From: DMHC Licensing eFiling

Subject: APL 22-026 – Implementation Filing Requirements Related to the Amendments to the Timely Access and Network Reporting Statutes and Regulation

Date: Friday, November 4, 2022 11:56 AM

Attachments: APL 22-026 – Implementation of Amendments to Timely Access and Network Reporting Statutes and Regulation (11.4.22).pdf

Dear Health Plan Representative:

The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 22-026: Implementation Filing Requirements Related to the Amendments to the Timely Access and Network Reporting Statutes and Regulation related to the amendments of the Timely Access and Network Reporting Statutes and Regulation (*See* Health and Safety Code sections 1367.03, 1367.031, & 1374.141, and title 28 CCR 1300.67.2.2).

Thank you.

Gavin Newsom, Governor
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ALL PLAN LETTER

DATE: November 4, 2022

TO: All Health Care Service Plans

FROM: Nathan Nau, Deputy Director of Office of Plan Monitoring

SUBJECT: Implementation of Amendments to Timely Access and Network Reporting Statutes and Regulation

I. Background

On January 13, 2022, the Department of Managed Health Care (Department) amended the Timely Access to Non-Emergency Health Care Services and Annual Timely Access and Network Reporting Requirement Regulation, codified in sections 1300.67.2.2 of Title 28 of the California Code of Regulations.[1] On March 16, 2022, the Department clarified the effective dates for the new requirements by further amending Rule 1300.67.2.2 and added in Rule 1300.67.2.3.[2]

Additionally, on or about October 8, 2021, the Governor signed Senate Bill (SB) 221 (Weiner, Chapter 724, Statutes of 2021) into law, which made changes to the timely access requirements, which are set forth in Sections 1367.03 and 1367.031 (hereinafter SB 221). SB 221 also provided an exemption from the Administrative Procedure Act (APA) to develop and adopt methodologies until July 1, 2025.[3] Rule 1300.67.2.2 and

[1] The amendments were made pursuant to the authority set forth in California Health and Safety Code sections 1340 et seq. (Act), including California Health and Safety Code sections 1367.03 and 1367.035. References herein to "Section" are to sections of the Knox-Keene Act. References to "Rule" refer to the California Code of Regulations, title 28.
[2] The amendments and additions were made pursuant to Section 1367.03(f)(3) and Government Code section 11343.8. (California Register 2022, No. 11).
[3] The Department is updating the standardized methodologies for reporting in Rule 1300.67.2.2, pursuant to Section 1367.03(f)(3) (as amended by SB 221). Updates to Annual Network Report Forms for Reporting Year 2023 will be issued via an All Plan

Rule 1300.67.2.3, including amendments made under the APA exemption, are hereinafter referred to as the Timely Access Regulation.

On or about March 4, 2022, the Department issued APL 22-007: Monitoring and Annual Reporting Changes due to SB 221, AB 457 and Amendments to Rule 1300.67.2.2 (hereinafter APL 22-007). Among other topics, APL 22-007 provided an overview of the changes to monitoring and annual reporting of the Timely Access Compliance Report and the Network Report brought about the amended Timely Access Regulation and SB 221 (collectively the Timely Access and Network Reporting Statutes and Regulation). In APL 22-007, the Department included a general description of the recent changes to the law, guidance regarding when plans must incorporate those changes into plan operations, clarification regarding the content of annual submissions to the Department and submission timeframes, and notification of a forthcoming checklist detailing what filings plans must submit to establish implementation of the Timely Access Statutes and Regulations.

This All Plan Letter (APL) provides information regarding implementation of the Timely Access and Network Reporting Statutes and Regulation, and the filing requirements for health care service plans, as referenced in APL 22-007.[4] The instructions provided herein are intended to be read in concert with the information and guidance published by the Department in APL 22-007, and are not intended to supersede APL 22-007, unless explicitly stated.

II. Application

The Timely Access Regulation establishes a variety of new monitoring and reporting requirements for health plans. The extent and scope of the new requirements vary depending on whether the health plan is a Reporting Plan or a Profile-Only Plan, which are defined in the regulation as follows:

- **Reporting Plans** are full-service plans or specialized mental health plans that meet the definition of reporting plan, as defined in Rule 1300.67.2.2, sub. (b)(17). Reporting plans are subject to all annual reporting requirements set forth in Rule 1300.67.2.2, sub. (h)(1)(A).

Letter on or before November 1, 2022. The Department will issue the updated PAAS Manual and PAAS Report Forms with the edits made for SB 221 in early 2023. Health plans shall use the PAAS Manual and PAAS Report Forms, incorporated into Rule 1300.67.2.2, beginning in Measurement Year (MY) 2023 for Reporting Year (RY) 2024. (See APL 22-007.) For RY 2023/MY 2022, health plans shall continue monitoring compliance with the timely access standards, and gathering and submitting the Timely Access Compliance Report information, in accordance with the 2009 version of Rule 1300.67.2.2, subs. (d) and (g)(2)(A)-(F) and the DMHC-issued MY 2019 Timely Access Compliance Report. (*See* Section 1367.03(f)(3), Rule 1300.67.2.3, and APL 22-007.)

[4] This All APL does not apply to plans licensed only to offer Medicare Advantage product lines or EAP products.

- **Profile-Only Plans** are health plans that do not meet the definition of reporting plan and are only subject to the annual network access profile reporting requirements, as set forth in Rule 1300.67.2.2, sub. (h)(1)(B). This includes subcontracted full-service plans, subcontracted specialized mental health plans, and all other specialized dental, vision, chiropractic, and acupuncture plans.[5] (Rule 1300.67.2.2, subs. (a)(1)-(2) and (h)(1)(B).)

All health plans subject to the Timely Access Regulation have reporting requirements; however, Reporting Plans and Profile-Only Plans have different annual reporting obligations. To ascertain the health plan's compliance and annual reporting obligations, identify the type of license issued to the health plan and the requirements set forth in Rule 1300.67.2.2, subs. (a)(1), (a)(2), and (h)(1) of the Timely Access Regulation. If the health plan is both a Reporting Plan and a Profile-Only Reporting Plan, file all required documents as a Reporting Plan. However, the health plan will complete a separate verification for each applicable plan type.

All health plans subject to the Timely Access Regulation are subject to the new requirements set forth in SB 221.

III. Implementation Filings

Health plans were required to revise all policies and procedures and related documents to reflect changes brought about via SB 221. (See APL 21-025, issued December 20, 2021.) Subsection (h)(5) of Rule 1300.67.2.2 requires health plans to file an Amendment to the health plan's license, pursuant to Section 1352, disclosing how the health plan will achieve compliance with the requirements of Rules 1300.67.2.2 and 1300.67.2.3. Rule 1300.67.2.2, sub. (h)(5) also requires a health plan to submit policies and procedures necessary for compliance with these requirements. To demonstrate compliance with the new requirements, health plans must make implementation filings, as detailed below.

A. Filings to Establish Compliance with the Timely Access and Network Reporting Statutes and Regulation

The Department has developed the following items as part of the filings to establish implementation of the changes required by the recent revisions to the Timely Access and Network Reporting Statues and Regulations. These items will be available in the "Downloads" section of the efiling web portal.

[5] Profile-Only Plans include restricted and limited health care service plans that meet the definition of subcontracted plan set forth in subsection (b)(13)(B) of Rule 1300.67.2.2.

1. *Verification for Implementation of Amendments to Timely Access and Network Reporting Statutes and Regulation*

As part of the implementation filing, plans are directed to submit a verification attesting to the adoption of all new requirements throughout the health plan's operations. The Department has developed templates tailored to each health plan type that health plans shall complete to verify compliance. The following verification templates are available for download in the efiling web portal:

- *Reporting Plan Verification for Implementation of Amendments to Timely Access and Network Reporting Statutes and Regulation;*
- *Profile-Only Full Service or Profile-Only Specialized Mental Health Plan Verification for Implementation of Amendments to Timely Access and Network Reporting Statutes and Regulation; and*
- *Profile-Only Specialized Dental, Vision, Chiropractic or Acupuncture Plan Verification for Implementation of Amendments to Timely Access and Network Reporting Statutes and Regulation.*

2. *Checklist for Implementation of Amendments to Timely Access and Network Reporting Statutes and Regulation*

To assist health plans in demonstrating compliance with the changes to the law brought about by the Timely Access and Network Reporting Statutes and Regulation, the Department has developed the *Checklist for Implementation of Amendments to Timely Access and Network Reporting Statutes and Regulation* ("Checklist"), which is available for download in the efiling web portal. The Checklist describes, by health plan type, the documents and exhibits that are likely to require amendment as a result of changes in the law and establishes filing deadlines for all implementation filings, consistent with the dates set forth in APL 22-007 and the amendments to Rule 1300.67.2.2.[6] The Checklist includes separate sections for each health plan type, as follows:

- *Filing Checklist for Reporting Plans Full Service or Specialized Mental Health Plans;*
- *Filing Checklist for Profile-Only Full Service or Profile-Only Specialized Mental Health Plans;*
- *Filing Checklist for Profile-Only Specialized Dental Plans; and*
- *Filing Checklist for Profile-Only Specialized Vision, Chiropractic, or Acupuncture Plans.*

[6] See the amendments, filed on March 16,2022, clarifying the effective dates for the new regulatory requirements in Rule 1300.67.2.2 and adding Rule 1300.67.2.3. See also footnote 3 above.

3. *Exhibit Filing Grids*

The Checklist requires health plans to complete a filing grid to accompany certain exhibit types. Each filing grid identifies new requirements in the Timely Access and Network Reporting Statutes and Regulation that may impact the specified exhibit and provides health plans with the opportunity to indicate where each new requirement is addressed within the exhibit. The Department will make following filing grids available for download in the efiling web portal:

- *Timely Access Policies and Procedures Filing Grid for Exhibit J-13-a*;
- *Annual Network Data Collection Filing Grid for Exhibit J-19*; and
- *Standards of Accessibility Filing Grid for Exhibit I-5-a*.

4. *Timely Access and Network Reporting Statutes and Regulation Compliance Filing Index*

After each health plan has made all necessary filings to demonstrate compliance with the Timely Access and Network Reporting Statutes and Regulation, the health plan will be required to submit a separate *Timely Access and Network Reporting Statutes and Regulation Compliance Filing Index* identifying each individual filing submitted by the health plan that demonstrates compliance with the new and revised law. The Department will make the *Filing Index* available for download in the efiling web portal.

B. New Exhibit J-19: Network Data Collection Processes

The Department has created a new efiling exhibit, Exhibit J-19, for health plans to submit policies and procedures related to their process of collecting and verifying the accuracy of data submitted as part of the annual network review submission. The Checklist provides further detail regarding the type of information that should be submitted in the Exhibit J-19.

C. Implementation Filings Timeline

- Due January 16, 2023: Verification(s) for Implementation of Amendments to Timely Access and Network Reporting Statutes and Regulation.

- Due January 31, 2023: Timely Access Policies and Procedures (Exhibit J-13-a) and accompanying *Timely Access Policies and Procedures Filing Grid for Exhibit J-13-a*.

- Due within the timeframes prescribed by law, but no later than January 3, 2024: All other updates, including:

    - Annual Network Data Collection Policies and Procedures (Exhibit J-19) and accompanying *Annual Network Data Collection Filing Grid for Exhibit J-19*;

- Standards of Accessibility (Exhibit I-5-a) and accompanying *Standards of Accessibility Filing Grid for Exhibit 1-5-a;*
- All other exhibits and documents, as applicable; and
- *Timely Access and Network Reporting Statutes and Regulation Compliance Filing Index* which shall identify filing numbers to affirm all relevant documents have been filed.

D. Network Service Area Confirmation Process – Future All Plan Letter

All health plans shall accurately report approved network service areas consistent with the network service area approved in licensure filings (i.e., Amendments and Notices of Material Modification submitted through the efiling web portal). Furthermore, Plans shall ensure that the network service area on file with the Department for each licensed network is consistent with the definition set forth in Rule 1300.67.2.2, sub. (b)(11).[7]

In order to ensure network service areas on file with the Department comply with the definition set forth in Rule 1300.67.2.2, sub. (b)(11), and to confirm consistency across health plan network submissions, the Department will establish a Network Service Area Confirmation process in which all health plans will review all licensed networks and ensure the service areas for each network are appropriately identified in accordance with the definition. The Department will issue a future All Plan Letter to further describe the process by which health plans will be able to confirm the network service area of its approved networks. This next communication will correspond with the Department's release of the updated County/ZIP Code list referenced in Rule 1300.67.2.2, subs. (h) that will be in effect for Reporting Year 2023.

IV. Timely Access and Annual Network Reporting Requirements

All Plan Letter 22-007, issued March 4, 2022, and the amended Rule 1300.67.2.2, sub. (h) and set forth the reporting requirements for Reporting Years 2023 and 2024. All health plans shall ensure they are gathering and reporting data in accordance with the instructions set forth therein. The Checklist identifies areas where health plans may need to revise or amend existing policies and procedures or submit other filings to ensure continued compliance; however, the Department wishes to draw health plans' attention to the following areas that are likely to have a greater impact on health plan processes:

A. Plan-to-Plan Contract Reporting Requirements

Under the previously enacted version of Rule 1300.67.2.2, reporting plans who met the definition of a subcontracted plan submitted data directly to the Department on behalf of

[7] Rule 1300.67.2.2, sub. (b)(11) defines network service area as, "the geographical area, and population points contained therein, where the plan is approved by the Department to arrange health care services consistent with network adequacy requirements."

the primary plan. Under the current Timely Access Regulation, a subcontracted plan, as defined in Rule 1300.67.2.2, sub. (b)(13)(B), does not submit data to the Department on behalf of the primary plan; the primary plan is responsible for this submission.[8] As a result, when a primary plan maintains a network that includes network providers made available through plan-to-plan contracts, as defined in Rule 1300.67.2.2(b)(13), the primary plan is required to report all network data on behalf of the health plan's own network and any network providers included in the primary plan's network due to a plan-to-plan contract with the subcontracted plan. (See Rule 1300.67.2.2, sub. (h)(3).)

B. Annual Reporting Requirements

Pursuant to APL 22-007, health plans shall start collecting and reporting data in accordance with the Timely Access and Network Reporting Statutes and Regulation. This will impact health plans' current policies and procedures related to annual network and timely access compliance reporting.

- **Annual Network Report.** With regard to annual network reporting, all reporting instructions set forth in the Timely Access Regulation and incorporated documents will be in effect for Reporting Year 2023.[9] Health plans shall file any new or updated policies and procedures, or other operational documents, required to demonstrate compliance with the Timely Access and Network Reporting Statutes and Regulation and APL 22-007 in accordance with timeframes set forth in the Checklist.

- **Timely Access Compliance Report.** With regard to Reporting Year 2024/Measurement Year 2023, all Timely Access and Network Reporting Statutes and Regulation and incorporated documents are in effect during the entire measurement year and reporting year.[10] The Department intends to issue the updated Reporting Year 2024/Measurement Year 2023 PAAS Manual and

[8] Beginning RY 2023, primary plans shall begin including subcontracted plan data in the Annual Network Report submission and the Network Access Profile; however, primary plans shall begin including subcontracted plan data in the Timely Access Compliance Report in Reporting Year 2024/Measurement Year 2023.

[9] The Annual Network Report Forms with validations will be released on or before November 1 of the year prior to the reporting year, per sections 1367.03(f)(3) and 1367.035(a), (g), and Rule 1300.67.2.2(h)(9). Certain report forms and instructions have been added or amended due to statutory changes. DMHC previewed the updated Annual Network Report Forms with stakeholders in 2022, pursuant to Section 1367.03(f)(3).

[10] Health plans can reference Rule 1300.67.2.3 and APL 22-007 for details on what new requirements are effective for Reporting Year 2023/Measurement Year 2022. APL 22-007 indicated that some of the changes to the monitoring requirements and reporting instructions set forth in the Timely Access and Network Reporting Statutes and Regulation and incorporated documents will be in effect for the Reporting Year 2023/Measurement Year 2022 Timely Access Compliance Report.

PAAS Report Forms with the edits made for SB 221 in late 2022 and/or early 2023.[11] Health plans shall file any new or updated policies and procedures, or other operational documents, required to demonstrate compliance with the Timely Access and Network Reporting Statutes and Regulation and APL 22-007 in accordance with the timeframes set forth in the Checklist. The updates to plan documents shall be effective for Reporting Year 2024/Measurement Year 2023 and ongoing for the Timely Access Compliance Report.

C. Networks with No Active Enrollment as of the Network Capture Date

If a reporting plan maintains a network in which there is no enrollment on the network capture date and the health plan does not anticipate enrollment during the reporting year, the reporting plan may request a waiver of the requirement to submit to the Department all information set forth in Rule 1300.67.2.2, subs. (h)(6) and (h)(7) for that network by submitting a Notice of Material Modification filing **prior to the network capture date of the reporting year**. When evaluating whether to grant the waiver, the Department may consider the following factors:

- The date the network last had enrollment;
- Whether the health plan anticipates enrollment during the reporting year;
- The date the health plan last submitted its network for review by the Department through an Amendment or Material Modification, pursuant to Sections 1351 and 1352 and Rules 1300.51 and 1300.52; and
- The date the health plan last submitted its network for review by the Department pursuant to Rule 1300.67.2.2.

Any Order issued by the Department approving a waiver will include a condition requiring the health plan to submit an annual Amendment filing renewing the waiver request for subsequent reporting years. In each annual Amendment filing, the health plan will be required to affirm that the network continues to not have associated enrollment and the health plan does not anticipate enrollment over the course of the measurement year.

The health plan shall continue to submit the network access profile information set forth in Rule 1300.67.2.2, sub. (h)(8) regardless of whether a waiver is granted with respect to the information set forth in the Timely Access Compliance Report and Annual Network Report, as set forth in Rule 1300.67.2.2, subs. (h)(6) and (h)(7).

If you have any questions about this APL, please contact the Office of Plan Monitoring. Questions related to Timely Access Compliance may be sent to TimelyAccess@dmhc.ca.gov. Questions related to Annual Network Reporting may be sent to ANRTeam@dmhc.ca.gov.

[11] DMHC previewed the updated PAAS Manual and PAAS Report Forms with stakeholders in 2022, pursuant to Section 1367.03(f)(3).