# Frequently Asked Questions

The Department of Managed Health Care (DMHC) has prepared frequently asked questions (FAQ) and responses arising from stakeholder comments, and pertinent to the amendments to 28 CCR § 1300.67.2 and incorporated documents, as noticed in APL 24-021 (December 12, 2024).[[1]](#footnote-2) This includes Amendments to Rule 1300.67.2 and the incorporated network adequacy standards and methodologies for Reporting Year (RY) 2025.

## General FAQ Responses – Updates to Rule 1300.67.2

1. **Why is the DMHC updating its Annual Network Reporting materials and network adequacy standards on an annual basis?**

DMHC is updating network adequacy standards on an annual basis under exemptions to the Administrative Procedures Act (APA) set forth in Health and Safety Code sections 1367.03(f)(3) and (5). The rollout of reporting requirements and network adequacy standards is on a staggered timetable, to provide time for health care service plans (plans) to implement the standards, and for the DMHC to test the standards and adjust if necessary.

1. **Within the network adequacy standards and methodology documents, the DMHC references network adequacy definitions in Rule 1300.67.2.2(b). Could the documents repeat these definitions in full, within each of the standards and methodology documents?**

Defined terms are subject to amendment throughout the period of the APA exemption set forth in Health and Safety Code Sections 1367.03(f)(3) and (5). Including defined terms in multiple locations increases the potential for error in amendments and inconsistent regulatory versions. The incorporated network adequacy standards are intended to reference the Rule as the single source for the defined term. The Department will consider creating a resource document once the APA exemption has expired and the definitions are not subject to APA exempt rulemaking.

1. **What happens if a plan is found to not meet the new network adequacy standards incorporated in Rule 1300.67.2 when the DMHC conducts its Annual Network Review? Will the DMHC take enforcement action against health plans for failing to meet the RY 2025 network adequacy standards?**

While the DMHC has the authority to take enforcement action against a plan for failing to meet the new specialist physician and PCP network adequacy standards introduced in APL 24-021, the DMHC does not intend to immediately refer networks to the Office of Enforcement for failure to meet new standards in RY 2025. If a plan’s network is not meeting a new standard in one or more counties within the network service area, the plan will be informed of the findings and may be required to submit a corrective action plan or otherwise demonstrate that its network has providers in sufficient numbers and locations to ensure accessibility of services as required under the Knox- Keene Act and implementing regulations. In subsequent reporting years, the DMHC may also rely upon the new standards and methodologies noticed in APL 24-021 as a basis for carrying out and completing enforcement action

The mental health network adequacy standards, including Mental Health Geographic Access Standards and Methodology, Counseling MHP Ratio Standards and Methodology, and Counseling MHP Accepting New Patients Standards and Methodology were released in previous years and are issued with amendments for RY 2025. In addition to requiring a corrective action plan, for RY 2025 the DMHC may rely on these standards as a basis for carrying out and completing enforcement action arising from the Annual Network Review, pursuant to the Administrative Procedures Act exemptions established in Section 1367.03(f). Since RY 2025 will be the first year of review of Medi-Cal networks under the Counseling MHP Ratio Standard and the Counseling MHP Distance Standard, the DMHC may require a corrective action plan, but will not immediately refer Medi-Cal networks to the Office of Enforcement for failure to meet these standards.

1. **Are plans required to provide each individual enrollee access to a provider according to the network adequacy standards incorporated in Rule 1300.67.2?**

The Department has amended Rule 1300.67.2 to clarify that plans must make required network provider types available to all enrollees in the network, and where applicable, within the network adequacy standards set forth in the Rule and incorporated documents. A plan may limit enrollee access to these providers based on the use of Knox-Keene Act compliant managed care tools, such as utilization management systems and prior authorization requirements. Where an enrollee is required to travel beyond the standards set forth in this section to obtain medically necessary services, that service is presumed to be unavailable, as defined in Rule 1300.67.2(b). Under Section 1367.03(a)(7) and Rule 1300.67.2.2(c)(7), when a provider is unavailable the health plan must arrange services with non-network providers.

1. **Rule 1300.67.2 (b) requires plans to use network providers to meet all access requirements and network adequacy standards in the Knox Keene Act and Title 28. In an inpatient setting, when the hospital or other facility is the network provider, are health plans required to make individual network providers available at the hospital or other facility?**

When a hospital or other facility is the network provider, the plan shall also ensure its network includes individual network providers that practice at the facility to ensure adequate access to covered services at the facility, including emergency room care. The DMHC has further updated Rule 1300.67.2(b) to clarify this requirement.

1. **Does the DMHC require pediatric providers to be reviewed separately for network adequacy?**

In the Annual Network Report submission for RY 2025, the DMHC requires plans to report whether a provider serves a pediatric population, an adult population, or both. DMHC will evaluate this data for future network adequacy requirements.

For the RY 2025 Annual Network Review, the DMHC is not measuring pediatric and adult providers separately for network adequacy. The DMHC is continuing to evaluate the development of network adequacy standards pertaining to providers of pediatric services.

## Geographic Access Standards and Methodology

1. **Within the Specialist Physician Geographic Access Standards and Methodology, how did the DMHC determine which counties to group together into a particular county type (i.e. large metro, metro, micro, rural, and CEAC)?**

The DMHC modeled its assignment of county types off the approach taken by the Centers for Medicare and Medicaid Services, which uses the same county classification system. The counties are categorized based on the total population of the county and the population density of the county. Counties with similar population and population densities are assigned the same county type.

1. **Do the Specialist Physician Geographic Access Standards and Methodology measure both time and distance?**

The specialist physician geographic access standards and methodology measure distance. The focus on driving distance, rather than time, results in clear requirements that allow for greater transparency and predictability for plans and consumers.

Additionally, the new standards set forth a stringent methodology for driving distance that is designed to accurately measure the distances to providers using available roads within each county. This methodology results in a more reliable, accurate, and comparable measure than what available driving time measurement approaches have been able to yield with existing technology.

1. **Will the DMHC release geographic access standards for additional specialty types or services?**

The DMHC is currently implementing quantitative network adequacy standards under an exemption to the Administrative Procedures Act (APA) established in Health and Safety Code section 1367.03(f)(5). In future measurement years, the DMHC intends to expand quantitative standards for geographic access to additional specialty types. This includes provider types identified by the Centers for Medicare and Medicaid Services (CMS) for state sponsored exchanges under 45 C.F.R. § 156.230.

## Accepting New Patients Standards and Methodology

1. **If a health plan’s network meets the thresholds in the Accepting New Patients Standards and Methodology documents, does this mean the plan has demonstrated that the provider type is available?**

If the network meets the Accepting New Patients thresholds set forth in Rule 1300.67.2 and incorporated documents, it signifies the health plan has demonstrated compliance with the applicable standards and methodologies. Both the PCP Accepting New Patients Standards and Methodology and the Counseling MHP Accepting New Patients Standards and Methodology measure whether there are sufficient network providers accepting new patients in each county within the plan's network service area for enrollees to access care. This is only one measure of network adequacy within a plan's network service area.

When developing these standards and methodologies, the DMHC considered the number and geographic distribution of providers within each network and county, to determine an appropriate standard for enrollee access to providers who are available to accept new patients. By calculating the percentage of network providers and provider locations accepting new patients at both the county level and network level, there is additional assurance that available network providers will be within a reasonable distance of all enrollees within the network.

1. **Why are there different Accepting New Patients thresholds for PCPs and Counseling MHPs?**

The DMHC developed the thresholds based on the overall reported capacity of network providers to accept new patients and expected patient need. This is based on data submitted annually by the industry. Because the utilization of primary care physicians (PCPs) is different from non-physician counseling mental health professionals (Counseling MHPs), the availability to accept new patients will vary for these provider types.

For example, most enrollees are required to select an in-network PCP; whereas only enrollees requiring counseling mental health care will access a Counseling MHP. Enrollees are expected to remain with an assigned PCP throughout the year, unless circumstances require a switch to a different PCP. The continuous nature of the assignment impacts the number of PCPs who must be available to accept new patients within each county in the network service area. If a managed care plan is operating as designed, fewer PCPs are expected to be accepting new patients because almost all existing patients should be assigned to a PCP and occupying the overall capacity of the PCP network. Conversely, some patients only require short-term or episodic care from a Counseling MHP, and Counseling MHPs must be available to accept new patients whenever the care needs arise in the enrollee population.

1. **Is a health plan required to meet the Accepting New Patients Standard for PCPs in counties that are outside of the network service area? How does the DMHC review counties outside the network service area that have in-network PCPs?**

The Department does not measure plans for compliance in counties that are not part of the plan's network service area. However, if the plan initially fails to meet the PCP Accepting New Patients standard in a Rural or CEAC County within the network service area, the plan may be able to meet the standard when the network includes PCPs in a neighboring county, whether or not the neighboring county is part of the network service area. This Alternative Methodology for a Combined County Threshold is set forth in detail in Schedule F of the PCP Accepting New Patients Standards and Methodology Document.

Please see Schedule F for details concerning the Alternative Methodology for a Combined County Threshold in Rural and CEAC Counties.

## Ratio Standards and Methodology

1. **The Specialist Physician Ratio Standards and Methodology documents contain information about alternative methodologies. Are these alternative methodologies automatically applied when the plan does not meet an applicable ratio standard?**

The DMHC has developed standards of accessibility that ensure patients have appropriate access to care and that take into consideration the diverse geography and health care delivery models present in the state. Rather than create a set of one-size-fits-all standards, the DMHC developed standards that are effective in most scenarios.

Where a plan is unable to meet the established standard, the DMHC will determine whether an alternative methodology applies. Alternative standards are only applicable when specific factors are present in a plan's network data that indicate a plan may be meeting provider capacity in the county through methods not captured by the standard. If one or more of these factors are present, it is a signal that the provider type may need to be evaluated for capacity using the alternative methodology.

Plans do not need to request application of an alternative methodology. If the plan’s specific circumstances qualify the network for consideration under an alternative methodology, the DMHC will automatically review the network accordingly.

1. **If a Plan cannot meet the established ratio standard, may it request an alternative standard?**

Plans cannot file individual requests for alternative specialist physician ratio standards. Rule 1300.67.2.1 does not apply to the specialist physician ratio standards and under the methodology noticed in APL 24-021 (December 12, 2024).

The alternative ratio standards for specialist physicians are set forth in Schedules D through D-6 of the Specialist Ratio Standards and Methodology for RY 2025. Alternative methodologies accommodate common reasons for variation in health care delivery in California. The use of established alternative methodologies and standards rather than a case-by-case review for alternative access increases transparency in the granting of alternative standards and ensures the equal application of alternative standards to all plans. An established set of alternative standards and methodologies also allows for predictable and more expedient application of alternative access standards.

1. **If a network does not meet a Specialist Physician Ratio Standard, how does the DMHC determine if the alternative methodology for "exclusive providers" applies? How do health plans know if their network providers are exclusive providers?**

When evaluating a plan network for applicability of an alternative methodology pertaining to the specialist physician ratio standards, the DMHC evaluates the network for the presence of exclusive providers using the methodology set forth in Schedule D-2, attached to the Specialist Physician Ratio Standards and Methodology for RY 2025. A network provider is considered an exclusive provider if the provider is not a network provider for other reporting plans for the reporting year. A plan will receive credit for an exclusive provider if the Annual Network data demonstrates the provider is not a network provider for other reporting plans.

When conducting its own monitoring, the plan can rely on exclusive providers to meet network adequacy if the plan has knowledge that a network provider has specifically contracted in an exclusive arrangement with the plan. Plans may also use other public sources of provider contracting data to conduct their own analysis of provider exclusivity (e.g. Medi-Cal enrolled provider data, other plan directories, and provider data sets maintained by the Centers for Medicare and Medicaid Services).

## Required Network Provider Types

1. **Are emergency medicine physicians a required network provider type?**

Yes, emergency medicine physicians are a required network provider type set forth in Rule 1300.67.2(b) and the incorporated Required Network Provider Types document. Pursuant to Rules 1300.67.2 and 1300.67.2.2, all covered services must be available through in-network providers. Emergency care is a covered service pursuant to Rule 1300.67, therefore plans have an obligation to make in-network emergency room physicians available and accessible to enrollees at in-network facilities. This facilitates care coordination with the in-network primary care team and any specialists the enrollee is currently seeing. It can also help ensure an enrollee’s timely transition to non-emergency care if needed.

1. **Are licensed home health agencies a required network provider type?**

Yes, a licensed home health agency (HHA) is listed as a required network provider type in the Required Network Provider Types document, incorporated by reference in Rule 1300.67.2.2(g). This term has been updated from "home health" to "licensed home health agency" to clarify the type of health care service required. Please see the [California Department of Public Health's](https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AppPacket/HHA-Initial.aspx) website for a full description of an HHA.

1. **Why are the geographic access standards set forth in Rule 1300.67.2(c) and incorporated documents described as minimum geographic access requirements?**

The geographic access standards incorporated by reference in Rule 1300.67.2 are the minimum standards of accessibility a plan must meet in order to establish network adequacy. The DMHC will use these standards to review health plan networks as part of the Annual Network Review. The DMHC may also use these standards to evaluate plans for network adequacy in other contexts, for example as part of plan filings for the purposes of licensure pursuant to Health and Safety Code sections 1351 and 1352, and Rules 1300.51, 1300.52, and 1300.52.4. (See Rule 1300.67.2(c)(2).)

As set forth in Rule 1300.67.2(c), a plan is also required to arrange for shorter travel distances or additional provider types within its network, if necessary to ensure that all covered services are readily available and accessible to all enrollees.

1. The Knox-Keene Act is set forth in California Health and Safety Code sections 1340 set seq. References to “Section” are to sections of the Knox-Keene Act. References to “Rule” refer to the California Code of Regulations, title 28. [↑](#footnote-ref-2)