 10 business days for Primary Care Providers and NPMH or 15 business days for Specialist Physicians, Psychiatrists and Ancillary Service Providers) for the Provider Survey Type in the County/Network. The Instruction Manual explains how to identify the “Number of Providers with a Non-Urgent Appointment Available within [10 Business Days or 15 Business Days]” using values from specified, other fields in the Raw Data Report Form for each provider survey type. It also explains that the “Number of Providers with a Non-Urgent Appointment Available within [10 Business Days or 15 Business Days]” is the numerator used to calculate the “Percentage of Providers with a Non-Urgent Appointment Available within [10 Business Days or 15 Business Days] (Unweighted)” field. Finally, the Instruction Manual references paragraphs 70-72 of the PAAS Manual, which contain related information for compliance determinations. This reference will have the benefit of ensuring a health plan can easily locate all instructions necessary to correctly complete this field.

This field implements proposed Rule 1300.67.2.2(f)(1)(H) [*Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form*] and Rule 1300.67.2.2(h)(6)(B)(i)k.1.-5. [*Results Tabs for each provider survey type*]. The purpose of these provisions is to calculate and record results of the PAAS in a consistent manner. This field and the related provisions of the Rule benefit consumers and health plans by providing clear instructions for calculating and recording PAAS results on the Results Report Form. Clear instructions for the methodology ensure the health plans gather and report accurate, uniform data to the DMHC. This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the standardized methodology. This field provides the method for calculating the number of providers who have a non-urgent appointment available within 10 or 15 business days, which are minimum standards under Rule 1300.67.2.2(c)(5). It also provides the number used in other calculations in the survey. The numbers in this field are part of a calculation of survey results to determine the availability of timely health care appointments. The information benefits consumers by providing measurable data the DMHC can use to ensure compliance by health plans with timely access standards.

Number of Providers with an Urgent Care Appointment Available within [48 Hours or 96 Hours] (All Provider Survey Types Except Ancillary Providers) field (Instruction Manual p. 77)

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual instructs the health plan to enter the number of network providers who indicated an urgent care appointment was available within the applicable standard under Rule 1300.67.2.2(c)(5) (48 hours for Primary Care Providers or 96 hours for NPMH, Specialist Physicians, and Psychiatrists) for the provider survey type in the County/Network. The Instruction Manual explains how to identify the “Number of Providers with an Urgent Care Appointment Available within [48 Hours or 96 Hours]” by using values from other specified fields. The Instruction Manual also explains that the “Number of Providers with an Urgent Care Appointment Available within [48 Hours or 96 Hours]” is the numerator used to calculate the “Percentage of Providers with an Urgent Care Appointment Available within [48 Hours or 96 Hours].” The Instruction Manual also references paragraphs 70-72 of the PAAS Manual, which contain related information for compliance determinations. This reference will have the benefit of ensuring a health plan can easily locate all instructions necessary to correctly complete this field. Finally, the Instruction Manual explains Ancillary Service Providers are not surveyed for urgent care appointments, so this field is not applicable for Ancillary Service Providers.

This field implements proposed Rule 1300.67.2.2(f)(1)(H) [*Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form*] and Rule 1300.67.2.2(h)(6)(B)(i)k.1.-4. [*Results Tabs for each provider survey type except ancillary providers*]. The purpose of these provisions is to calculate and record results of the PAAS in a consistent manner. This field and the related provisions of the Rule benefit consumers and health plans by providing clear instructions for calculating and recording PAAS results on the Results Report Form. Clear instructions for the methodology ensure the health plans gather and report accurate, uniform data to the DMHC. This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the DMHC’s standardized methodology. This field provides the method for calculating the number of providers who have an urgent appointment available within 48 or 96 hours, which are minimum standards under Rule 1300.67.2.2(c)(5). It also provides the number used in other calculations in the PAAS. The numbers in this field are part of a calculation of survey results to determine the availability of timely health care appointments. The information benefits consumers by providing measurable data the DMHC can use to ensure compliance by health plans with timely access standards.

Number of Providers within County/Network field (Instruction Manual p. 73)

This field appears in the following PAAS form:

- Results Report Form.

The instruction Manual instructs the health plan to enter the number of network providers that were identified as a unique provider in the health plan's Contact List Report Form for the provider survey type in the County/Network. The instructions explain how the health plan must identify unique providers using information entered in the health plan's Contact List Report Form, and directs the health plan to review Step 2 in the PAAS Manual for further instructions and details regarding identification of unique providers. This reference will have the benefit of ensuring a health plan can easily locate all instructions necessary to correctly complete this field. This field is necessary for the health plan to determine the "Required Sample Size" for the PAAS.

This field implements proposed Rule 1300.67.2.2(f)(1)(H) [*Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form*] and Rule 1300.67.2.2(h)(6)(B)(i)k.1.-5. [*Results Tabs for each provider survey type*]. The purpose of these provisions is to calculate and record results of the PAAS in a consistent manner. This field and the related provisions of the Rule benefit consumers and health plans by providing clear instructions for calculating and recording PAAS results on the Results Report Form. Clear instructions for the methodology ensure the health plans gather and report accurate, uniform data to the DMHC, allowing the DMHC to conduct efficient regulatory review. This field is necessary to implement Health and Safety Code section 1367.03 (f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the DMHC's standardized methodology. This field provides the method for calculating the required sample size for administering the PAAS by determining the number of providers within the county/network. The required sample size is the minimum number of survey responses the health plan must obtain from its random sample of each provider survey type, according to the instructions in paragraphs 20-23 of the PAAS Manual. The required sample sizes ensure that the PAAS surveys enough network providers to produce results with appropriate statistical confidence limits. The required sample size therefore results in the benefit of ensuring a health plan surveys an appropriate number of network providers for each county/network, to produce statistically reliable and comparable results across all health plans, as required by Health and Safety Code section 1367.03(f)(2). The information in this field ultimately benefits consumers by providing measurable data the DMHC can use to ensure compliance by health plans with timely access standards.

Number of Subcontracted Plan Enrollees field (Instruction Manual p. 98)

This field appears in the following ANR form:

- Network Service Area and Enrollment Report Form.

The Instruction Manual instructs the health plan to provide the total number of enrollees in the reported county and ZIP Code for the identified network and product line, that have been delegated to the subcontracted plan identified in the "Subcontracted Plan License Number" and "Subcontracted Plan Network ID" fields of the report form.

The information from this field is necessary to implement Health and Safety Code section 1367.035(a) and (g), which require health plans to report network data specified by the DMHC. This field requires the total number of enrollees in the reported county and ZIP Code, for the identified network and product line, that have been delegated to the subcontracted plan identified in the "Subcontracted Plan License Number" and "Subcontracted Plan Network ID" fields of the report form. The information in this "Number of Subcontracted Plan Enrollees" field is also necessary to implement Health and Safety Code section 1367, which holds a health plan ultimately responsible for compliance with the Knox-Keene Act, notwithstanding delegation of functions to other entities such as subcontracted health plans. This field ensures the DMHC can understand how many enrollees the health plan assigned to a subcontracted plan, and ensures this number of subcontracted enrollees is available to the DMHC for the purpose of network adequacy compliance review.

This field implements proposed Rule 1300.67.2.2(h)(7)(A)(i) which requires the Service Area and Enrollment Report Form to be reported to the DMHC as part of the health plan's ANR. This field benefits health plans and stakeholders by clarifying the data that must be filed for DMHC review, clarifying terms use by the DMHC, and ensuring consistent and comparable health plan reports, as required by Health and Safety Code section 1367.02(f)(2). The DMHC benefits by receiving uniform, comparable data to evaluate compliance with timely access and network adequacy requirements, which will help promote efficient regulatory review by the DMHC. Consumers benefit from having adequate networks to fulfill their health care needs. Health plans benefit from having clear standards for information they need to report to DMHC. Health plans also benefit from evaluation of their data because the DMHC can evaluate the data and work with health plans to resolve identified issues.

Outcome field (Instruction Manual p. 44)

This field appears in the following PAAS Report Forms:

- Primary Care Providers Raw Data Report Form
- Non-Physician Mental Health Care Providers Raw Data Report Form
- Specialist Physicians Raw Data Report Form
- Psychiatrists Raw Data Report Form
- Ancillary Service Providers Raw Data Report Form

The Instruction Manual instructs the health plan to indicate the network provider's PAAS outcome, based on the criteria set forth in the PAAS Manual, paragraphs 58-60 and 63, by entering one of the specified values, such as "eligible – completed survey," "refused – refused/declined to respond," or other possible outcomes. The instruction's reference to relevant portions of the PAAS Manual clarifies that health plans must read the PAAS Manual to understand the criteria that result in the listed "outcomes." This reference will have the benefit of ensuring a health plan can easily locate all instructions necessary to correctly complete this field.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the DMHC's standardized methodology. This field provides the values used to describe outcomes after administering the survey and explains how to enter them into the Raw Data Report Forms in a consistent manner. This data will be used to calculate results and determine the timely availability of health care appointments. The information benefits consumers by providing measurable data the DMHC can use to ensure compliance by health standards with timely access standards.

This field implements proposed Rule 1300.67.2.2(f)(1)(G) [Record the survey outcome, the provider's survey responses, and compliance determinations on the Raw Data Report Form] and (h)(6)(B)(i)f.-j. [Raw Data Report Forms for all provider survey types]. These provisions benefit consumers and health plans by providing clear instructions for completing the PAAS. Clear instructions for the methodology ensure the plans gather and report accurate, uniform data to the DMHC.

Patient Location field (Instruction Manual p. 125)

This field appears in the following ANR form:

- Telehealth Report Form.

The Instruction Manual instructs the health plan to provide the location where an enrollee may receive telehealth services, as set forth in Appendix E of the Instruction Manual, if the network provider is available for synchronous interactions with the enrollee.

The information from this field is necessary to implement Health and Safety Code section 1367.035(a) and (g), which require health plans to report network data specified by the DMHC. This field requires the health plan to provide the location where an enrollee may receive telehealth services if the network provider is available for synchronous interactions with the enrollee. This field ensures this number is considered for network adequacy purposes because the availability of telehealth services may provide additional options for patients to receive health care services. This field will also give the DMHC information necessary to understand where enrollees receive synchronous telehealth services, which will allow the DMHC to identify trends that may warrant adjustment of standards, pursuant to Health and Safety Code section 1367.03(i).

This field implements proposed Rule 1300.67.2.2(h)(7)(A)(vii), which requires the Telehealth Report Form to be reported as part of the ANR. This field benefits health plans and stakeholders by clarifying the data that must be filed for DMHC review, clarifying terms used by the DMHC, and ensuring consistent and comparable health plan reports, as required by Health and Safety Code section 1367.03(f)(2). The DMHC benefits by receiving uniform, comparable data to evaluate timely access to health care services and network adequacy, which will help promote efficient regulatory review by the DMHC. Consumers benefit from having adequate networks to fulfill their health care needs. Health plans benefit from having clear standards for information they need to report to DMHC. Health plans also benefit from evaluation of their data because the DMHC can

evaluate the data and work with health plans to ensure compliance with timely access standards.

Percentage of Ancillary Service Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types field (Instruction Manual p. 89)

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual explains that this field is copied from the "Percentage of Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types (Weighted)" field from the Network by Provider Survey Type Tab for Ancillary Providers. The Instruction Manual clarifies how this field is calculated by referring health plans to the explanation of how this field is calculated in the Network by Provider Survey Type Tab (see pp. 87-93 of the Instruction Manual). The Instruction Manual also explains how the value in this field is auto-calculated with values from other specified fields entered by the health plan in to the Summary of Rates of Compliance Tab, so the health plan can verify the value in the percentage field. This information will assist the health plan in ensuring the information in the form is correct and enable the DMHC to validate the reported information.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the DMHC's standardized methodology. This field provides the method for calculating and verifying the percentage of providers with timely appointments for urgent care and non-urgent appointment types for ancillary providers. The information benefits consumers by providing measurable data the DMHC can use to ensure compliance by health plans with timely access standards. The information benefits health plans by providing data health plans can use to identify and resolve issues providing timely access to care for patients. Clear instructions for the PAAS methodology ensure the health plans gather and report accurate, uniform data.

This field implements proposed Rule 1300.67.2.2 (f)(1)(H) [Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form] and subsection (h)(6)(B)(i)k.6. [Summary of Rates of Compliance Tab]. These provisions require the health plan to calculate and record the Summary of Rates of Compliance for the PAAS so the health plan can identify whether each network met or exceeded the threshold rate of compliance as set forth in Rule 1300.67.2.2(b)(11)(A). If the network failed to meet or exceed the rate of compliance, the health plan shall implement prompt investigation and corrective action, as set forth in Rule 1300.67.2.2(d)(3) and (f)(1)(I), to bring the network into compliance. This rule benefits consumers and health plans by providing clear instructions for completing the PAAS and for taking necessary corrective action to ensure network adequacy.

Percentage of Ineligible Providers field (Instruction Manual p. 80)

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual instructs the health plan to verify this auto-calculated field is accurately reflected in the Results Report Form based on numbers in specified fields for each provider survey type in the County/Network.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the DMHC's standardized methodology. This field provides the method for verifying calculation of the percentage of ineligible providers. It is important to identify the providers that were ineligible to be surveyed because large percentages of ineligible providers raises question about PAAS data quality, leading to both statistical reliability and bias concerns. If health plans cannot reliably identify eligible network providers, as indicated by samples with large percentages of ineligible providers, it raises concern that health plan's Contact List Report Forms may not include all eligible providers. Likewise, if health plans are not successfully identifying eligible network providers, and non-identified providers show a different likelihood of having an available appointment within timely access standards, then samples drawn from the incomplete or incorrect sample frames may be biased. Therefore, the information in this field is necessary to ensure the health plan's PAAS is based on reliable and complete data. The information benefits consumers by providing measurable data the DMHC can use to ensure compliance by health plans with timely access standards. The information benefits plans by providing data health plans can use to identify and resolve issues administering the PAAS to accurately measure the network's ability to provide timely access to care for patients.

This field implements proposed Rule 1300.67.2.2 (f)(1)(H) [Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form] and subsection (h)(6)(B)(i)k.1.-5 [Results Report Forms for each provider survey type]. These provisions benefit consumers and health plans by providing clear instructions for completing the PAAS and recording results from the PAAS. Clear instructions for the methodology ensure the health plans gather and report accurate, uniform data, which will facilitate efficient regulatory review by the DMHC.

Percentage of Non-Physician Mental Health Care Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types field (Instruction Manual p. 88)

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual instructs the health plan that this field is copied from "Percentage of Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types (Weighted)" field from the Network by Provider Survey Type Tab for Non-Physician

Mental Health Care Providers. It refers the health plan to the explanation of how this field is calculated in the Network by Provider Survey Type Tab. The Instruction Manual clarifies how this field is calculated by referring health plans to the explanation of how this field is calculated in the Network by Provider Survey Type Tab (see pp. 87-93 of the Instruction Manual). The Instruction Manual also explains how the value in this percentage field is auto-calculated with values entered by the health plan in other specified fields. This information will assist the health plan in ensuring the information in the form is correct and enable the DMHC to validate the reported information.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the DMHC's standardized methodology. This field provides the method for calculating and verifying the percentage of providers with timely appointments for urgent care and non-urgent appointment types for non-physician mental health care providers. The data benefits consumers by providing measurable data the DMHC can use to ensure compliance by health plans with timely access standards. Clear instructions for the PAAS methodology ensure the health plans gather and report accurate, uniform data.

This field implements proposed Rule 1300.67.2.2 (f)(1)(H) [Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form] and subsection (h)(6)(B)(i)k.6. [Summary of Rates of Compliance Tab]. These provisions require the health plan to calculate and record the Summary of Rates of Compliance for the PAAS so the health plan can identify whether each network met or exceeded the threshold rate of compliance as set forth in Rule 1300.67.2.2(b)(11)(A). If the network failed to meet or exceed the rate of compliance, the health plan shall implement prompt investigation and corrective action, as set forth in Rule 1300.67.2.2(d)(3) and (f)(1)(I), to bring the network into compliance. This rule benefits consumers and health plans by providing clear instructions for completing the PAAS and for taking necessary corrective action to ensure network adequacy.

Percentage of Non-Responding Providers field (Instruction Manual p. 79)

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual instructs the health plan to verify this auto-calculated field is accurately reflected in the Results Report Form based on the numbers in specified other fields. These instructions will assist the health plan in ensuring the information in the report form is correct and enable the DMHC to validate the reported information.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the DMHC's standardized methodology. This field provides the method for verifying calculation of the percentage of nonresponding providers. It is important to identify the providers that did not respond to be surveyed because large percentages of network providers who fail or refuse to respond raise concern for statistical bias in the sample. If

network providers who fail or refuse to respond have a different likelihood of having an available appointment within the timely access standards, then results calculated from the sample may be biased. Therefore, the information in this field helps the DMHC understand whether the PAAS results are based on reliable and complete data. The value in this field is used to calculate rates of compliance. The data benefits consumers by providing measurable data the DMHC can use to ensure compliance by health plans with timely access standards.

This field implements proposed Rule 1300.67.2.2 (f)(1)(H) [Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form] and subsection (h)(6)(B)(i)k.1.-5 [Results Report Forms for each provider survey type]. These provisions benefit consumers and health plans by providing clear instructions for completing the PAAS and recording results from the PAAS. Clear instructions for the methodology ensure the health plans gather and report accurate, uniform data, which will facilitate efficient regulatory review by the DMHC.

Percentage of Primary Care Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types field (Instruction Manual p. 88).

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual instructs the health plan that this field is copied from "Percentage of Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types (Weighted)" field from the Network by Provider Survey Type Tab for Primary Care Providers. The Instruction Manual clarifies how this field is calculated by referring health plans to the explanation of how this field is calculated in the Network by Provider Survey Type Tab (see pp. 87-93 of the Instruction Manual). The Instruction Manual also explains how the value in this field is auto-calculated with values from other specified fields entered by the health plan in to the Summary of Rates of Compliance Tab, so the health plan can verify the value in the field. This information will assist the health plan in ensuring the information in the form is correct and enable the DMHC to validate the reported information.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the DMHC's standardized methodology. This field provides the method for calculating and verifying the percentage of providers with timely appointments for urgent care and non-urgent appointment types for primary care providers. The information benefits consumers by providing measurable data the DMHC can use to ensure compliance by health plans with timely access standards. The information benefits health plans by providing data health plans can use to identify and resolve issues providing timely access to care for patients. Clear instructions for the PAAS methodology ensure the health plans gather and report accurate, uniform data.

This field implements proposed Rule 1300.67.2.2 (f)(1)(H) [Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form] and subsection (h)(6)(B)(i)k.6. [Summary of Rates of Compliance Tab]. These provisions require the health plan to calculate and record the Summary of Rates of Compliance for the PAAS so the health plan can identify whether each network met or exceeded the threshold rate of compliance as set forth in Rule 1300.67.2.2(b)(11)(A). If the network failed to meet or exceed the rate of compliance, the health plan shall implement prompt investigation and corrective action, as set forth in Rule 1300.67.2.2(d)(3) and (f)(1)(I), to bring the network into compliance. This rule benefits consumers and health plans by providing clear instructions for completing the PAAS and for taking necessary corrective action to ensure network adequacy.

Percentage of Providers with a Non-Urgent Appointment Available within [10 Business Days or 15 Business Days] (Unweighted) field (Instruction Manual p. 82)

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual explains that this is an auto-calculated field and instructs the health plan to verify data using values from other specified fields in the Results tabs for each provider survey type and to ensure the correct calculation of the percentage. This field and its instructions assist the health plan in ensuring the information in the form is correct and enables the DMHC to validate the reported information.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the DMHC's standardized methodology. This field provides the method for calculating and verifying the percentage of network providers with a non-urgent appointment available within 10 Business Days or 15 Business Days (minimum standards in Rule 1300.67.2.2(c)(5)). The information benefits consumers by providing measurable data the DMHC can use to ensure compliance by health plans with timely access standards.

This field implements proposed Rule 1300.67.2.2 (f)(1)(H) [Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form] and subsection (h)(6)(B)(i)k.1.-5 [Results Report Forms for each provider survey type]. These provisions benefit consumers and health plans by providing clear instructions for completing the PAAS and recording results from the PAAS. Clear instructions for the methodology ensure the health plans gather and report accurate, uniform data, which will facilitate efficient regulatory review by the DMHC.

Percentage of Providers with an Urgent Care Appointment Available within [48 Hours or 96 Hours] (Unweighted) (All Provider Survey Types Except Ancillary Providers) field (Instruction Manual p. 81)

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual instructs the health plan to verify the auto-calculated fields are accurately reflected in the Results Report Form, based on the numbers in other specified fields. The Instruction Manual describes how the health plan must verify the correct calculation of the percentage of network providers with an urgent care appointment available in 48 or 96 hours (standards from Rule 1300.67.2.2(c)(5)). The instructions also clarify that the field is inapplicable to Ancillary Service Providers, because those providers are not surveyed for urgent care appointments. This information will assist the health plan in ensuring the information in the report form is correct and enable the DMHC to validate the reported information.

The information from this field is necessary to implement Health and Safety Code section 1367.03 (f), which requires health plans to report timely access data in the manner specified by the DMHC. This field provides the method for calculating and verifying the percentage of urgent appointments available within 48 or 96 hours (minimum standards under Rule 1300.67.2.2(c)(5)). The data benefits consumers by providing measurable data the DMHC can use to ensure compliance by health plans with timely access standards.

This field implements proposed Rule 1300.67.2.2 (f)(1)(H) [Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form] and subsection (h)(6)(B)(i)k.1.-4. [Results Report Forms for each provider survey type except Ancillary Service Providers]. These provisions benefit consumers and health plans by providing clear instructions for completing the PAAS and recording results from the PAAS. Clear instructions for the methodology ensure the health plans gather and report accurate, uniform data, which will facilitate efficient regulatory review by the DMHC.

Percentage of Providers with Timely Appointments for Non-Urgent Appointments (Weighted) field (Instruction Manual p. 94)

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual explains that this field auto-calculates the percentage of network providers with timely appointments for non-urgent care appointments for each provider survey type and for the entire network. The Instruction Manual instructs the health plan how the value in this field is calculated with values from other specified fields entered by the health plan in the Results tabs for each provider survey type. This information will

assist the health plan in ensuring the information in the form is correct and enable the DMHC to validate the reported information.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the DMHC's standardized methodology. This field provides the method for calculating and verifying the percentage of network providers with timely appointments for non-urgent appointments (weighted). The data benefits consumers by providing measurable data the DMHC can use to ensure compliance with health plans with timely access standards.

This field implements proposed Rule 1300.67.2.2s (f)(1)(H) [Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form] and subsection (h)(6)(B)(i)k.7. [Network by Provider Survey Type Tab]. These provisions are necessary to calculate and record results of the PAAS and benefit consumers and health plans by providing clear instructions for completing the PAAS and recording PAAS results in a consistent manner. Clear instructions for the methodology ensure the health plans gather and report accurate, uniform data that will allow the DMHC to conduct efficient regulatory review and ensure health plans provide timely access to care through adequate networks.

Percentage of Providers with Timely Appointments for Urgent and Non-Urgent Appointment Types (Weighted) field (Instruction Manual p. 95)

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual explains that for each Provider Survey Type in each network, this field auto-calculates the percentage of network providers with timely appointments for urgent care and non-urgent appointments by taking the weighted average of the percentage of network providers with timely appointments for urgent care and non-urgent appointments. The Instruction Manual directs the health plan how to calculate the value in this field with values from other fields entered by the health plan in to the Results tabs. This information will assist the health plan in ensuring the information in the report form is correct and enable the DMHC to validate the reported information and effectively determine the health plan's compliance with the law.

The information from this field is necessary to implement Health and Safety Code section 1367.03 (f), which requires health plans to report timely access data to DMHC in the manner specified by the DMHC. This field provides the method for calculating and verifying the weighted percentage of network providers with timely appointments for urgent and non-urgent appointment types. The information benefits consumers by providing measurable data the DMHC can use to ensure compliance by health plans with timely access standards. The information benefits health plans by providing data plans can use to identify and resolve issues providing timely access to care for patients.

This field implements proposed Rule 1300.67.2.2s (f)(1)(H) [Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form] and subsection (h)(6)(B)(i)k.7. [Network by Provider Survey Type Tab]. These provisions are necessary to calculate and record results of the PAAS and the information benefits consumers and health plans by providing clear instructions for completing the PAAS and recording PAAS results in a consistent manner. Clear instructions for the methodology ensure the health plans gather and report accurate, uniform data that will allow the DMHC to conduct efficient regulatory review and ensure health plans provide timely access to care through adequate networks.

Percentage of Providers with Timely Appointments for Urgent Care Appointments (Weighted) field (Instruction Manual p. 92)

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual instructs the health plan that for each Provider Survey Type in each network, this field auto-calculates the percentage of network providers with timely appointments for urgent care appointments for the entire network. The Instruction Manual explains how the value in this field is calculated with values entered by the health plan in other specified fields. This information will assist the health plan in ensuring the information in the form is correct and enable the DMHC to validate the reported information.

The information from this field is necessary to implement Health and Safety Code section 1367.03 (f) which requires health plans to report timely access data to DMHC in the manner specified by the DMHC. This field provides the method for calculating and verifying the weighted percentage of network providers with timely appointments for urgent care appointments. The information benefits consumers by providing measurable data the DMHC can use to ensure compliance by health plans with timely access standards.

This field implements proposed Rule 1300.67.2.2s (f)(1)(H) [Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form] and subsection (h)(6)(B)(i)k.7. [Network by Provider Survey Type Tab]. These provisions are necessary to calculate and record results of the PAAS and the information benefits consumers and health plans by providing clear instructions for completing the PAAS and recording PAAS results in a consistent manner. Clear instructions for the methodology ensure the health plans gather and report accurate, uniform data that will allow the DMHC to conduct efficient regulatory review and ensure health plans provide timely access to care through adequate networks.

Percentage of Psychiatrists with Timely Appointments for Urgent Care and Non-Urgent Appointment Types (Instruction Manual p. 89)

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual instructs the health plan that this field is copied from "Percentage of Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types (Weighted)" field from the Network by Provider Survey Type Tab for Psychiatrists. The Instruction Manual clarifies how this field is calculated by referring health plans to the explanation of how this field is calculated in the Network by Provider Survey Type Tab (see pp. 87-93 of the Instruction Manual). The Instruction Manual also explains how the value in this field is auto-calculated with values from other specified fields entered by the health plan in to the Summary of Rates of Compliance Tab, so the health plan can verify the value in the percentage field. This information will assist the health plan in ensuring the information in the form is correct and enable the DMHC to validate the reported information.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the DMHC's standardized methodology. This field provides the method for calculating and verifying the percentage of providers with timely appointments for urgent care and non-urgent appointment types for psychiatrists. The information benefits consumers by providing measurable data the DMHC can use to ensure compliance by health plans with timely access standards. The information benefits health plans by providing data health plans can use to identify and resolve issues providing timely access to care for patients.

This field implements proposed Rule 1300.67.2.2 (f)(1)(H) [Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form] and subsection (h)(6)(B)(i)k.6. [Summary of Rates of Compliance Tab]. These provisions require the health plan to calculate and record the Summary of Rates of Compliance for the PAAS so the health plan can identify whether each network met or exceeded the threshold rate of compliance as set forth in Rule 1300.67.2.2(b)(11)(A). If the network failed to meet or exceed the rate of compliance, the health plan shall implement prompt investigation and corrective action, as set forth in Rule 1300.67.2.2(d)(3) and (f)(1)(I), to bring the network into compliance. This rule benefits consumers and health plans by providing clear instructions for completing the PAAS and for taking necessary corrective action to ensure network adequacy. Clear instructions for the PAAS methodology ensure the health plans gather and report accurate, uniform data.

Person Spoken to* field (Instruction Manual p. 45)

This field appears in the following PAAS Report Forms:

- Primary Care Providers Raw Data Report Form
- Non-Physician Mental Health Care Providers Raw Data Report Form

- Specialist Physicians Raw Data Report Form
- Psychiatrists Raw Data Report Form
- Ancillary Service Providers Raw Data Report Form

The Instruction Manual instructs the health plan to enter the name of the person who responded to the PAAS on behalf of the network provider, if applicable.

The information from this field is necessary to implement Health and Safety Code section 1367.03(f) which requires health plans to report timely access data to DMHC in the manner specified by the DMHC. This field provides the name of the person who responded to the PAAS on behalf of the network provider. Health plans enter the information in the Raw Data Report Forms and the information is used to report information on the Results Forms to the DMHC. The information benefits consumers by providing data the DMHC can use to ensure compliance by health plans with timely access standards. The information benefits plans by providing data plans can use to identify and resolve issues providing timely access to care for patients. Additionally, this information identifies the individual who responded to the PAAS, allowing the provider and the health plan to follow up with the individual if the PAAS reveals any problems with administration of the survey.

This field implements proposed Rule 1300.67.2.2(f)(1)(F) [Administer the Provider Appointment Availability Survey...] and subsection (h)(6)(B)(i)f.-j. [Raw Data Report Forms for each provider survey type]. These provisions benefit consumers and plans by providing clear instructions for completing the PAAS and recording PAAS results. Clear instructions for the methodology ensure the plans gather and report accurate, uniform data. This field benefits health plans and stakeholders by clarifying the data that must be filed for DMHC review, clarifying terms use by the DMHC, and ensuring complete, consistent, and comparable health plan reports. The DMHC benefits by receiving uniform, comparable data to evaluate timely access to health care services and network adequacy, allowing the DMHC to conduct efficient regulatory review. Consumers benefit from having adequate networks to fulfill their health care needs. Health plans benefit from having clear standards for information they need to report to DMHC. Plans also benefit from evaluation of their data because the DMHC can evaluate the data and work with health plans to resolve identified issues.

Phone Number field (Instruction Manual p. 101)

This field appears in the following ANR forms:

- Mental Health Professional and Mental Health Facility Report Form
- Other Outpatient Provider Report Form
- PCP and PCP Non-Physician Medical Practitioner Report Form
- Specialist and Specialist Non-Physician Medical Practitioner Report Form

The Instruction Manual instructs the health plan to enter the phone number an enrollee may use to schedule an appointment at the reported practice address or location, if applicable. However, if no individual provider is reported in the record, the health plan must report the phone number an enrollee may use to schedule an appointment with the

entity network provider at the reported practice address, if applicable.

The information from this field is necessary to implement Health and Safety Code section 1367.035(a) and (g), which requires health plans to report network data specified by the DMHC. This field requests the phone number the enrollee uses to schedule an appointment at the reported practice address and location, which will give the health plan and DMHC information necessary to assess the ways an enrollee may seek an appointment and obtain necessary health care services.

This field implements proposed Rule 1300.67.2.2(h)(7)(B) which requires the specified report forms to be reported as part of the ANR. This field benefits health plans and stakeholders by clarifying the data that must be filed for DMHC review, clarifying terms use by the DMHC, and ensuring consistent and comparable health plan reports, as required by Health and Safety Code section 1367.03(f)(2). The DMHC benefits by receiving uniform, comparable data to evaluate timely access to health care services and network adequacy, which will allow the DMHC to conduct efficient regulatory review and ensure health plans provide timely access to care through adequate networks. Consumers benefit from having adequate networks to fulfill their health care needs. Health plans benefit from having clear standards for information they need to report to DMHC. Plans also benefit from evaluation of their data because the DMHC can evaluate the data and work with health plans to resolve identified issues.

Phone Number 1 field; Phone Number 2 field; and Phone Number 3 field (Instruction Manual p. 28)

These fields appear in the following PAAS forms:

- Primary Care Providers Contact List Report Form
- Non-Physician Mental Health Care Providers Contact List Report Form
- Specialist Physicians Contact List Report Form
- Psychiatrists Contact List Report Form
- Ancillary Service Providers Contact List Report Form
- Primary Care Providers Raw Data Report Form
- Non-Physician Mental Health Care Providers Raw Data Report Form
- Specialist Physicians Raw Data Report Form
- Psychiatrists Raw Data Report Form
- Ancillary Service Providers Raw Data Report Form

The Instruction Manual instructs the health plan that these fields are included for the health plan's use in conducting the PAAS only and the information shall not be submitted to DMHC in the report form.

This field is added to implement Health and Safety Code section 1367.03 which requires the health plans to use the standardized DMHC methodologies for reporting data to the DMHC concerning timely access to care. This field implements Rule 1300.67.2.2 (F)(1)(F) [Administer the Provider Appointment Availability Survey ...] and (f)(1)(G) [Record the survey outcome] which provide the methodology for implementing the PAAS and

recording the outcomes, responses and compliance determinations on the Raw Data Report Forms. It implements Rule 1300.67.2.2(h)(6)(B)(i)a.-j., which requires the Raw data and Contact List Report Forms to be completed and submitted to the DMHC.

This field gives health plans space within the Report Forms to record phone numbers, if that is helpful to the health plan, but specifies this information is not required to be submitted to the DMHC. Health plans benefit from having clear standards for information they do not need to report to DMHC.

Practice Address field (Instruction Manual p. 28)

This field appears in the following ANR forms:

- Hospital and Clinic Report Form
- Mental Health Professional and Mental Health Facility Report Form
- Other Outpatient Provider
- PCP and PCP Non-Physician Medical Practitioner Report Form
- Specialist and Specialist Non-Physician Medical Practitioner Report Form

This field also appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form
- Non-Physician Mental Health Care Providers Contact List Report Form
- Specialist Physicians Contact List Report Form
- Psychiatrists Contact List Report Form
- Ancillary Service Providers Contact List Report Form
- Primary Care Providers Raw Data Report Form
- Non-Physician Mental Health Care Providers Raw Data Report Form
- Specialist Physicians Raw Data Report Form
- Psychiatrists Raw Data Report Form
- Ancillary Service Providers Raw Data Report Form

The Instruction Manual instructs the health plan to provide the street number and street name of the practice address. If the network provider also serves as a telehealth provider, the health plan is instructed to report only the physical locations at which the network provider delivers in-person health care services.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the standardized DMHC methodology. This field implements Health and Safety Code section 1367.035(a)(1), which requires health plans to report the location of provider offices. This field benefits health plans and consumers by identifying the location of the practice address where enrollees may obtain in-person health care services, which helps the DMHC determine the types of health care services provided within network service areas, and the adequacy of the network serving that area.

The information about “practice address” is also gathered and documented on the PAAS Contact List and Raw Data Report Forms as part of the process for identifying network providers to be surveyed in the PAAS. This field assists DMHC in implementing statutory authority to develop and implement requirements for health plans to report data pursuant to Health and Safety Code section 1367.03 (f). Health and Safety Code section 1367.03(f) requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans. This field also implements Rule 1300.67.2.2(h)(6)(B)(i)a.-j. which require health plans to complete and provide PAAS Raw Data and Contact List Report Forms to DMHC. It also implements proposed Rule 1300.67.2.2(h)(7)(B)(i)-(v) which require the health plan to provide ANR Report Forms to the DMHC. This field benefits consumers, stakeholders and DMHC by providing data that can be used to ensure accurate assessment of timely access to health care services and an adequate network. This field benefits health plans by clarifying the data that must be filed for DMHC review, clarifying terms use by DMHC, and ensuring consistent and comparable health plan reports.

Practice Address 2 field (Instruction Manual p. 28)

This field appears in the following ANR forms:

- Hospital and Clinic
- Mental Health Professional and Mental Health Facility Report Form
- Other Outpatient Provider
- PCP and PCP Non-Physician Medical Practitioner Report Form
- Specialist and Specialist Non-Physician Medical Practitioner Report Form

This field also appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form
- Non-Physician Mental Health Care Providers Contact List Report Form
- Specialist Physicians Contact List Report Form
- Psychiatrists Contact List Report Form
- Ancillary Service Providers Contact List Report Form
- Primary Care Providers Raw Data Report Form
- Non-Physician Mental Health Care Providers Raw Data Report Form
- Specialist Physicians Raw Data Report Form
- Psychiatrists Raw Data Report Form
- Ancillary Service Providers Raw Data Report Form

The Instruction Manual instructs the health plan to provide the number of the office, suite, building or other location identifier for the practice address, if applicable.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be gathered and reported to the DMHC in compliance with the DMHC’s standardized methodology. This field implements Health and Safety Code section 1367.035(a)(1) which requires health plans to report the location of provider

offices. This field benefits health plans and consumers by identifying the specific location of the practice address where enrollees may obtain health care services. That information helps the DMHC determine the types of health care services provided within network service areas, and the adequacy of the network serving that area.

The specific information about “practice address” is also gathered and documented on the PAAS Contact List and Raw Data Report Forms as part of the process for identifying network providers to be surveyed. This field assists DMHC in implementing statutory authority to develop and implement requirements for health plans to report data pursuant to Health and Safety Code section 1367.03(f). Health and Safety Code section 1367.03(f) requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by network providers and health plans. This field also implements Rule 1300.67.2.2, subsections (h)(6)(B)(i)a.-j., which require health plans to complete and provide PAAS Raw Data and Contact List Report Forms to DMHC. It also implements proposed Rule 1300.67.2.2, subsection (h)(7)(B)(i)-(v) which requires the health plan to provide specified ANR Report Forms to the DMHC. This field benefits consumers, stakeholders, and DMHC by providing data that can be used to ensure accurate assessment of timely access to health care services and an adequate network. This field benefits health plans by clarifying the data that must be filed for DMHC review, clarifying terms use by DMHC, and ensuring consistent and comparable health plan reports, as required by Health and Safety Code section 1367.03(f)(2).

Product Line field (Instruction Manual p. 97)

This field appears in the following ANR forms:

- Network Service Area and Enrollment Report Form
- Timely Access and Network Adequacy Grievance Report Form

For the Network Service Area and Enrollment Report Form, in the Enrollment and Network Service Area tabs, the Instruction Manual instructs the health plan to provide the product line(s) using the reported network in the reported ZIP Code and county, as set forth in Appendix A of the Instruction Manual. Similarly, for the Timely Access and Network Adequacy Grievance Report Form, the Instruction Manual instructs the health plan to provide the product line within which the enrollee was enrolled, as set forth in Appendix A of the Instruction Manual, on the date of the grievance. Referencing Appendix A will allow health plans to easily locate the standardized terminology related to product lines, which will reduce the burden on health plans.

This field is added to implement Health and Safety Code section 1367.035(a) and (g) which require a health plan to provide network data specified by DMHC as part of its annual report submitted pursuant to Health and Safety Code section 1367.03(f). This field implements Health and Safety Code section 1367.035(a)(6) which requires the health plan to report to the DMHC grievances regarding network adequacy and timely access that the health care service plan received during the preceding calendar year. This field implements Rule 1300.67.2.2(h)(7)(B)(vi) and (viii), which require the health plan to submit

to the DMHC the specified report forms. This field benefits consumers, stakeholders, and DMHC by providing data that can be used to ensure accurate assessment of timely access to health care services and an adequate network. It benefits health plans and stakeholders by clarifying the data that must be filed for DMHC review, clarifying terms use by DMHC, and ensuring consistent and comparable health plan reports. DMHC benefits by receiving uniform, comparable data to evaluate timely access to health care services and network adequacy, including information necessary to identify trends in deficiencies related to particular product lines. Consumers benefit from having adequate networks to fulfill their health care needs.

Proportion of Non-Contracted to Contracted Providers field (Instruction Manual p. 130)

This field appears in following:

- Out-Of-Network Payment Report Form.

The Instruction Manual instructs the health plan to provide the Number of Non-Contracted Providers at Facility in proportion to the Number of Contracted Providers at Facility. It instructs the health plan about the required format to use to report this information.

This field is added to implement Health and Safety Code section 1371.31(a)(4), which requires information about the proportion of non-contracted to contracted providers to be included in the health plan's ANR pursuant to Health and Safety Code section 1367.035, in the manner specified by the DMHC. This field implements proposed Rule 1300.67.2.2(h)(7)(C), which requires the health plan to provide to the DMHC the Out-of-Network Payment Report Form, in which this field appears. This field benefits consumers, stakeholders, and the DMHC by providing data that can be used to gain insight into the composition of a health plan's network, especially in relation to individual providers working in contracting health facilities. In particular, a very high proportion of *noncontracted* providers at contracting facilities may suggest the health plan has an insufficient number of *contracting* providers at that facility. This information will allow the DMHC and health plans to assess this factor and make necessary adjustments to help ensure enrollees have appropriate access to network providers. This field also benefits health plans and stakeholders by clarifying the data that must be filed for DMHC review, clarifying terms use by DMHC, and ensuring consistent and comparable health plan reports. DMHC benefits by receiving uniform, comparable data to evaluate timely access to health care services and network adequacy. Consumers benefit from having adequate networks to fulfill their health care needs.

Provider Category field (Instruction Manual p. 127).

This field appears in the following ANR form:

- Timely Access and Network Adequacy Grievance Report Form.

The instructions tell the health plan to provide the category of provider that is the subject of the enrollee complaint. The Instruction Manual directs the health plan to Appendix F (located on Instruction Manual p. 153) for the list of potential categories and the definition of each.

This field implements Health and Safety Code section 1367.035(a) and (g), which require a health plan to provide network adequacy data specified by the DMHC, and Health and Safety Code section 1367.035(a)(6), which requires the health plan to report to the DMHC grievances regarding network adequacy and timely access that the health care service plan received during the preceding calendar year. This field is also necessary to implement Health and Safety Code section 1367.03(f)(2) because this field ensures health plans report the required information in a consistent manner, resulting in comparable reports, as required by the statute. Finally, this field also implements proposed Rule 1300.67.2.2(h)(7)(B)(viii), which requires the health plan to provide to the DMHC the specified ANR Report Form. This field benefits consumers, stakeholders, and the DMHC by identifying provider categories that relate to reported grievances. This information can help identify health plans product lines and networks with insufficient types of providers in specified types of health care services. The data in this field is necessary to allow the DMHC to understand the provider categories related to enrollee grievances about timely access and network adequacy. This information about the type and context of these grievances will help the DMHC identify trends in timely access and network adequacy complaints, which will help the DMHC identify compliance issues and seek appropriate corrective action from health plans.

This field benefits health plans and stakeholders by clarifying the data that must be filed for DMHC review, clarifying terms use by DMHC, and ensuring consistent and comparable health plan reports. The DMHC benefits by receiving uniform, comparable data to evaluate timely access to health care services and network adequacy, which will promote efficient regulatory review by the DMHC. Consumers benefit from having adequate networks to fulfill their health care needs.

Provider Group field (Instruction Manual p. 27).

This field appears in the following ANR forms:

- Timely Access and Network Adequacy Grievance Report Form;
- Mental Health Professional and Mental Health Facility Report Form;;
- Other Outpatient Provider Report Form
- PCP and PCP Non-Physician Medical Practitioner Report Form;
- Specialist and Specialist Non-Physician Medical Practitioner Report Form; and
- Telehealth Report Form.

This field appears in PAAS forms:

- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;

- Psychiatrists Contact List Report Form
- Ancillary Service Providers Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

The instructions tell the health plan to provide the name of the provider group affiliated with the network provider, if applicable, in the Contact List Report Forms.

The instructions differ slightly for the Provider Group field used in other forms. This slight difference is necessary to ensure the instructions are clear and understandable in the context of each specific form.

For the Timely Access and Network Adequacy Grievance Report Form, the Instruction Manual instructs the health plan that, if the provider that is the subject of the complaint is affiliated with a provider group, and the enrollee was assigned to that provider group at the time of the complaint, the health plan must provide the name of the provider group. For purposes of the Other Outpatient Provider Report Form, the Instruction Manual instructs the health plan to provide the name of the provider group affiliated with the individual network provider, if applicable. If no individual provider is reported in this record, the Instruction Manual instructs the health plan to report the provider group affiliated with the entity network provider, if applicable.

This field implements Health and Safety Code section 1367.035(a) and (g) because it requires health plans to report network data in the manner specified by the DMHC. This field benefits the DMHC by providing data that can be used to identify the composition of a health plan's network, including participating provider groups, which will help the DMHC assess the adequacy of health plan networks and determine which reported grievances relate to identified provider groups.

This field assists DMHC in implementing statutory authority to specify standardized reporting methodologies, under Health and Safety Code section 1367.03(f), which requires annual reports concerning timely access and network adequacy to be comparable so consumers can assess the performance by health plans. The information from this field is necessary because it ensures that health plans are identified and surveyed in a uniform manner, allowing for comparison of reports.

This field also implements Rule 1300.67.2.2(h)(6)(B)(i)a.-j., which require health plans to complete and submit PAAS Raw Data Report Forms and Contact List Report Forms to DMHC. This field also implements proposed Rule 1300.67.2.2(h)(7)(B), which require the health plan to provide the above ANR Report Forms to the DMHC. This field also implements Rule 1300.67.2.2(f)(1)(A)-(F) [which require health plans to conduct and record the results of the PAAS using the PAAS Report Forms]. This field is a component of the DMHC's standardized methodology for identifying and surveying network providers. This Provider Group field provides data that can be used to ensure accurate assessment

of timely access to health care services and an adequate network. This field benefits health plans and stakeholders by clarifying the data that must be filed for DMHC review, clarifying terms use by DMHC, and ensuring consistent and comparable health plan reports. DMHC benefits by receiving uniform, comparable data to evaluate timely access to health care services and network adequacy, which will promote efficient regulatory review. Consumers benefit from having adequate networks to fulfill their health care needs.

Provider Language 1, 2, and 3 fields (Instruction Manual p. 101).

These fields appears in the following ANR forms:

- Mental Health Professional and Mental Health Facility Report Form;
- Other Outpatient Provider;
- PCP and PCP Non-Physician Medical Practitioner Report Form;
- Specialist and Specialist Non-Physician Medical Practitioner Report Form; and
- Telehealth Report Form.

The instructions tell the health plan to provide the language(s) spoken by the network provider, other than English, as set forth in Appendix C (located on Instruction Manual p. 142), if applicable.

This field implements Health and Safety Code section 1367.035(a) and (g) because it requires a health plan to report network data in the manner specified by the DMHC. It benefits the DMHC by identifying any languages other than English spoken by network providers, which helps the DMHC assess the network's ability to serve the health plan's enrollees. This field implements Rule 1300.67.2.2(h)(8)(D)(iv) [requiring provider languages to be reported to the DMHC using protocols for standardized terminology]. This field benefits the DMHC, consumers, and health plans by tracking languages spoken by providers using the standardized terminology provided by DMHC or by connecting the health plan's terminology to the terminology used by the DMHC through the crosswalk tables provided by the DMHC. Therefore, reporting this information in a standardized manner will result in comparable reports, as required by Health and Safety Code section 1367.03(f)(2). This field benefits consumers, health plans, and the DMHC by providing information about languages spoken by providers and by ensuring uniform data is reported to the DMHC.

Provider Survey Type field (Instruction Manual p. 29).

This field appears in the following PAAS forms:

- Results Report Form;
- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;
- Ancillary Service Providers Contact List Report Form;

- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

The Instruction Manual for the Results Report Form instructs the health plan to enter the provider survey type for which the health plan is reporting PAAS results. For the Network by Provider Survey Type Tab within the Results Report Form, the Instruction Manual explains that the Provider Survey Type field auto-populates based on the corresponding Results Report Form Tab for the specific Provider Survey Type (e.g., Primary Care Providers Results Tab). For the Contact List Report Forms and Raw Data Report Forms, the Instruction Manual instructs the health plan to enter the applicable provider survey type. Thus, for the Primary Care Providers Contact List and Raw Data Report Forms, the health plan enters “Primary Care Providers” in this field.

This field is necessary to implement Health and Safety Code section 1367.03(f) because it requires health plans to enter data in required report forms in a uniform manner that follows the standardized methodology developed by the DMHC. The information ensures timely access and network adequacy data is comparable so consumers, health plans and the DMHC can assess the performance by health plans, as required by Health and Safety Code section 1367.03(f)(2).

This field also implements Rule 1300.67.2.2(h)(6)(B)(i)a.-j. [Contact List Report Forms and Raw Data Report Forms, for each provider survey type], k.1.-5. [tabs for each provider survey type, within the Results Report Form], and k.7. [the Network by Provider Survey Type tab within the Results Report Form]. This field is also necessary to implement Rule 1300.67.2.2(f)(1), which sets forth the DMHC’s standardized methodology the health plans must use to conduct the PAAS, including the requirement to survey the five defined provider survey types (see Rule 1300.67.2.2(b)(15)). This field benefits consumers because it is a component of the requirement for health plans to report uniform timely access data to DMHC, which will allow the DMHC to conduct efficient regulatory review and require health plans to take appropriate corrective action, if necessary, to ensure enrollees have timely access to health care services from each of the provider survey types.

Provider Type field (Instruction Manual p. 39).

This field appears in the following ANR form:

- Other Outpatient Provider Report Form.

This field also appears in the following forms:

- Ancillary Service Providers Contact List Report Form; and
- Ancillary Service Providers Raw Data Report Form.

The instructions tell the health plan to enter the provider type that describes the individual/entity/facility network provider's area of practice, as set forth in Appendix B (located on p. 133 of the Instruction Manual). In the Other Outpatient Provider Report Form, the Instruction Manual also says that if no *individual* provider is reported in this record, the health plan must report the provider type that describes the *entity* network provider's area of practice. These instructions have the benefit of helping health plans understand how to correctly complete this field, as it appears in the various report forms.

This field is necessary to implement Health and Safety Code section 1367.03(f) because it requires health plans to enter data in required report forms in a uniform manner that follows the standardized methodology developed by the DMHC. The information ensures timely access and network adequacy data is comparable so consumers, health plans and the DMHC can assess the performance by health plans, as required by Health and Safety Code section 1367.03(f)(2).

This field also implements Health and Safety Code section 1367.035(a) and (g) because it requires a health plan to report network data in the manner specified by the DMHC. This field benefits the DMHC by identifying the provider types in the health plan's report, which helps the DMHC understand the composition of the health plan's reported network, so the DMHC can assess the network adequacy for that kind of provider.

This field also implements Rule 1300.67.2.2(h)(6)(B)(i)e. and j. [Ancillary Service Providers Contact List Report Form and Ancillary Service Providers Raw Data Report Form]. This Provider Type field benefits consumers because it is a component of the requirement for health plans to report uniform timely access data to DMHC, which will allow the DMHC to conduct efficient regulatory review and require health plans to take appropriate corrective action, if necessary, to ensure enrollees have timely access to health care services through adequate networks. This field is also necessary to implement Rule 1300.67.2.2(h)(7)(B)(iv) [Other Outpatient Provider Report Form' and (h)(8)(D)(iii) [requiring provider types to be reported to the DMHC using protocols for standardized terminology]. This field benefits the DMHC, consumers, and health plans by tracking provider types using the standardized terminology provided by DMHC or by connecting the plan's terminology to the terminology used by the DMHC through the crosswalk tables provided by the DMHC. Therefore, reporting this information in a standardized manner will result in comparable reports, as required by Health and Safety Code section 1367.03(f)(2).

Qualified Advanced Access Provider [QAAP] field (Instruction Manual p. 29).

This field appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form, and
- Primary Care Providers Raw Data Report Form.

The Instruction Manual tells the health plan to enter "Y" (for "yes") if the health plan identified this network provider as a QAAP. The instructions also reference paragraphs

54-57 of the PAAS Manual [regarding the QAAP modality for the PAAS] and Rule 1300.67.2.2(c)(5)(I) and (d)(2)(E) for further details regarding verification of advanced access providers. This reference will have the benefit of ensuring health plans can easily locate related instructions necessary to correctly complete this field in the report forms.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology. This field benefits the DMHC, health plans, and consumers by ensuring submission of uniform data that can be measured and calculated to provide information to plans concerning timely access to care. This field is necessary to implement Rule 1300.67.2.2, (c)(5)(I) [allowing health plans to demonstrate compliance with time-elapsing standards for appointments by implementing standards for advanced access providers], and (d)(2)(E) [requiring health plans to "verify" that providers actually provide advanced access within the Rule's definition]. This field implements the Rule's provisions allowing a health plan to verify a network provider as a QAAP so that the network provider does not have to be surveyed in the PAAS. This field benefits the DMHC, consumers, and health plans to have network providers who are verified and do not have to be surveyed in the PAAS. The DMHC benefits by receiving uniform data that can be measured and used to calculate comparable rates of compliance, as required by Health and Safety Code section 1367.03(f)(2).

Question 1 - Date When is the next available appointment date with [Provider Name] for a non-urgent appointment* field (Instruction Manual p. 68).

This field appears in the following PAAS form:

- Ancillary Service Providers Raw Data Report Form.

The Instruction Manual instructs the health plan to respond to this question based upon the network provider's response to question 1 of the PAAS, or the appointment data obtained in response to this question through the Extraction PAAS modality, and instructs the health plan to enter the date of the network provider's next available non-urgent appointment in this field. The Instruction Manual instructs the health plan to enter "NA" if the network provider indicated that this appointment type is not applicable, or if the network provider is a non-responder or ineligible. The Instruction Manual also references paragraphs 54-60 of the PAAS Manual, which contain related information and instructions. The Instruction Manual also instructs the health plan to enter "Unknown" if the network provider is not scheduling appointments at the time of the survey because the network provider is out of the office (e.g., vacation, maternity leave, etc.). These instructions and references to the PAAS Manual will have the benefit of allowing health plans to easily locate all instructions necessary to correctly complete this field in the report form.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology, to result in comparable TARs, as required by Health and Safety Code section 1367.03(f)(2). This field is also necessary to implement Rule 1300.67.2.2(c)(5), which specifies standards for enrollee wait-times for certain

appointments. This field relates to subsection (c)(5) because this field records the survey response showing whether the network provider could offer a timely appointment, in compliance with subsection (c)(5). Additionally, this field implements Rule 1300.67.2.2(f)(1)(F) [specifying how a health plan must administer the PAAS] and (h)(6)(B)(i)j. [requiring submission of the Ancillary Service Providers Raw Data Report Form with the TAR]. This field will therefore benefit consumers, DMHC, network providers and health plans because it is a component of the Rule's requirement for a health plan to administer a standardized survey and gather and record standardized data that can be used to identify issues with timely access to care for patients.

Question 1 - Time When is the next available appointment time with [Provider Name] for a non-urgent appointment* field (Instruction Manual p. 68).

This field appears in the following PAAS form:

- Ancillary Service Providers Raw Data Report Form.

The Instruction Manual tells the health plan that, based on the network provider's response to the PAAS question regarding the next available non-urgent appointment (PAAS Question 1) (or the appointment data obtained in response to this question through Extraction PAAS modality), the health plan must enter the time of the network provider's next available appointment in this field. The Instruction Manual instructs the health plan to enter "NA" if the network provider indicated this appointment type is not applicable, or the network provider is a non-responder or ineligible. The Instruction Manual also references paragraphs 54-60 of the PAAS Manual, which contain related instructions and information. The Instruction Manual also instructs the health plan to enter "Unknown" if the network provider is not scheduling appointments at the time of the survey because the network provider is out of the office (e.g., vacation, maternity leave, etc.). These instructions and references to the PAAS Manual will have the benefit of allowing health plans to easily locate all instructions necessary to correctly complete this field in the report form.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology, to result in comparable TARs, as required by Health and Safety Code section 1367.03(f)(2). This field benefits the DMHC, health plans, and consumers by collecting uniform data that the DMHC can be measured to determine health plans' compliance with timely access requirements. This field is also necessary to implement Rule 1300.67.2.2(c)(5), which specifies standards for enrollee wait-times for certain appointments. This field relates to subsection (c)(5) because this field records the survey response showing whether the network provider could offer a timely appointment, in compliance with subsection (c)(5). This field also implements Rule 1300.67.2.2(f)(1)(F) [specifying how a health plan must administer the PAAS] and (h)(6)(B)(i)j. [requiring submission of the Ancillary Service Providers Raw Data Report Form with the TAR]. This field will therefore benefit consumers, DMHC, network providers and health plans because it is a component of the Rule's requirement for a health plan to administer a standardized survey and gather and record standardized data to identify issues with timely access to care for patients.

Question 1 and 2 - Date When is the next available appointment date with [Provider Name] for [an urgent care or a non-urgent appointment]* field (Instruction Manual p. 45).

This field appears in the following PAAS forms:

- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;;
- Specialist Physicians Raw Data Report Form; and
- Psychiatrists Raw Data Report Form.

The Instruction Manual tells the health plan that, based on the network provider's response to the PAAS questions regarding the next available urgent care appointment (Question 1) or non-urgent appointment (Question 2) (or the appointment data obtained in response to these questions through the Extraction PAAS modality), the health plan must enter the date of the network provider's next available appointment in the field applicable to the appointment type. The Instruction Manual instructs the health to enter "NA" if the network provider indicated that this appointment type is not applicable or the network provider is a non-responder or ineligible. The Instruction Manual also references PAAS Manual, paragraphs 58-60, which contain related information and instructions. The Instruction Manual also instructs the health plan to enter "NA" if the network provider indicated that the network provider is a Qualified Advanced Access Provider, and the instructions reference the PAAS Manual, paragraphs 54-67, which contain related information and instructions. The Instruction Manual also instructs the health plan to enter "Unknown" if the network provider is not scheduling appointments at the time of the survey because the network provider is out of the office (e.g., vacation, maternity leave, etc.). These instructions and references to the PAAS Manual will have the benefit of allowing health plans to easily locate all instructions necessary to correctly complete this field in the report form.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology, to result in comparable TARs, as required by Health and Safety Code section 1367.03(f)(2). This field benefits the DMHC, health plans, and consumers by collecting uniform data that the DMHC can measure to determine health plan compliance with timely access requirements. This field also implements Rule 1300.67.2.2, subsections (f)(1)(F) [specifying how a health plan must administer the PAAS] and (h)(6)(B)(i)f.-i. [Raw Data Report Forms for provider survey types]. This field will therefore benefit consumers, DMHC, network providers and health plans because it is a component of the Rule's requirement for a health plan to administer a standardized survey and gather and record standardized data that can be used to identify issues with timely access to care for patients.

Question 1 and 2 - Time When is the next available appointment time with [Provider Name] for [an urgent care or a non-urgent appointment]?* field (Instruction Manual p. 45).

This field appears in the following PAAS forms:

- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form; and
- Psychiatrists Raw Data Report Form.

The Instruction Manual instructs the health plan that, based on the network provider's response to the PAAS questions regarding the next available urgent care appointment (Question 1) or non-urgent appointment (Question 2) (or the appointment data obtained in response to these questions through the Extraction PAAS modality), the health plan must enter the time of the network provider's next available appointment in the field applicable to the appointment type. The Instruction Manual instructs the health plan to enter "NA" if the network provider indicated that this appointment type is not applicable, or the network provider is a non-responder or ineligible. The Instruction Manual also references PAAS Manual, paragraphs 58-60, which contain related information and instructions. The Instruction Manual also instructs the health plan to enter "NA" if the network provider indicated that the network provider is a Qualified Advanced Access Provider, and the instructions reference the PAAS Manual, paragraphs 54-67, which contain related information and instructions. The Instruction Manual also instructs the health plan to enter "Unknown" if the network provider is not scheduling appointments at the time of the survey because the network provider is out of the office (e.g., vacation, maternity leave, etc.). These instructions and references to the PAAS Manual will have the benefit of allowing health plans to easily locate all instructions necessary to correctly complete this field in the report form.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology, to result in comparable TARs, as required by Health and Safety Code section 1367.03(f)(2). This field benefits the DMHC, health plans, and consumers by collecting uniform data that the DMHC can measure to determine health plan compliance with timely access requirements. This field is also necessary to implement Rule 1300.67.2.2(c)(5), which specifies standards for enrollee wait-times for certain appointments. This field relates to subsection (c)(5) because this field records the survey response showing whether the network provider could offer a timely appointment, in compliance with subsection (c)(5). This field also implements Rule 1300.67.2.2, subsections (f)(1)(F) [specifying how a health plan must administer the PAAS] and (h)(6)(B)(i)f.-i. [Raw Data Report Forms for provider survey types]. This field will therefore benefit consumers, DMHC, network providers and health plans because it is a component of the Rule's requirement for a health plan to administer a standardized survey and gather and record standardized data that can be used to identify issues with timely access to care for patients.

Rate of Compliance Non-Urgent Appointments (All Provider Survey Types) field (Instruction Manual p. 86).

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual explains that this field auto-calculates the probability of an enrollee obtaining a non-urgent appointment using the weighted average of the non-urgent appointment rate for each provider survey type across all counties. It explains to the health plan how the value in this field is calculated using values from other specified fields. This number is auto-calculated based on the information entered by the health plan in the Results Report Form tab for each provider survey type.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology, to result in comparable TARs, as required by Health and Safety Code section 1367.03(f)(2). This field benefits the DMHC, health plans, and consumers by collecting uniform data that the DMHC can measure to determine health plan compliance with timely access requirements. This field is also necessary to implement Rule 1300.67.2.2(c)(5), which specifies standards for enrollee wait-times for certain appointments. This field relates to subsection (c)(5) because this field records the rate at which the health plan network was able to offer a timely appointment, in compliance with subsection (c)(5). This field implements Rule 1300.67.2.2, subsections (h) and (i), and (h)(6)(B)(i)k.6. which benefit consumers, DMHC, network providers and health plans by requiring the plan to calculate and record results on the Results Report Form, identify whether the network met or exceeded the rate of compliance set forth in Rule 1300.00 (b)(11)(A), and report the data to the DMHC in a consistent manner.

Rate of Compliance Urgent Care Appointments (All Provider Survey Types) field (Instruction Manual p. 84).

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual explains that this field auto-calculates the probability of an enrollee obtaining an urgent appointment using the weighted average of the non-urgent appointment rate for each provider survey type across all counties. It explains to the health plan how the value in this field is calculated using values from other specified fields. This number is auto-calculated based on the information entered by the health plan in the Results Report Form tab for each provider survey type (except ancillary service providers, which are not surveyed in the PAAS for urgent appointments).

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's

standardized methodology, to result in comparable TARs, as required by Health and Safety Code section 1367.03(f)(2). This field benefits the DMHC, health plans, and consumers by collecting uniform data that the DMHC can measure to determine health plan compliance with timely access requirements. This field is also necessary to implement Rule 1300.67.2.2(c)(5), which specifies standards for enrollee wait-times for certain appointments. This field relates to subsection (c)(5) because this field records the rate at which the health plan network was able to offer a timely appointment, in compliance with subsection (c)(5). This field implements Rule 1300.67.2.2, subsections (h) and (i), and (h)(6)(B)(i)k.6. which benefit consumers, DMHC, network providers and health plans by requiring the plan to calculate and record results on the Results Report Form, identify whether the network met or exceeded the rate of compliance set forth in Rule 1300.00 (b)(11)(A), and report the data to the DMHC in a consistent manner.

Required Sample Size field (Instruction Manual p. 75).

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual instructs the health plan to provide the required sample size necessary to achieve a statistically reliable sample for the provider survey type in the County/Network. The Instruction Manual explains that the required sample size is determined by using the "Number of Providers within County/Network" and the Sample Size Chart set forth in Appendix 1, located on p. 35 of the PAAS Manual.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology, to result in comparable TARs, as required by Health and Safety Code section 1367.03(f)(2). This field benefits the DMHC, health plans, and consumers by collecting uniform data that the DMHC can measure to determine health plan compliance with timely access requirements. This field implements the requirement for a required sample size, which is the minimum number of survey responses the health plan must obtain from its random sample of each provider survey type, according to the instructions in paragraphs 20-23 of the PAAS Manual. The required sample sizes ensure that the PAAS surveys enough network providers to produce results with appropriate statistical confidence limits. The required sample size therefore results in the benefit of ensuring a health plan surveys an appropriate number of network providers for each county/network, to produce statistically reliable and comparable results across all health plans, as required by Health and Safety Code section 1367.03(f)(2).

The information in this field ultimately benefits consumers by providing measurable data the DMHC can use to ensure compliance by health plans with timely access standards. This field also implements Rule 1300.67.2.2 (f)(1)(C) [Determine the number of network providers from which the plan is required to obtain survey responses to meet the required sample size] and (h)(6)(B)(i)k.1.-5. [Results Report Form tabs for each provider survey type] which benefit consumers, DMHC, network providers and health plans by requiring

the plan to determine a statistically reliable and comparable sample size and report required Results Report Forms data to the DMHC.

Required Sample Size Achieved field (Instruction Manual p. 75).

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual tells the health plan to enter "Y" if the health plan administered the survey to a randomly selected sample of network providers and was able to obtain a sufficient number of survey responses from network providers to reach the required sample size based on the "Required Sample Size" and the "Total Number of Providers Responded to Survey" fields. The Instruction Manual instructs the health plan to enter "Y" if the health plan surveyed a census of network providers and was able to obtain a sufficient number of completed responses from network providers to reach or exceed the required sample size based on the "Required Sample Size" and the "Total Number of Providers Responded to Survey" fields. The Instruction Manual also instructs the health plan to enter "N" if the health plan was unable to meet the required sample size. The Instruction Manual clarifies that, even if the health plan was unable to meet the required sample size, the health plan must still report all required information in the Results Report Form. These instructions will result in the benefit that the health plan will clearly understand how to correctly complete this field in the report forms.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology, to result in comparable TARs, as required by Health and Safety Code section 1367.03(f)(2). This field benefits the DMHC, health plans, and consumers by collecting uniform data that the DMHC can measure to determine health plan compliance with timely access requirements. This field implements the requirement for a required sample size, which is the minimum number of survey responses the health plan must obtain from its random sample of each provider survey type, according to the instructions in paragraphs 20-23 of the PAAS Manual. The required sample sizes ensure that the PAAS surveys enough network providers to produce results with appropriate statistical confidence limits. The required sample size therefore results in the benefit of ensuring a health plan surveys an appropriate number of network providers for each county/network, to produce statistically reliable and comparable results across all health plans, as required by Health and Safety Code section 1367.03(f)(2).

The information in this field ultimately benefits consumers by providing measurable data the DMHC can use to ensure compliance by health plans with timely access standards. This field implements Rule 1300.67.2.2(h) (requiring the TAR) and (h)(6)(B)(i)k.1.-5. [Results Report Form tabs for each provider survey type] which benefit consumers, DMHC, network providers and health plans by requiring the plan to identify whether it met the statistically reliable and comparable sample size and report required Results Report Forms data to the DMHC. This information will allow the DMHC to assess the health

plan's compliance with the PAAS methodology and will provide valuable context for the health plan's PAAS results.

Resolution Determination field (Instruction Manual p. 128)

This field appears in the following ANR form:

- Timely Access and Network Adequacy Grievance Report Form.

The Instruction Manual tells the health plan to provide the resolution determination for this grievance pursuant to Appendix F, which lists the resolution determinations and the definition of each (Instruction Manual, p. 153). The health Plan may link its own terminology to the standardized terminology set forth in Appendix F by using the crosswalk tables within the health plan profile.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology, to result in comparable TARs, as required by Health and Safety Code section 1367.03(f)(2). This field also implements Health and Safety Code section 1367.035(a)(6), which requires the health plan to provide the DMHC data on grievances related to timely access and network adequacy that the plan received during the preceding year. It also implements Health and Safety Code section 1367.03(g)(2), which requires the DMHC director to periodically evaluate grievances "to determine if any audit, investigative, or enforcement actions should be undertaken" by the DMHC. This data regarding the resolution of grievances is necessary to allow the DMHC to track and evaluate grievances and the ways health plans resolve those grievances. Evaluation of this data to see whether the grievance was resolved in favor of the plan, the enrollee or partially in favor of the enrollee benefits the DMHC, consumer and health plan because the DMHC may determine whether it needs to investigate or audit a health plan. Rule 1300.67.2.2(h)(7)(B)(viii) [requiring health plans to submit the Timely Access and Network Adequacy Grievance Report Form in the ANR] helps the DMHC to ensure timely access to health care and network adequacy for consumers by requiring the resolution determination data to be reported to DMHC.

Sample Type field (Instruction Manual p. 43).

This field appears in the following PAAS forms:

- Results Report Form;
- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

For the Results Report Form, the Instruction Manual instructs the health plan that, for each provider survey type within the County/Network, the health plan must indicate the

PAAS sample type by entering: "Random Sample" if the health plan administered the survey to a randomly selected sample of network providers but did not survey all network providers within the County/Network; "Sample Exhaustion" if the health plan intended to administer the survey to a randomly selected sample of network providers but surveyed all network providers within the County/Network through the replacement of network providers from the oversample; or "Census" if the health plan conducted a census (surveyed all the network providers in the County/Network). The Instruction Manual instructs the health plan to review Step 3 located on p. 9 of the PAAS Manual [Determine Sample and Oversample Size] for further details related to selecting the network providers the health plan is required survey under the PAAS. These instructions and the reference to the PAAS Manual will have the benefit of allowing a health plan to easily locate all information and instructions necessary to correctly complete this field in the report forms.

For the PAAS Raw Data Report Forms, the Instruction Manual instructs the plan to enter "Random Sample" if the health plan administered the survey to a randomly selected sample of network providers in the County/Network, or to enter "Census" if the health plan conducted a census (surveyed all the network providers) in the County/Network. These instructions will have the benefit of allowing a health plan to easily locate all information and instructions necessary to correctly complete this field in the report forms.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology, to result in comparable TARs, as required by Health and Safety Code section 1367.03(f)(2). This field benefits consumers, health plans and DMHC by providing information regarding the sample type a health plan used to complete the PAAS. Information about what sample type the health plan used will allow the DMHC to ensure the health plan adhered to the PAAS Methodology, as required by Rule 1300.67.2.2(f). Indicating which sample type the health plan used to survey also provides transparency that gives the DMHC valuable context while reviewing the health plan data. It benefits the DMHC, health plans and consumers to gather and submit uniform data that can be measured and calculated to provide information to plans concerning timely access to care.

This field also implements Rule 1300.67.2.2 (f)(1)(G) [Record the survey outcome, the provider's survey responses, and compliance determinations on the Raw Data Report Form] and (H) [Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form], and (h)(6)(B)(i)f.-j. and k.1.-5. [PAAS Raw Data Report Forms and Results Report Form, for each provider survey type]. This field is a component of the requirement for the health plan to conduct the PAAS and record the results using an identified sample type, and report required Raw Data and Results Report Forms data to the DMHC, in a consistent manner.

Sampling Error Non-Urgent Appointment Rates (\pm) field (Instruction Manual pp. 87-88).

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual explains that this field auto-calculates the sampling error for the non-urgent appointment rate. The Instruction Manual provides the formula and specifies the fields used to calculate the number in this field, and explains this number is auto-calculated based on the information entered by the health plan in Results Report Form tab for each provider survey type.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology. This field benefits consumers, health plans and DMHC because the data regarding sampling errors must be uniform to result in comparable reports, as required by Health and Safety Code section 1367.03(f)(2). Calculating the sampling error provides information regarding the statistically reliability of the data. It benefits the DMHC, health plans and consumers to gather and submit uniform data that can be measured and calculated to provide information to plans concerning timely access to care. This field implements Rule 1300.67.2.2, subsections (f)(1)(H) [Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form], and (h)(6)(B)(i)k.6. [the Results Report Form Summary of Rates of Compliance Tab], which benefit consumers, the DMHC, network providers and health plans by providing statistically reliable and comparable data and reporting required Results Report Forms data to the DMHC. The rule benefits consumers, health plans and the DMHC by requiring uniform data to be calculated and reported so that issues with timely access to care and be identified and resolved.

Sampling Error Urgent Care Appointment Rates (\pm) field (Instruction Manual p. 85)

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual informs the health plan that this field auto-calculates the sampling error for the urgent care appointment rate. It provides the formula and fields used to calculate the number in this field. This number is auto-calculated based on the information entered by the health plan in the Results Tab.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology. It benefits consumers, health plans, and DMHC if the Summary of Rates of Compliance Tab calculates the sampling error because auto-calculation reduces the likelihood of calculation errors, and the data in the health plan reports must be uniform and comparable, pursuant to Health and Safety Code section

1367.03(f)(2). Calculating the sampling error is part of the process that ensures the health plan TAR provides statistically reliable data to the DMHC. It benefits the DMHC, health plans, and consumers to gather and submit uniform data that can be measured and calculated to provide information to plans concerning timely access to care. This field implements Rule 1300.67.2.2(f)(1)(H) [Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form], and (h)(6)(B)(i)k.6. [the Results Report Form Summary of Rates of Compliance Tab], which benefit consumers, the DMHC, network providers and health plans by providing statistically accurate and comparable data and reporting required Results Report Forms to the DMHC. The field benefits consumers, health plans, and the DMHC because it is a component of the process requiring uniform data to be calculated and reported so that issues with timely access to care can be identified and resolved.

Specialty field (Instruction Manual p. 27).

This field appears in the following ANR forms:

- Timely Access and Network Adequacy Grievance Report Form;
- Mental Health Professional and Mental Health Facility Report Form;
- PCP and PCP Non-Physician Medical Practitioner Report Form;
- Specialist and Specialist Non-Physician Medical Practitioner Report Form; and
- Telehealth Report Form.

This field also appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form; and
- Psychiatrists Raw Data Report Form.

The Instruction Manual instructs the health plan to enter the network provider's specialty or subspecialty, as of the network capture date. The Instructions reference Appendix B, regarding standardized terminology for provider types (beginning on p. 133 of the Instruction Manual). For the Specialist NPMP, the Instruction Manual instructs the health plan to provide the type of certificate or acknowledgment of special qualifications, as recognized by the National Commission on Certification of Physician Assistants and the California Board of Registered Nursing, if the network provider has earned an additional specialty certificate from the appropriate state licensing board, as set forth in Appendix B, as of the network capture date. For the Timely Access and Network Adequacy Grievance Report Form, the Instruction Manual instructs the health plan to provide the specialty of the network provider who is the subject of the complaint, and clarifies the entry should reflect the provider's specialty as of the date of the grievance. These instructions and the

reference to the Instruction Manual Appendix B will have the benefit of allowing a health plan to easily locate all information and instructions necessary to correctly complete this field in the report forms.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology, to result in comparable TARs. This field is necessary to implement Health and Safety Code section 1367.035(a)(6), which requires the health plan to report to the DMHC grievances regarding network adequacy and timely access that the health care service plan received during the preceding calendar year.. It also implement Health and Safety Code section 1367.035(a)(2), by gathering network provider data by area of specialty. It benefits consumers, health plans, and DMHC to examine timely access to health care services by network provider specialty because that information allows the DMHC to understand and assess the composition of the health plan network and determine whether it includes a comprehensive range of providers adequate to serve the enrollees. It also benefits DMHC, health plans, and consumers to compare data concerning grievances by specialty for purposes of network adequacy and timely access, because this information will help identify trends in grievances related to specialties.

This field implements Rule 1300.67.2.2(f)(1)(A)-(F) [requirements for the PAAS], and (h)(6)(B)(i)a.-d. and f.-i. [PAAS Contact List Report Forms], and (h)(7)(B)(i), (ii), (v), (vii), and (viii) [specified ANR Report Forms], which benefit consumers, the DMHC, network providers and health plans by providing a standardized methodology to gather, report and calculate statistically accurate and comparable data to the DMHC. The field benefits consumers, health plans, and the DMHC because it is a component of the process requiring uniform data to be calculated and reported so that issues with timely access to care and network adequacy can be identified and resolved.

State field (Instruction Manual p. 28).

This field appears in the following ANR forms:

- Hospital and Clinic Report Form;
- Mental Health Professional and Mental Health Facility Report Form;
- Other Outpatient Provider Report Form;
- PCP and PCP Non-Physician Medical Practitioner Report Form;
- Specialist and Specialist Non-Physician Medical Practitioner Report Form; and
- Telehealth Report Form.

This field also appears in the following PAAS Report Forms:

- Results Report Form;
- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;

- Ancillary Service Providers Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

The Instruction Manual tells the health plan to provide the state in which the practice address is located. For the Telehealth Report Form, the health plan is instructed to provide the state in which the network provider's distant site is located (i.e., the location where the network provider is located when delivering telehealth services), as described on p. 123 of the Instruction Manual. For the PAAS Results Report Form, the Instruction Manual instructs the health plan to enter the state for which the health plan is reporting results.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology, to result in comparable TARs. This field is necessary to implement Health and Safety Code section 1367.035 (a)(1), which requires the health plan to provide the provider's office location as part of the annual reports regarding network adequacy. It benefits consumers, health plans, and DMHC to examine timely access to health care services by location because that information allows the DMHC to assess the composition of a network and locations where health care services are available, which assists the DMHC in assessing the adequacy of the network. This field implements Rule 1300.67.2.2 (f)(1)(A)-(F)) [requirements for the PAAS], (h)(6)(B)(i)a.-j. [PAAS Contact List and Raw Data Report Forms] and k.1.-5. [Results Report Form tabs for each provider survey type], and (h)(7)(B)(i)-(v) and (vii) [specified ANR Report Forms], which benefit consumers, the DMHC, and health plans by providing a standardized methodology to gather, report and calculate statistically accurate and comparable data and reporting required data to the DMHC. The field benefits consumers, health plans, and the DMHC because it is a component of the process requiring uniform data to be calculated and reported so that issues with timely access to care can be identified and resolved.

Subcontracted Plan License Number field (Instruction Manual p. 27).

This field appears in the following ANR forms:

- Timely Access and Network Adequacy Grievance Report Form;
- Out-Of-Network Payment Report Form;
- Network Service Area and Enrollment Report Form;
- Hospital and Clinic Report Form;
- Mental Health Professional and Mental Health Facility Report Form;
- Other Outpatient Provider Report Form;
- PCP and PCP Non-Physician Medical Practitioner Report Form;
- Specialist and Specialist Non-Physician Medical Practitioner Report Form; and

- Telehealth Report Form'

This field also appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;
- Ancillary Service Providers Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form;
- Ancillary Service Providers Raw Data Report Form; and
- Results Report Form.

The Instruction Manual provides slightly varying instructions that pertain to the particular report form to which the instructions apply. For the Timely Access and Network Adequacy Grievance Report Form, the Instruction Manual instructs the health plan to complete this field if the reporting plan has a plan-to-plan contract with a subcontracted plan for the delivery of services to enrollees within the network, and the grievance concerns a network provider or providers available through the subcontracted plan's network, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). The Instruction Manual also instructs the health plan that each health plan's license number is available in DMHC's web portal. These instructions will result in the benefit that the health plan will clearly understand how to correctly complete this field for this report form.

The Instruction Manual phrases the instructions slightly differently for the following ANR Report Forms:

- Out-Of-Network Payment Report Form;
- Hospital and Clinic Report Form;
- Mental Health Professional and Mental Health Facility Report Form;
- Other Outpatient Provider Report Form;
- PCP and PCP Non-Physician Medical Practitioner Report Form;
- Specialist and Specialist Non-Physician Medical Practitioner Report Form; and
- Telehealth Report Form.

For these ANR forms, the Instruction Manual instructs the health plan to provide the subcontracted plan license number. The health plan is instructed to complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). Each health plan's license number is available on DMHC's web portal. These instructions will result in the benefit that the health plan will clearly understand how to correctly complete this field for these report forms.

The instructions differ slightly for the report forms. This slight difference is necessary to ensure the instructions are clear and understandable in the context of each specific report form.

For the Network Service Area and Enrollment Report Form, the Instruction Manual instructs the health plan to provide the subcontracted plan license number. It instructs the health plan to complete this field if the reporting plan has a plan-to-plan contract with a subcontracted plan for the delivery of services to enrollees within the network, as these terms are defined in Rule 1300.67.2.2(b)(12). Each health plan's license number is available on DMHC's web portal. These instructions will result in the benefit that the health plan will clearly understand how to correctly complete this field for this report form.

For the PAAS Results Report Form, including all tabs for provider survey types, the Instruction Manual instructs the health plan that, if the health plan is reporting results for PAAS data obtained from a subcontracted plan, pursuant to paragraph 8b of the PAAS Manual, enter the subcontracted plan's license number. The Instruction Manual instructs the health plan that each health plan's license number is available on DMHC's web portal. These instructions will result in the benefit that the health plan will clearly understand how to correctly complete this field for this report form.

For the Raw Data and Contact List Report Forms, the Instruction Manual instructs the health plan to enter the subcontracted plan license number and to complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). The Instruction Manual instructs the health plan that each health plan's license number is available on DMHC's web portal. These instructions will result in the benefit that the health plan will clearly understand how to correctly complete this field for this report form.

This Subcontracted Plan License Number field is necessary to implement Health and Safety Code section 1367.035 (a)(6) and (g), which require the health plan to report to the DMHC timely access and network adequacy grievances for the preceding year, and data requested by DMHC. This data provides additional information used to evaluate grievances as well as information that clearly identifies the health plan's subcontracted plan. It also provides information about enrollment related to subcontracted plans, which is necessary when the DMHC evaluates the network's adequacy to serve enrollees. Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12) clarify the definitions of network providers and subcontracted plan, and the Instruction Manual's references to those definitions will allow health plans to easily locate relevant definitions and understand how to correctly complete this field.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology, to result in comparable reports. This field implements Rule 1300.67.2.2(f)(1)(A)-(F) [requirements for the PAAS], and (h)(6)(B)(i)a.-j., k., and k.1.-5. [specified PAAS Report forms, (h)(7)(B)(i)-(viii) and (vii) and (h)(7)(C) [specified ANR Report Forms] which benefit consumers, the DMHC, and health plans by providing a standardized methodology to gather, report and calculate statistically accurate and

comparable data and reporting required data to the DMHC.

The field benefits consumers, health plans, and the DMHC because it is a component of the process requiring uniform data to be calculated and reported so that issues with timely access to care and network adequacy can be identified and resolved.

Subcontracted Plan Network ID field (Instruction Manual p. 27).

This field appears in the following ANR forms:

- Timely Access and Network Adequacy Grievance Report Form;
- Network Service Area and Enrollment Report Form;
- Hospital and Clinic Report Form;
- Mental Health Professional and Mental Health Facility Report Form;
- Other Outpatient Provider Report Form;
- PCP and PCP Non-Physician Medical Practitioner Report Form;
- Specialist and Specialist Non-Physician Medical Practitioner Report Form;
- Telehealth Report Form.

This field appears in the following form:

- Out-Of-Network Payment Report Form;

This field also appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;
- Ancillary Service Providers Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form;
- Ancillary Service Providers Raw Data Report Form; and
- Results Report Form.

The instructions differ slightly for the report forms. This slight difference is necessary to ensure the instructions are clear and understandable in the context of each specific form. For the following ANR forms:

- Hospital and Clinic Report Form;
- Mental Health Professional and Mental Health Facility Report Form;
- PCP and PCP Non-Physician Medical Practitioner Report Form;
- Specialist and Specialist Non-Physician Medical Practitioner Report Form; and
- Telehealth Report Form.

The Instruction Manual tells the health plan to provide the subcontracted plan network identifier. The health plan is instructed to complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). These instructions will result in the benefit that the health plan will clearly understand how to correctly complete this field for this report form.

For the Other Outpatient Provider and Network Service Area and Enrollment Report Form, the Instruction Manual instructs the health plan to provide the subcontracted plan network identifier and to complete this field if the reporting plan includes the network provider in this Network Name due to a plan-to-plan contract with a subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(12). These instructions will result in the benefit that the health plan will clearly understand how to correctly complete this field for this report form.

For the Out-Of-Network Payment Report Form, the Instruction Manual instructs the health plan to provide that the subcontracted plan network identifier and to complete this field if the reporting plan has a plan-to-plan contract with the subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12), and the out-of-network payment was made by the subcontracted plan when arranging services for the reporting plan's enrollee. These instructions will result in the benefit that the health plan will clearly understand how to correctly complete this field for this report form.

For the Timely Access and Network Adequacy Grievance Report Form, the Instruction Manual instructs the health plan to provide the subcontracted plan network identifier. The health plan is instructed to complete this field if the reporting plan has a plan-to-plan contract with the subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12), and the grievance concerns a network provider or providers available through the subcontracted plan's network. These instructions will result in the benefit that the health plan will clearly understand how to correctly complete this field for this report form.

For the PAAS Results Report Form tabs for the provider survey types, the Instruction Manual instructs the health plan that, if the health plan is reporting results for PAAS data obtained from a subcontracted plan, pursuant to paragraph 8b of the PAAS Manual, the health plan must enter the subcontracted plan network identifier. These instructions will result in the benefit that the health plan will clearly understand how to correctly complete this field for this report form.

For the PAAS Contact List and Raw Data Report Forms, the Instruction Manual instructs the health plan to enter the subcontracted plan network identifier. The health plan is instructed to complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). These instructions will result in the benefit that the health plan will clearly understand how to correctly complete this field for this report form.

This Subcontracted Plan License Number field is necessary to implement Health and Safety Code section 1367.035 (a)(6) and (g), which require the health plan to report to the DMHC timely access and network adequacy grievances for the preceding year, and data requested by DMHC. This data provides information used to evaluate grievances as well as information that clearly identifies the health plan's subcontracted plan. This field also provides information about enrollment related to subcontracted plans, which is necessary when the DMHC evaluates the network's adequacy to serve enrollees. Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12) clarify the definitions of network providers and subcontracted plan, and the Instruction Manual's references to those definitions will allow health plans to easily locate relevant definitions and understand how to correctly complete this field.

This field implements Rule 1300.67.2.2(f)(1)(A)-(F) [requirements for the PAAS], and (h)(6)(B)(i)a.-j.], (k), k.1.-5. [specified PAAS Report forms, (h)(7)(B)(i)-(viii) and (vii) and (h)(7)(C) [specified ANR Report Forms] which benefit consumers, the DMHC, and health plans by providing a standardized methodology to gather, report and calculate statistically accurate and comparable data and reporting required data to the DMHC. The field benefits consumers, health plans, and the DMHC because it is a component of the process requiring uniform data to be calculated and reported so that issues with timely access to care and network adequacy can be identified and resolved.

Supervising Specialist Specialty field (Instruction Manual p. 109).

This field appears in the following ANR form:

- Specialist and Specialist Non-Physician Medical Practitioner Report Form.

The Instruction Manual instructs the health plan to provide the supervising physician's specialty or subspecialty, as of the network capture date.

This field is necessary to implement Health and Safety Code section 1367.035(g) which requires the health plan to provide network data requested by the DMHC. This data assists the DMHC to evaluate network adequacy in relation to non-physician medical practitioner specialists, who are supervised by an appropriate specialist. It also implements Rule 1300.67.2.2(h)(7)(B)(ii), which requires reporting of specified network data to the DMHC using provided report forms. This rule benefits DMHC, consumers and health plans by providing clear requirements for ANR reporting, and by providing uniform data to the DMHC to review and evaluate network adequacy. This will have the benefit of resulting in comparable reports, as required by Health and Safety Code section 1367.03(f)(2).

Survey Completed via* field (Instruction Manual p. 44).

This field appears in the following PAAS forms:

- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;

- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

The Instruction Manual tells the health plan to indicate whether the PAAS survey was completed via "Phone", "Fax", "Email/Online", "Extraction – Electronic", "Extraction – Manual", or "Qualified Advanced Access Provider". The Instruction Manual instructs the health plan to use the Qualified Advanced Access Provider modality only for Primary Care Providers (as described in the PAAS Manual, paragraphs 42-55). The Instruction Manual also instructs the health plan that for non-responding and ineligible providers, the health plan must enter the last method the health plan used in attempting to survey the network provider.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology, to result in comparable TARs, as required by Health and Safety Code section 1367.03(f)(2). The PAAS results are primary component of the TAR, and information about which method the health plan used to complete the PAAS will allow the DMHC to ensure the health plan adhered to the required methodology in the PAAS Manual and Rule 1300.67.2.2(f), which will help ensure the TAR was conducted correctly and results in a TAR that accurately represents the health plan's networks. This field implements Rule 1300.67.2.2 (f)(1)(G) [Record the survey outcome, the provider's survey responses, and compliance determinations on the Raw Data Report Form] and (h)(6)(B)(i)f.-j. [PAAS Raw Data Report Forms], which benefits consumers, the DMHC, and health plans by providing a standardized methodology to report and calculate statistically reliable and comparable data to the DMHC. The field benefits consumers, health plans, and the DMHC because it is a component of the process requiring uniform data to be calculated and reported so that issues with timely access to care and network adequacy can be identified and resolved.

Survey Modality field (Instruction Manual p. 43).

This field appears in the following PAAS forms:

- Results Report Form;
- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

The Instruction Manual tells the health plan to enter the survey administration modality (or modalities) used to obtain the survey data for the provider survey type in the County/Network using the following values that reflect the three permissible PAAS survey modalities, and the combinations of different modalities that a health plan might use to conduct its PAAS: "Three Step Protocol", "Qualified Advanced Access Provider", "Extraction", "Three Step Protocol/Qualified Advanced Access Provider", "Three Step

Protocol/Extraction", "Qualified Advanced Access Provider/Extraction", "Three Step Protocol/Qualified Advanced Access Provider/Extraction". The Instruction Manual also instructs the health plan to review paragraphs 42-55 of the PAAS Manual for further information related to PAAS modalities, and reminds the health plans may use the Qualified Advanced Access Provider modality only for Primary Care Providers (a requirement established in the PAAS Manual, p. 54; see also Rule 1300.67.2.2(c)(5)(I) and (b)(1)).

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology, to result in comparable TARs, as required by Health and Safety Code section 1367.03(f)(2). This field implements Rule 1300.67.2.2(f)(1)(G) [Record the survey outcome, the provider's survey responses, and compliance determinations on the Raw Data Report Form] and (h)(6)(B)(i)f.-j. [specified PAAS Report Forms], which benefit consumers, the DMHC, network providers and health plans by providing a standardized methodology to report and calculate statistically reliable and comparable data to the DMHC. This field also provides the DMHC the information necessary to see what survey modality or modalities the health plan used to conduct the PAAS, which will allow the DMHC to determine whether the health plan adhered to the relevant provisions of the DMHC's standardized methodologies for those modalities. That information will help ensure the TAR was conducted correctly and results in a TAR that accurately represents the health plan's networks. The field benefits consumers, health plans, and the DMHC because it is a component of the process requiring uniform data to be calculated and reported so that issues with timely access to care and network adequacy can be identified and resolved.

Telehealth Delivery Modality field (Instruction Manual p. 125).

This field appears in the following ANR form:

- Telehealth Report Form.

The Instruction Manual tells the health plan to enter the telehealth modality used by the network provider to deliver telehealth services, as set forth on p. 152 of the Instruction Manual, in Appendix E. The health plan may alternatively link its own terminology to the standardized terminology set forth in Appendix E by using the crosswalk tables within the health plan profile (Rule 1300.67.2.2(h)(8)(D)).

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology, to result in comparable reports. This field is also necessary to implement Health and Safety Code section 1367.035(g), which requires the health plan to provide data requested by the DMHC. This data assists the DMHC to evaluate network adequacy, which include health care services provided via a telehealth model. It also implements Rule 1300.67.2.2(h)(7)(B)(vii), which requires the health plan to submit data regarding telehealth services to the DMHC using the Telehealth Report Form. This field will also give the DMHC information necessary to understand how enrollees receive

telehealth services, which will allow the DMHC to identify trends that may warrant adjustment of standards, pursuant to Health and Safety Code section 1367.03(i).

The field benefits consumers, health plans, and the DMHC because it is a component of the process requiring uniform data to be calculated and reported so that issues with timely access to care and network adequacy can be identified and resolved.

Time Survey Completed* field (Instruction Manual p. 45).

This field appears in the following PAAS forms:

- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

The Instruction Manual instructs the health plan to enter the time the PAAS response was completed or the time the appointment data was extracted. The Instruction Manual also instructs the health plan to enter "NA" if the network provider declined to respond or was ineligible for the PAAS.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology, to result in comparable TARs. This field implements Rule 1300.67.2.2(f)(1)(G) [Record the survey outcome, the provider's survey responses, and compliance determinations on the Raw Data Report Form] and (h)(6)(B)(i)f.-j. [PAAS Raw Data Report Forms]. This field also implements Rule 1300.67.2.2(f)(1)(F) [requirements for administration of the PAAS], because the "time the survey was completed" is necessary information for the DMHC to determine whether the health plan adhered to the PAAS timelines required in the Rule. The field benefits consumers, health plans, and the DMHC because it is a component of the process requiring uniform data to be calculated and reported so that issues with timely access to care and network adequacy can be identified and resolved.

Total Number of Providers in Network (Non-Urgent Appointments) field (Instruction Manual p. 93).

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual explains that for each provider survey type in each network, this field auto-calculates the sum of the network providers in all counties. Network providers in counties where no network providers responded to the non-urgent appointment request are not included in the sum. The Instruction Manual explains how the value for this field is calculated using values from other specified fields.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology, to result in comparable TARs. This field implements Rule 1300.67.2.2 (f)(1)(H) [Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form] and (h)(6)(B)(i)k.7. [Network by Provider Survey Type Tab of the Results Report Form], which benefit consumers, the DMHC, and health plans by providing a standardized methodology to calculate and record statistically reliable and comparable data reported to the DMHC. The field benefits consumers, health plans, and the DMHC because it is a component of the process requiring uniform data to be calculated and reported so that issues with timely access to care and network adequacy can be identified and resolved.

Total Number of Providers in Network (Urgent Care Appointments) field (Instruction Manual p. 90).

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual explains that for each provider survey type in each network, this field auto-calculates the sum of the network providers in all counties. Network providers in counties where no network providers responded to the urgent care appointment request are not included in the sum. The Instruction Manual explains how the value for this field is calculated using values from other specified fields.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology, to result in comparable TARs. This field implements Rule 1300.67.2.2(f)(1)(H) [Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form] and (h)(6)(B)(i)k.7. [Network by Provider Survey Type Tab of the Results Report Form], which benefit consumers, the DMHC, and health plans by providing a standardized methodology to calculate and record statistically reliable and comparable data reported to the DMHC. The field benefits consumers, health plans, and the DMHC because it is a component of the process requiring uniform data to be calculated and reported so that issues with timely access to care and network adequacy can be identified and resolved.

Total Number of Providers Responded to Survey field (Instruction Manual p. 79).

This field appears in the following PAAS form:

- Results Report Form.

The Instruction Manual tells the health plan to verify the auto-calculated field is accurately reflected in the Results Report Form, based on the numbers in specified fields, for the provider survey type in the County/Network. The Instruction Manual specifies the fields

and methods for calculating values within those fields to help the health plan understand how to verify the auto-calculated field for each provider Survey Type in the County/Network. This information will assist the health plan in ensuring the information in the form is correct and enable the DMHC to validate the reported information.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology, to result in comparable TARs. This field implements Rule 1300.67.2.2, subsections (f)(1)(H) [Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form] and (h)(6)(B)(i)k.1.-5. [Results Report Form tabs for each provider survey type]. This information also helps the DMHC understand how many of each provider survey type responded to the health plan's PAAS, which will provide valuable context for the health plan's PAAS results. These provisions benefit consumers, the DMHC, network providers and health plans by providing a standardized methodology to calculate and record statistically reliable and comparable data reported to the DMHC. The field benefits consumers, health plans, and the DMHC because it is a component of the process requiring uniform data to be calculated and reported so that issues with timely access to care and network adequacy can be identified and resolved.

Type of Care field (Instruction Manual p. 121).

This field appears in following ANR form:

- Hospital and Clinic Report Form.

The Instruction Manual tells the health plan to identify whether the hospital is a network provider for basic hospital services, tertiary care services, or both at the identified practice address.

This field is necessary to implement Health and Safety Code section 1367.035(g), which requires the health plan to provide data requested by the DMHC. This data assists the DMHC to evaluate network adequacy, which includes the type of hospital care provided at a hospital's practice address. Information about the type of care provided at the hospital will help the DMHC evaluate the network's ability to serve the enrollees. This field also implements Rule 1300.67.2.2 (h)(7)(B)(iii), which requires the health plan to submit data regarding hospitals to the DMHC using the provided report form. The field benefits consumers, health plans, and the DMHC because it is a component of the process requiring uniform data to be calculated and reported so that issues with network adequacy can be identified and resolved.

Type of License / Certificate field (Instruction Manual p. 30).

This field appears in the following ANR forms:

- Mental Health Professional and Mental Health Facility Report Form, and
- Telehealth Report Form.

This field also appears in the following PAAS forms:

- Non-Physician Mental Health Care Providers Contact List Report Form, and
- Non-Physician Mental Health Care Providers Raw Data Report Form.

The Instruction Manual tells the health plan to provide the network provider's type of license or certificate, as set forth on p. 148 of the Instruction Manual, in Appendix D. Alternatively, the Plan may link its own terminology to the standardized terminology set forth in Appendix D by using the crosswalk tables within the health plan profile (Rule 1300.67.2.2(h)(8)(D)). These instructions and references will help the health plan easily locate standardized terminology for this field, and ensure the health plan can understand how to correctly complete this field in the report forms.

This field is necessary to implement Health and Safety Code section 1367.035(g), which requires the health plan to provide data requested by the DMHC. This data informs the DMHC of the type of license or certificate held by a network provider, which is relevant to network adequacy because licensure/certification is relevant to the network provider's qualification to provide health care services. This field also implements Rule 1300.67.2.2(h)(7)(B)(v) and (vii) which require the health plan to submit data regarding mental health professionals and telehealth to the DMHC using the provided report forms. This field also implements Rule 1300.67.2.2(h)(8)(D), which benefits consumers, health plans network providers and DMHC by providing standardized license or certificate terminology, while also providing health plans flexibility to use their own internal terminology, if that better suits the health plan's operations. Uniform data is beneficial for efficient identification of network providers. Clear identification of network providers is beneficial for evaluating network adequacy.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology, to result in comparable reports. This field implements Rule 1300.67.2.2 (f)(1)(A)-(F) [regarding administering the PAAS] and (h)(6)(B)(i)b. and g. [specified PAAS Report Forms], which benefit consumers, the DMHC, network providers and health plans by providing a standardized methodology to sample, gather, and record statistically reliable and comparable data reported to the DMHC. The field benefits consumers, health plans, and the DMHC because it is a component of the process requiring uniform data to be calculated and reported so that issues with timely access to care and network adequacy can be identified and resolved.

Unique Provider field (Instruction Manual p. 29).

This field appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form; and
- Ancillary Service Providers Contact List Report Form.

The Instruction Manual instructs the health plan to enter "Y" if the network provider was identified as a unique provider after conducting the unique provider and duplicate record identification process described in paragraphs 15-19 of the PAAS Manual. The Instruction Manual instructs the health plan to enter "N" if this entry was identified as a duplicate provider.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology, to result in comparable TARs. As noted in this ISOR's discussion of paragraphs 15-19 of the PAAS Manual, identifying unique providers prevents a single network provider from being surveyed more than once in the PAAS, thus reducing the burden on providers and ensuring the PAAS results reflect an appropriate cross-section of the network. This field implements Rule 1300.67.2.2 (f)(1)(D) [Select the network providers to be surveyed for each network] and (h)(6)(B)(i)a.-e. [specified PAAS Report Forms], which benefit consumers, the DMHC, network providers and health plans by providing a standardized methodology to select the network providers to be surveyed in the PAAS, and by requiring data be reported to the DMHC in a consistent manner. The rule benefits consumers, health plans and the DMHC by ensuring that uniform data regarding timely access to health care services is calculated and reported for evaluation and resolution, if applicable. The field benefits consumers, health plans, and the DMHC because it is a component of the process requiring uniform data to be calculated and reported so that issues with timely access to care and network adequacy can be identified and resolved.

Unscheduled Urgent Services field (Instruction Manual p. 102).

This field appears in the following ANR forms:

- Hospital and Clinic Report Form;
- Other Outpatient Provider Report Form; and
- PCP and PCP Non-Physician Medical Practitioner Report Form.

The Instruction Manual tells the health plan to identify the network provider's availability to deliver unscheduled urgent services, as defined on p.8 of the Instruction Manual. The Instruction Manual also instructs the health plan to identify whether the clinic or network provider delivers unscheduled urgent services at the reported practice address.

This field is necessary to implement Health and Safety Code section 1367.035(g), which requires the health plan to provide network adequacy data requested by the DMHC. This data allows the DMHC to evaluate network adequacy, which includes whether the clinic or network provider is available to provide unscheduled urgent care services (as required by Health and Safety Code section 1367, which requires health plans to make services readily available at reasonable times). This field also implements Rule 1300.67.2.2(h)(7)(B)(i), (iii) and (iv), which require the health plan to submit data to the DMHC using the provided ANR report forms. The field benefits consumers, health plans, and the DMHC because it is a component of the process requiring uniform data to be calculated and reported so that issues network adequacy can be identified and resolved.

ZIP Code field (Instruction Manual p. 28).

This field appears in the following ANR forms:

- Hospital and Clinic Report Form;
- Network Service Area and Enrollment Report Form;
- Hospital and Clinic Report Form;
- Mental Health Professional and Mental Health Facility Report Form;
- Network Service Area and Enrollment Report Form;
- Other Outpatient Provider Report Form;
- PCP and PCP Non-Physician Medical Practitioner Report Form; and
- Specialist and Specialist Non-Physician Medical Practitioner Report Form.

This field also appears in the following PAAS forms:

- Primary Care Providers Contact List Report Form;
- Non-Physician Mental Health Care Providers Contact List Report Form;
- Specialist Physicians Contact List Report Form;
- Psychiatrists Contact List Report Form;
- Ancillary Service Providers Contact List Report Form;
- Primary Care Providers Raw Data Report Form;
- Non-Physician Mental Health Care Providers Raw Data Report Form;
- Specialist Physicians Raw Data Report Form;
- Psychiatrists Raw Data Report Form; and
- Ancillary Service Providers Raw Data Report Form.

For the PAAS Report Forms, the Instruction Manual tells the health plan to provide the ZIP code in which the practice address is located.

For the Network Service Area and Enrollment Report Form, Network Service Area tab, the Instruction Manual instructs the health plan to provide the ZIP Codes associated with the reported county within the health plan's network service area for the reported network. For the Network Service Area and Enrollment Report Form, Enrollment tab, the Instruction Manual instructs the health plan to provide the ZIP Code within the reported county where identified enrollees reside or work, and to report the ZIP Code that qualifies an enrollee to be enrolled in the network and product line.

This field is necessary to implement Health and Safety Code section 1367.035(a)(2), which requires the health plan to provide provider practice locations. This data allows the DMHC to evaluate types of providers available by ZIP Code, which provides information necessary for the DMHC to evaluate access to care in different zones where enrollees live or work. This field also implements Rule 1300.67.2.2(h)(7)(B)(i)-(viii) which require the health plan to submit data to the DMHC using the provided ANR report forms. The field benefits consumers, health plans, and the DMHC because it is a component of the process requiring uniform data to be calculated and reported so that issues network adequacy can be identified and resolved.

This field is necessary to implement Health and Safety Code section 1367.03(f)(2) because it requires data to be submitted to the DMHC in compliance with the DMHC's standardized methodology, to result in comparable reports. This field implements Rule 1300.67.2.2(f)(1)(A)-(D) [regarding the PAAS] and (h)(6)(B)(i)a.-j. [specified PAAS Report Forms], which benefit consumers, the DMHC, and health plans by providing a standardized methodology to select the networks to be surveyed, develop contact lists, determine the number of network providers from which the plan must obtain survey responses to meet a required sample size, and select the network providers to be surveyed. This field also assists health plans, consumers, and the DMHC by requiring data be reported to the DMHC in a consistent manner. The field benefits consumers, health plans, and the DMHC because it is a component of the process requiring uniform data to be calculated and reported to enable network adequacy issues to be identified and resolved.

iii. Rule 1300.67.2.3, as proposed to be adopted (necessity):

The purpose of proposed Rule 1300.67.2.3 is to ensure health plans gather data, use quality assurance processes, and annually report to the DMHC consistent with current practices and existing rules, in the year leading up to implementation of Rule 1300.67.2.2. As described in sections II.D and II.E.i of this ISOR, several provisions of proposed Rule 1300.67.2.2 take effect in 2022 to give health plans the time necessary to implement the new Rule. In the meantime, however, health plans must continue to conduct quality assurance processes and submit their annual reports, pursuant to existing requirements. Accordingly, the DMHC proposes to adopt Rule 1300.67.2.3 to preserve the existing data collection and reporting rule during the interim period, before the proposed Rule 1300.67.2.2 takes full effect.

Although the entire proposed Rule 1300.67.2.3 in the proposed draft text appears as underlined, added language, most of this language is the same as the language in existing Rule. In other words, the provision of Rule 1300.67.2.3(a) and (b) are substantially the same as provisions in the existing timely access regulation (subsections (g) and (d) of Rule 1300.67.2.2, as currently promulgated), with slight modifications to leave out obsolete language or to improve clarity and consistency.

Subsection (a) of Rule 1300.67.2.3 describes the filing, implementation and reporting requirements for measurement year 2020 (i.e., the report due in CY 2021). This subsection is necessary to implement Health and Safety Code sections 1367 (requiring ready access to health care services), 1367.03(f) (timely access and annual TAR) and 1367.035(a) (network adequacy and annual ANR). This provision preserves the relevant requirements in Rule 1300.67.2.2(g) (as currently promulgated), and is necessary to ensure that health plans do not skip a reporting year due to the delayed effective dates under proposed Rule 1300.67.2.2. Subsection (a) requires health plans to submit, by March 31, 2021, the report required pursuant to Health and Safety Code section 1367.02(f)(2) (which include the ANR required by Health and Safety Code section 1367.035(a)).

Subsection (a)(1)(A)-(G) specify the required contents of the TAR to preserve the requirements that currently exist in subsections (g)(2)(A)-(G) of the existing timely access Rule. Similar to existing requirements proposed Rule 1300.67.2.3 requires the TAR to include 1) the timely access standards in the health plan's policies and procures, including any approved alternative standards; 2) the rates of compliance with time elapsed standards set forth in Rule 1300.67.2.2(c)(5) (rates must be developed using a statistically reliable sampling methodology, as specified); 3) indication of whether the health plan identified a) incidents of non-compliance resulting in substantial harm to an enrollee, or b) patterns of non-compliance, as well as descriptions of the non-compliance and the health plan's response; 4) a list of all provider groups and individual providers utilizing advanced access appointment scheduling; 5) a description of how the health plan and its network providers use triage, telemedicine, and health information technology to provide timely access to care; 6) the results of the most recent annual enrollee and provider surveys and a comparison to the previous year's survey results and a discussion of the relative change in survey results; 7) information confirming the status of the health plan's network physicians, hospitals, and other network providers, including specified details. These provisions will help health plans understand how to comply with Health and Safety Code section 1367.03(f)'s requirement for an annual TAR, submitted in a manner specified by the DMHC. It will also ensure that the DMHC continues to receive health plan reports necessary to determine compliance with standards under the Knox-Keene Act in the interim before full implementation of proposed Rule 1300.67.2.2.

Subsection (b) of Rule 1300.67.2.3 specifies the required quality assurance processes (QAP) for measurement year 2021 (i.e., the processes the health plan will use during CY 2021 to supply data and information for the report due in 2022). This subsection is necessary to implement Health and Safety Code sections 1367.03(f) (annual TAR) and 1367.035(a) (annual ANR). This provision preserves the relevant requirements in Rule 1300.67.2.2(d) (as currently promulgated), and is necessary to ensure that health plans continue to conduct quality assurance processes and have the information necessary to submit required annual reports, in the time leading up to full implementation of proposed Rule 1300.67.2.2. As described previously in this ISOR, annual reports pursuant to Health and Safety Code section 1367.03 and 1367.035 are retrospective; the health plan must gather data for the reports in the year before the reports are due. Subsection (b) ensures health plans conduct necessary quality assurance and enrollee and provider surveys that will give the health plan the data for measurement year 2021. Subsection (b) will ensure health plans continue to conduct quality assurance processes to ensure the health plan provides timely access to care through adequate networks, which will help ensure enrollees have appropriate access to necessary health care.

Subsection (c) of Rule 1300.67.2.3 specifies that the definitions in proposed Rule 1300.67.2.2(b) apply for the purpose of Rule 1300.67.2.3, except the definition of PON in Rule 1300.67.2.2(b)(11)(A). Subsection (b)(11)(A) specifies that PAAS results showing health plan rates of compliance below certain thresholds constitutes a PON. It is necessary to specify that Rule 1300.67.2.2(b)(11)(A)'s definition of PON does not apply under Rule 1300.67.2.3 because health plans will not have implemented the new PAAS requirements specified in Rule 1300.67.2.2 during CY 2021. This provision will have the benefit of helping health plans clearly understand what definitions from Rule 1300.67.2.2

apply under Rule 1300.67.2.3, which will help ensure health plans use the correct definition and report to the DMHC in a consistent manner. This, in turn, will help ensure the health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2).

Subsection (d) of Rule 1300.67.2.3 specifies that Rule 1300.67.2.3 becomes inoperative on December 31, 2021. This is necessary to make Rule 1300.67.2.3 inoperative as proposed Rule 1300.67.2.2 becomes fully operative on January 1, 2022. This is necessary to implement Health and Safety Code sections 1367.03 and 1367.035, by ensuring consistent TAR and ANR requirements. This provision will have the benefit of allowing health plans to clearly understand which requirements apply and how to comply with TAR and ANR requirements, during the first year and subsequent years after promulgation of Rule 1300.67.2.2 and 1300.67.2.3.

iv. Instruction Manual: Definitions (Necessity)

The Instruction Manual, which is incorporated by reference in Rule 1300.67.2.2, provides detailed instructions on how a health plan must complete the required report forms and the Network Access Profile, and submit the annual reports and information through the DMHC's web portal. Previous sections of this ISOR have described the provisions from the Instruction Manual, as they relate to specific requirements in Rule 1300.67.2.2. Additionally, section II.E.iii of the ISOR described the purpose and necessity of each of the instructions related to the required report forms. However, in order to ensure the Instruction Manual's directions are clear and result in consistently-reported information from health plans, the Instruction Manual also contains definitions for terms used in the Instruction Manual. The definitions are necessary to implement Health and Safety Code sections 1367.03(f) and 1367.035(a), by ensuring that health plans use consistent terminology while reporting required information and data to the DMHC, resulting in comparable reports as required by Health and Safety Code section 1367.03(f)(2). These definitions will all result in the benefit that health plans will clearly understand how to correctly complete the required report forms, and the annual reports will be comparable. Comparable and accurate health plan reports will allow enrollees and consumers to compare health plan performance and select health care coverage in an informed manner. The following sections describe the specific purpose and necessity of each definition in the Instruction Manual, which are located in pages 3-8 of the Instruction Manual.

1. **"Accepting New Patients"** is defined in the Instruction Manual to mean the network provider's practice is open to establish patient care with enrollees who are not already patients. This definition is necessary to implement Health and Safety Code section 1367.035(a)(4), which requires the ANR to include information regarding "providers with open practices." Standardizing the meaning of "accepting new patients" will ensure health plans report this information consistently, resulting in a comparable annual report, as required under Health and Safety Code section 1367.03(f)(2). Additionally, the definition of "accepting new patients" includes all of the following criteria:

- The network provider's practice is open in all product lines using the network, without limitations other than those in Rule 1300.67.2.2(b)(9)(C), (i.e. referral, prior authorization, or election to change PCP). This criterion ensures that the network provider is truly available within the *entire* network, which will allow the ANR to accurately reflect which providers are accepting new patients.
 - The practice is open to new patient appointments at the reported practice address within the same appointment timeframes available to existing patients. This criterion ensures that the network provider is truly available within the network. Additionally, the annual reports must be consistent and comparable under Health and Safety Code section 1367.03(f)(2), meaning it is necessary to have uniformity in the appointment wait-times anticipated for every patient. This provision will allow the ANR to accurately reflect which providers are accepting new patients.
 - The network provider has notified the health plan the practice is open to new patients and the network provider is appropriately listed in the health plan provider directory. This criterion ensures that only network providers who are properly listed in the health plan's provider directory, as required by Health and Safety Code section 1367.27, are considered to be "accepting new patients." Enrollees and consumers use a health plan's network provider directory to see which providers are available, and a network provider who isn't properly listed in the directory is, in a practical sense, invisible to enrollees. This provision is necessary to ensure only network providers visible to enrollees count as "accepting new patients," which will help ensure the ANR accurately reflects the network, from the perspective of an enrollee.
 - The network provider's practice does not limit the accessibility or availability using a waitlist, or longer wait-times for new patients. This criterion helps ensure that the network provider is truly available within the network. Assignment to a waitlist does not truly give enrollees access to the provider. Additionally, the annual reports must be consistent and comparable under Health and Safety Code section 1367.03(f)(2), meaning it is necessary to have uniformity in the appointment wait-times anticipated for every patient. This provision will allow the ANR to accurately reflect which providers are accepting new patients.
2. **"Basic hospital services" or "general acute care hospital services"** is defined in the Instruction Manual to mean the services described in the definition of general acute care hospital in Health and Safety Code section 1250(a). This definition is necessary to implement Health and Safety Code section 1367.035(a)(3), which requires the ANR to include information regarding hospitals. Standardizing the meaning of these terms will ensure health plans report this information consistently, resulting in a comparable annual report, as required under Health and Safety Code section 1367.03(f)(2). Additionally, this definition is consistent with the definition existing in the Health and Safety Code. This will help ensure health plans understand the term and instructions that use the term, because it is a familiar term consistent with existing law.

3. **“Clinic”** is defined in the Instruction Manual to have the definition set forth in Health and Safety Code section 1200(a). This definition is necessary to implement Health and Safety Code section 1367.035(a), which requires the ANR to include information regarding provider office locations and network provider practices, and other information related to the structure and capacity of a health plan network. Standardizing the meaning of this term will ensure health plans report this information consistently, resulting in a comparable annual report, as required under Health and Safety Code section 1367.03(f)(2).
4. **“Crosswalk”** or **“crosswalk table”** is defined in the Instruction Manual as the tool allowing a health plan to identify its terminology equivalent to DMHC-standardized terminology. This definition clarifies that it allows health plans to report required data using the health plan’s preferred terminology, and that once the health plan completes the crosswalk table within the DMHC’s web portal, the health plan’s report forms uploaded to the DMHC’s web portal will link the health plan’s terminology to the DMHC-standardized terminology. This definition is consistent with Rule 1300.67.2.2(h)(8)(D), which how the health plan must use standardized terminology for its TAR and ANR. This provision has the benefit of allowing health plans to use their own terminology if that would best suit the health plan’s operations, while also ensuring the DMHC is able to compare information from different health plans. This provision is necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2).
5. **“Entity provider”** is defined in the Instruction Manual to mean an organization comprised of more than one individual provider that delivers a particular health care service to patients. The term “entity provider” is used to report information related to ancillary outpatient providers (for example, labs, pharmacies, radiology centers, etc.), which contract with health plans as a single business, rather than as individual providers. This definition is necessary to reflect the business arrangements between health plans and these entities as they exist within the health care industry. This provision is also necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2).
6. **“Facility”** is defined in the Instruction Manual to mean a licensed hospital, ambulatory surgery center, laboratory, radiology or imaging center, or other outpatient setting as described in Health and Safety Code section 1248.1, and any other facility described under Health and Safety Code section 1371.9(f)(1). This provision is also necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2). Additionally, this definition is consistent with definitions existing in the Health and Safety Code. This will help ensure health plans understand the term and instructions that use the term, because it is a familiar term consistent with existing law.

7. **“Full-time”** is defined in the Instruction Manual to mean the network provider dedicates 32 hours per week or more to providing health care services to patients within the network provider’s practice area. This definition’s 32-hour threshold for full-time status is consistent with the threshold used by OSHPD when it conducts PCP surveys to determine provider shortage designations.⁸⁴ The DMHC determined it is a reasonable standard for the purpose of the ANR because it reflects a normal 40-hour work week with an eight-hour variance to account for other necessary provider duties. This definition is necessary to implement Health and Safety Code section 1367.035(a), which requires the ANR to include information regarding provider office locations and network provider practices, and other information related to the structure and capacity of a health plan network. This provision is also necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2).
8. **“Grievance”** is defined in the Instruction Manual to use the same definition as Rule 1300.68, which implements the DMHC’s requirements for enrollee grievances. This definition is necessary to implement Health and Safety Code section 1367.035(6), which requires the ANR to include information grievances regarding network adequacy and timely access. This definition will help ensure health plans understand the term and instructions that use the term, because it is a familiar term consistent with existing law.

The definition of “grievance” also includes standardized “complaint categories” (i.e., the types of grievance the health plan might receive from enrollees). To report this information, the health plan must use standardized terms: 1) geographic access; 2) language assistance plan; 3) language assistance provider; 4) office wait time; 5) provider directory error; 6) provider not taking new patients; 7) telephone access plan; 8) telephone access provider; 9) timely access (to appointments); and 10) timely authorization.⁸⁵ These complaint categories are necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2). They will also result in the benefit that the grievance data reported pursuant to Health and Safety Code section 1367.035(a)(6) will cover a broad range of the most common topics for consumer complaints, and result in an ANR that accurately represents the performance of a health plan network.

⁸⁴ The DMHC consulted OSHPD staff to learn about the standard for full-time status for the purpose of provider shortage designations. OSHPD indicates the “full-time” definition is based on the federal definition used for the Health Resources & Services Administration (HRSA), National Health Services Corps loan repayment program, which defines full-time clinical practice (see <https://nhsc.hrsa.gov/loan-repayment/lrp/service-requirements.html>). OSHPD adapts that federal definition of full-time, by allowing eight hours per week for tasks other than patient care (such as administrative tasks).

⁸⁵ See Appendix F of the Instruction Manual, starting at p. 153.

The definition of “grievance” also includes standardized terms for the “nature of the resolution,” i.e., the action the health plan took to resolve the grievance. The resolution methods include: 1) authorization approved; 2) authorization denied; 3) change medical group (i.e., the health plan helped the enrollee switch to a different provider group); 4) change PCP; 5) change specialist; 6) enrollee educated (i.e., the health plan explained relevant rules to the enrollee); 7) no confirmed access issue (i.e., the health plan research determined the grievance did not involve an access problem, and no assistance in obtaining a timely appointment or other information was given to the enrollee); 8) out-of-network referral (i.e., the health plan authorized a non-network provider to meet the enrollee’s needs); 9) provider is educated (i.e., the health plan informs the network provider of his or her responsibility to provide access to care to enrollees; 10) re-adjudicated claim (i.e., the health plan pre-processes the claim for services to reflect in-network benefits; 11) updated provider directory; or 12) secured timely appointment. These standardized “grievance resolutions” are intended to allow health plans to report, in a standardized manner, the health plan response to an enrollee grievance. These standardized terms are necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2).

The definition of “grievance” also includes standardized “resolution determination” categories (i.e., the ultimate outcome of the health plan’s resolution of the grievance). To report this information, the health plan must use standardized terms: 1) enrollee favor (the health plan’s decision was wholly in the enrollee’s favor); 2) partial enrollee favor (only a portion of the health plan’s decision is in the enrollee’s favor); or 3) health plan favor (the health plan’s decision was wholly in the health plan’s favor). These standardized “resolution determination” terms are intended to allow health plans to report, in a standardized manner, the health plan resolution of an enrollee grievance. These standardized terms are necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2).

9. “**Individual provider**” is defined in the Instruction Manual as a single individual who delivers health care services to patients. This standardized term will assist health plans in properly reporting this information in the report. This definition is necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2).
10. “**Name**,” when referring to a network provider, is defined in the Instruction Manual as the same name appearing on the network provider’s state license or certificate, and where licensure/certification is not required, name is defined as the professional name used by the network provider to deliver health care services. This definition will help health plans clearly understand how to report all network providers within each network, as required by proposed Rule

1300.67.2.2(h)(7)(A)(iii). This definition is necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2).

11. **“National Provider Identifier”** (NPI) is defined in the Instruction Manual as the numbers associated with a network provider, as registered through the National Plan and Provider Enumeration System. This definition will help health plans clearly understand how to report all network providers within each network, as required by proposed Rule 1300.67.2.2(h)(7)(A)(iii), including NPI number as required by proposed Rule 1300.67.2.2(h)(8)(D)(viii). This definition is necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2).
- 12-17. **“Network,” “network capture date,” “network identifier,” “network name,” “network provider,” and “network service area,”** are all defined in the Instruction Manual by referencing the proposed definitions of those terms in Rule 1300.67.2.2(b)(4), and (b)(4)-(10). These definitions are necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2). These definitions will also have the benefit of referring health plans to the relevant portions of the Rule, which will make it easier for health plans to find the relevant definitions necessary to complete their reports.
18. **“Network tier”** is defined in the Instruction Manual as a set of network providers available at the same cost-share level, within a tiered network. The term “network tier” excludes out-of-network providers. The Instruction Manual also defines “tiered network” as a network with network providers in the same practice are of specialty or expertise who are available to enrollees at different cost sharing levels. These definitions are necessary for health plans to report network adequacy data related to the structure and capacity and adequacy of a network, pursuant to Health and Safety Code section 1367.035, in a manner consistent with Health and Safety Code section 1367.27(h)(12) (requiring a health plan’s provider directory to include specified information, including the network tier to which the provider is assigned). These definitions are also necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2).
19. **“Number of enrollees assigned to a particular provider”** is defined in the Instruction Manual as the sum of all enrollees within the network that the health plan, its subcontracted plan, or its delegated provider group has assigned to a network provider, across all of the network provider’s locations within the network. This definition is necessary to implement Health and Safety Code section 1367.035, which requires submission of data regarding provider availability, assignment of patients to PCPs, provider capacity, and the adequacy of the health plan network. This definition will help health plans clearly understand how to report

information required by proposed Rule 1300.67.2.2(h)(3) (requiring the reporting health plan to include all network providers and enrollment). It will also help the DMHC assess the capacity of network providers, based on their reported patient load. This definition is necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2).

20. **“Part-time”** is defined in the Instruction Manual as a network provider who dedicates less than 31 hours per week to providing health care services within the network provider’s practice area. This definition of part-time relates to the definition of “full-time,” in item 7, above (which is consistent with the threshold used by OSHPD when it conducts PCP surveys to determine provider shortage designations). The DMHC determined it is a reasonable standard for the purpose of the ANR because it reflects a normal 40-hour work week with an eight-hour variance to account for other necessary provider duties (such as administrative tasks). Anything less is considered part-time, for the purpose of the required reports. This definition is necessary to implement Health and Safety Code section 1367.035(a), which requires the ANR to include information regarding provider office locations and network provider practices, and other information related to the structure and capacity of a health plan network. This provision is also necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2).
21. **“Plan-to-plan contract”** is defined in the Instruction Manual by referencing the proposed definition of that term in Rule 1300.67.2.2(b)(12). This definition is necessary to implement Health and Safety Code sections 1367.03 and 1367.035 because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2). This definition will also have the benefit of referring health plans to the relevant portion of the Rule, which will make it easier for health plans to find the relevant definition necessary to complete their reports.
22. **“Practice address”** and **“practice location or locations”** are defined in the Instruction Manual as the physical location(s) where the network provider delivers health care services. This definition is necessary to implement Health and Safety Code section 1367.035(a), which requires health plans to report network data, including provider office location. This definition is also necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2).
23. **“Primary care physician”** is defined in the Instruction Manual by referencing the definition of that term existing in Rule 1300.45(m), which defines the term as “a physician who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, or for initiating referral for specialist care. A primary care physician may be either a physician who has limited his practice of medicine to general practice or who is a board-certified or board-

eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner.” This definition is necessary to implement Health and Safety Code section 1367.035, which requires health plans to report specified network data, including data about primary care providers. This definition is also necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2). This definition will also have the benefit of referring health plans to the relevant regulation, which will make it easier for health plans to find the relevant definitions necessary to complete their reports.

- 24-28. **“Primary plan,” “product line,” “provider group,” “subcontracted plan,” and “reporting plan”** are all defined in the Instruction Manual by referencing the proposed definitions of those terms in Rule 1300.67.2.2(b)(12)(A), (b)(13), (b)(14), (b)(12)(B), and (b)(16). These definitions are necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2). These definitions will also have the benefit of referring health plans to the relevant portions of the Rule, which will make it easier for health plans to find the relevant definitions necessary to complete their reports.
29. **“Specialty” and “subspecialty”** are defined in the Instruction Manual as the primary specialty or subspecialty types the network provider currently practiced in the identified network, and for which the network provider has been credentialed by the health plan. These definitions are necessary to implement Health and Safety Code section 1367.035(a)(2), which requires the ANR to include the network provider’s area of specialty. This definition will help health plans clearly understand how to report all network providers and their specialties and subspecialties, as required by proposed Rule 1300.67.2.2(h)(8)(D)(iii) (requiring reporting of provider types, including specialty and subspecialty).
30. **“Telehealth”** is defined in the Instruction Manual by referencing the definition in Business and Professions Code section 2290.5, which is: *“the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.”* This definition is necessary to implement Health and Safety Code section 1367.035(a), which requires the ANR to include information regarding network adequacy. Telehealth is one way a health plan may arrange for health care services, and should therefore be considered when assessing network adequacy. Standardizing the meaning of this term will ensure health plans report this information consistently, resulting in a comparable annual report, as required under Health and Safety Code section 1367.03(f)(2). Additionally, this Business and Professions Code definition is effective under the Health and Safety Code (see Health and Safety Code section 1374.13, which incorporates the Business and Professions

Code definition). Using consistent definitions will help ensure health plans understand the term and instructions using the term, because it is a familiar term consistent with existing law.

31. **“Telehealth modality”** is defined in the Instruction Manual as the method by which an enrollee receives telehealth services. The definition further clarifies telehealth modality may include direct patient care or provider-to-provider services, in a synchronous or asynchronous interaction, and states telehealth modalities may include live two-way video or audio interactions, e-consults, remote patient monitoring, store and forward interactions, remote clinician advice or triage services, or other methods of delivering treatment that meet the definition of “telehealth.” The listed telehealth modalities encompass the methods for delivering telehealth known to the DMHC, and contain flexibility for new methods that may be developed in the future. Receiving information about the telehealth modalities used by health plans will allow the DMHC to better understand the ways health plans provide services via telehealth to identify trends that may warrant adjustment of standards, pursuant to Health and Safety Code section 1367.03(i). It is necessary to specify standardized ways to report this information, to ensure health plans use consistent terms and report a comparable TAR, as required by Health and Safety Code section 1367.03(f)(2).
32. Telehealth **“patient location”** is defined in the Instruction Manual as the location where a patient may receive telehealth services, and may include a medical facility, the patient’s personal residence, or a personal mobile device. This definition will help health plans understand how to correctly report this information to the DMHC, and will help the DMHC receive accurate and comparable data about where enrollees utilize telehealth services. This definition is also necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2).
33. **“Tertiary services”** are defined in the Instruction Manual as highly specialized or complex medical care performed by specialists and subspecialists, often using advanced technology in state of the art facilities, including intensive care facilities, for patients with unusually severe, complex or uncommon health problems. This definition is consistent with the definition used by the National Institutes for Health, meaning health plans will likely be familiar with the definition and able to easily identify such services for inclusion in reports to the DMHC.⁸⁶ This definition is also necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2).
34. **“Unscheduled urgent services”** are defined as services available to enrollees on a same-date or similar basis to diagnose and treat illnesses and injuries that,

⁸⁶ See National Center for Biotechnology Information, Resources, defining “tertiary healthcare”: <https://www.ncbi.nlm.nih.gov/mesh/68063128>.

according clinical appropriateness requirements, require care earlier than a scheduled appointment, as specified. The definition further clarifies that it includes physicians or non-physician providers who meet all of the following criteria: 1) provider urgent services on an outpatient basis in a practitioner's office or otherwise outside of an emergency room setting, in accordance with Rule 1300.67(c); 2) have basic diagnostic services onsite, for use during hours of operation; and 3) provide unscheduled urgent services through expanded hours, as specified. Information about a network provider's availability to deliver unscheduled urgent services will help the DMHC accurately assess the health plan network's ability to deliver necessary health care services to enrollees. This definition is also necessary to implement Health and Safety Code sections 1367.03 and 1367.035, because it will ensure health plan reports are comparable, as required by Health and Safety Code section 1367.03(f)(2).

v. Results Report Form: Summary of Rates of Compliance Tab (Necessity)

The DMHC explained the necessity of each field of the PAAS Report Forms, including the Results Report Form,⁸⁷ in section II.E.ii of this ISOR. This section II.E.v of the ISOR further describes the necessity of the organization of the Results Report Form's "Summary of Rates of Compliance Tab." First, in that tab, the following fields are grouped under a header called "Rates of Compliance":

- Rate of Compliance Urgent Care Appointments (All Provider Survey Types)
- Sampling Error Urgent Care Appointment Rates (\pm)
- Rate of Compliance Non-Urgent Care Appointments (All Provider Survey Types)
- Sampling Error Non-Urgent Care Appointment Rates (\pm)

The "rates of compliance" header is not, itself, a field that requires information from the health plan. However, grouping the fields listed above under a header called "Rates of Compliance" is necessary to clarify the meaning and contents of those fields in the report form. Rates of compliance are a vital piece of information regarding timely access compliance, and this header will have the benefit of ensuring health plans understand what portion of the report form must contain this information. This header will also help the DMHC to easily locate this information for the purpose of regulatory compliance review.

Second, in the "Summary of Rates of Compliance Tab," the following fields are grouped under a header called, "Percentage of Providers with an Appointment within Standard (Weighted by Number of Providers in County)":

- Percentage of Primary Care Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types
- Percentage of Non-Physician Mental Health Care Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types
- Percentage of Specialist Physicians with Timely Appointments for Urgent Care and Non-Urgent Appointment Types

⁸⁷ The Results Report Form is incorporated by reference in Rule 1300.67.2.2(h)(6)(B)(i)k.

- Percentage of Psychiatrists with Timely Appointments for Urgent Care and Non-Urgent Appointment Types
- Percentage of Ancillary Service Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types

The “Percentage of Providers with an Appointment within Standard (Weighted by Number of Providers in County)” header is not, itself, a field that requires information from the health plan. However, grouping the fields listed above under this header is necessary to clarify the meaning and contents of the fields in the report form. The header will allow the health plan to easily understand how the fields listed above are related by identifying the overall category of information in the fields (i.e., percentage of each provider survey type with a timely appointment). This information is necessary for health plans to report timely access compliance to the DMHC in a consistent manner, as required by Health and Safety Code section 1367.02(f), and this header will have the benefit of ensuring health plans understand what portion of the report form must contain this information. This header will also help the DMHC to easily locate this information for the purpose of regulatory compliance review.

IDENTIFICATION OF EACH TECHNICAL, THEORETICAL, AND EMPIRICAL STUDY OR REPORT CONSIDERED

No such studies or reports were considered in the drafting of the proposed and amended regulation.

DOCUMENTS RELIED UPON

- Health and Safety Code sections 1367, 1367.27, 1367.03, 1367.035, 1367.04, 1371.31, 1373.65, 1375.9, 1386.
- Business and Professions Code section 2290.5.
- Welfare and Institutions Code section 14087.325.
- Title 28 CCR Rules 1004, 1300.51, 1300.67.2.2, 1300.67.2.
- Measurement Year 2018 [PAAS] Methodology, available at: <https://www.dmhc.ca.gov/Portals/0/Docs/OPM/MY%202018%20PAAS%20Methodology.pdf>.
- DMHC All Plan Letter (APL) 17-007 (OPM) TIMELY ACCESS COMPLIANCE REPORTS, MEASUREMENT YEARS 2016 and 2017.
- DMHC APL 18-002 (OPM) TIMELY ACCESS COMPLIANCE REPORTS, MEASUREMENT YEAR 2018 (MY 2018), available here: <https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL%2018-002%20-%20Timely%20Access%20Compliance%20Reports%20MY%202018%20%2801-19-2018%29.pdf>.
- APL 19-008 (OPM) TIMELY ACCESS COMPLIANCE REPORTS, MEASUREMENT YEAR 2019 (MY 2019), available at: <https://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL%2019-008%20-%20Timely%20Access%20Compliance%20Reports%20MY%202019%20%283-8-2019%29.pdf>.

- National Center for Biotechnology Information, Resources, defining “tertiary healthcare”: <https://www.ncbi.nlm.nih.gov/mesh/68063128>.
- Annual Timely Access Compliance Report Instructions Measurement Year 2019.
- Informal Stakeholder Comments to 9/20/2019 Draft Proposed Text.
- Cattaneo & Stroud, Active California Medical Groups, March 15, 2019, located at: <http://cattaneostroud.com/wp-content/uploads/2017/05/12-Web.pdf>.

REASONABLE ALTERNATIVES

The DMHC conducted pre-notice discussions with interested parties pursuant to Government Code section 11346.45. Through written and verbal comments submitted during stakeholder workshops and meetings, the DMHC considered different alternative approaches presented by the stakeholders. Based on written and verbal comments from stakeholders, the DMHC developed the proposed regulation. The DMHC finalized the proposed regulation after considering comments from stakeholders.

Pursuant to Government Code Section 11346.2(b)(4)(A), the DMHC must describe reasonable alternatives that were considered by the DMHC or that have otherwise been identified or brought to the attention of the DMHC and that are proposed as more effective in carrying out the purpose for which the above action is proposed, or are proposed as equally effective and less burdensome to affected private persons than the proposed action, or are proposed as more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

The following alternatives were considered:

1. Regarding the threshold rate of compliance and PON definition in proposed Rule 1300.67.2(b)(11)(A), the DMHC considered measuring the availability of provider appointments within each health plan network by auditing real-world patient appointments. Under this alternative, health plans could use medical records and providers’ practice management software to ascertain whether an enrollee was offered an appointment within the time-elapsed standards, whether the appointment was rescheduled, and whether the enrollee declined the first available appointment due to personal scheduling preferences. Under the audit approach, the DMHC could implement a 100% rate of compliance. However, after numerous discussions with health plans and stakeholders, the DMHC determined that using an audit approach is not currently possible within California’s health plan industry due to provider system limitations.
2. Survey providers at the provider group level:
As an alternative to conducting the PAAS at the county and network levels, the DMHC considered requiring health plans to conduct surveys at the provider group level. Conducting the PAAS at the provider group level would have ensured that each contracted provider group complied with appointment availability standards. However, the DMHC determined that this approach

would have been overly burdensome to health plans and providers, including small businesses. Due to the limited numbers of specialist providers within provider groups, health plans would have been required to survey a large number of specialist providers in their network. Surveying providers at the county and network levels allows health plans to survey fewer providers if they contract with multiple specialists within the same geographical area.

The DMHC will consider all reasonable alternatives submitted by members of the public during the comment period.

BENEFIT OF THE REGULATION

The DMHC, health plans, and consumers will benefit from the proposed regulatory action because it will specify clear and consistent requirements for reporting timely access and network adequacy data and related information to the DMHC, and will allow the DMHC to effectively enforce related laws. By adopting this proposed regulatory action, the DMHC largely codifies the reporting process developed with close consultation with stakeholders since the enactment of SB 964, and the requirements of the proposed Rule are largely familiar to regulated health plans and to network providers, meaning the Rule will be non-disruptive to existing business operations and systems. Additionally, the DMHC's APA exemption under Health and Safety Code section 1367.03(f) expires on January 1, 2020, and this proposed regulatory action will result in the benefit of clear, codified regulatory standards for health plan timely access and network adequacy compliance reports. This will benefit consumers by continuing to hold health plans accountable for providing ready access to necessary health care through adequate networks, as required by the Knox-Keene Act.

ECONOMIC IMPACT

The DMHC has determined that the proposed Rule will have a statewide economic impact as described in the attachment to Form 399, and as described below. The specific economic impact on various categories is as follows:

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. Health plans that received the questionnaire estimated their personnel costs related to compliance with the proposed Rule. For first-year implementation, health plans (excluding the outlier health plan, which indicated that this estimate was not quantifiable) responded as follows:

Table 3

| Health Plan | Implementation costs | Percentage Spent on Personnel Costs | Estimated Personnel Expenses |
|---------------|---------------------------------|-------------------------------------|-------------------------------|
| Health plan 1 | Less than \$50,000 | 75% | Less than \$37,500 |
| Health plan 2 | Between \$50,000 and \$100,000 | 53% | Between \$26,500 and \$53,000 |
| Health plan 3 | Between \$100,000 and \$200,000 | 39% | Between \$39,000 and \$78,000 |
| Health plan 4 | \$380,000 | 24% | \$91,200 |

The DMHC anticipates that the average health plan will incur the following costs associated with implementation of the Rule can be attributed to personnel costs:

Low estimate: $\$194,200 / 3,308,077 = \0.06 per enrollee

High estimate $\$259,700 / 3,308,077 = \0.08 per enrollee

Based on these results, the DMHC believes health plans will be able to comply with the requirements of this proposed Rule without the need to hire additional personnel.

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.

Creation of New Businesses or the Elimination of Existing Businesses Within the State of California

The proposed Rule will neither create new businesses nor eliminate existing businesses. The proposed Rule affects only existing businesses, and does not require the creation of any new businesses. As discussed, health plans have already implemented the majority of the requirements of the proposed Rule, pursuant to the APA-exempt mandatory methodologies. The DMHC is unaware of any existing businesses that have been created or eliminated as a result of these requirements. The promulgation of the proposed regulatory amendments and additions will neither create nor eliminate businesses within the State of California, because the proposed regulatory action merely clarifies existing requirements for health plans that are already in place.

Expansion of Businesses or Elimination of Businesses Currently Doing Business Within the State of California

As discussed above, the proposed Rule is unlikely to cause a significant increase in workload on existing health plan personnel. The DMHC estimates that the average health plan will spend **between \$0.19 and \$0.23** per enrollee to implement the proposed Rule,

and **between \$0.10 and \$0.16** per enrollee for ongoing costs associated with the proposed Rule. The DMHC has not observed an expansion in health plan businesses as a result of the APA-exempt methodologies. Additionally, as discussed above, the indirect impact on providers that the proposed Rule imposes requires only 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 additionally does not believe that vendors that contract with health plans subject to this Rule will expand as a result of implementation. The DMHC asked health plans that received the questionnaire discussed above to report the percentage of expenses attributed to vendor costs. When a health plan does not use a vendor to complete the Provider Appointment Availability Survey, costs attributed to this requirement were included in the personnel costs, as discussed above. Based on the survey results, the DMHC estimates that health plans will increase vendor contracting spending between **\$0.02 and \$0.04** per enrollee to implement the proposed regulation and on an ongoing annual basis. Health plans will additionally spend less than **\$0.01** per enrollee at implementation for vendor translation services. Due to this relatively low increase in contracting costs, the DMHC does not anticipate that the proposed Rule will cause significant expansion of vendor businesses.

Based on the above analysis, the DMHC has determined that 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.

The Benefits to the Health and Welfare of California Residents

The proposed Rule benefits the health and welfare of California residents by ensuring that 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 Rule 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 Rule will allow the DMHC to collect data in a useful way and to 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 the DMHC to continue to draw useful conclusions about timely access to health care, and to use these conclusions to better protect consumers' health care rights.