# **Amendments to 28 CCR § 1300.67.2:**

**§ 1300.67.2. Accessibility of Services.**

(a) The definitions set forth in Rule 1300.67.2.2 (b), and the documents incorporated therein, are applicable to this section and shall apply to the plan’s requirement to meet network adequacy with respect to all required filings, including those specified in Health and Safety Code sections 1352, 1367.03, 1367.035, 1371.31, 1374.141 and Rules 1300.51, 1300.52, 1300.52.4, and 1300.67.2.1.

(b) Within each network service area of a plan, all covered ~~basic health care~~ services ~~and specialized health care services~~ shall be readily available and accessible to each of the plan’s enrollees~~;~~ and shall meet all access requirements and network adequacy standards set forth in the Knox-Keene Act and Title 28, including the requirements set forth in this section.

(1) A plan shall rely only on network providers, as defined in Rule 1300.67.2.2(b)(10), to demonstrate compliance with these standards.

(2) A plan that uses a tiered network shall demonstrate compliance with these standards based on providers available at the lowest cost-sharing tier, as defined.

(c) ~~(a)~~ The location of network providers, as defined in Rule 1300.67.2.2(b)(10), providing the covered ~~health care~~ services of the plan shall be within reasonable proximity of the business or personal residences of enrollees, and so located as to not result in unreasonable barriers to accessibility. The geographic access standards established in this section set forth minimum standards of accessibility that a plan must meet in order to meet network adequacy. A plan must 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 consistent with the standards established in this section. Where an enrollee is required to travel beyond the standards set forth in this section, that service is presumed to be unavailable, as defined in Rule 1300.67.2.2(b).

(1) For the purposes of the network adequacy review conducted pursuant to Health and Safety Code section 1367.035, in addition to the geographic accessibility requirements set forth within subsection (c) of this Rule, the plan shall meet geographic accessibility standards with respect to the location of network specialist physicians, mental health facilities, and non-physician mental health professionals, as established by the Department. ~~Such geographic accessibility standards and the accompanying review methodology shall be set forth in the document entitled Mental Health Geographic Access Standards and Methodology, which is hereby incorporated by reference. The Department shall use the version of this document noticed on the Department's website at www.dmhc.ca.gov, on or before January 15th of the reporting year as set forth in Rule 1300.67.2.2(b)(18).~~ A plan that meets the geographic accessibility standards set forth within the incorporated standards and methodology documents identified below ~~Meeting the geographic accessibility standards set forth therein~~ shall demonstrate compliance with this provision for the ~~identified~~ network provider types identified within these documents.

(A) ~~The g~~Geographic accessibility standards ~~set forth in the Mental Health Geographic Access Standards and Methodology may also be considered by the Department when evaluating network adequacy for the purposes of licensure pursuant to~~[~~Health and Safety Code sections 1351~~](https://1.next.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000213&cite=CAHSS1351&originatingDoc=IA0D64C60DF8411EEB6C9D34798039C1D&refType=LQ&originationContext=document&transitionType=DocumentItem&ppcid=920eb3a2613b4af8a941a19436a4987e&contextData=(sc.Search))~~and~~[~~1352~~](https://1.next.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000213&cite=CAHSS1352&originatingDoc=IA0D64C60DF8411EEB6C9D34798039C1D&refType=LQ&originationContext=document&transitionType=DocumentItem&ppcid=920eb3a2613b4af8a941a19436a4987e&contextData=(sc.Search))~~, and Rules 1300.51, 1300.52, and 1300.52.4.~~and the accompanying review methodology for specialist physicians and non-physician mental health professionals shall be set forth in the following documents, which are hereby incorporated by reference:

(i) Specialist Physician Geographic Access Standards and Methodology; and

(ii) Mental Health Geographic Access Standards and Methodology.

The Department shall use the version of these documents noticed on the Department’s website at [www.dmhc.ca.gov](http://www.dmhc.ca.gov), on or before January 15th of the reporting year as set forth in Rule 1300.67.2.2(b)(18).

(B) ~~For the purposes of~~ Where a plan is unable to meet the geographic access standards referenced in subsection (A), the Department shall review the plan in accordance with the alternative geographic accessibility standards ~~for mental health facilities and non-physician mental health professionals, the alternative accessibility standards and methodology~~ and methodologiesset forth in the Specialist Physician Geographic Access Standards and Methodology and the Mental Health Geographic Access Standards and Methodology documents, when applicable. The process for requesting alternative accessibility standards set forth in ~~shall apply.~~ Rule 1300.67.2.1 shall not apply to the ~~requests for alternative~~ geographic accessibility standards for specialist physicians, mental health facilities, and non-physician mental health professionals, unless otherwise indicated within the incorporated standards and methodology documents.

(C) For network provider types not specified in the Specialist Physician Geographic Access Standards and Methodology and the Counseling Non-Physician Mental Health Professional Geographic Access Standards and Methodology documents, the plan shall ensure the providers are within reasonable proximity of enrollees, and so located as to not result in unreasonable barriers to accessibility.

(2) The geographic accessibility standards set forth in the Specialist Physician Geographic Access Standards and Methodology and the Mental Health Geographic Access Standards and Methodology may also be considered by the Department when evaluating network adequacy 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.

(3) ~~(2)~~ With regard to geographic access to primary care providers and hospitals throughout the network service area, the geographic accessibility standards set forth in subsections (i) and (ii) of Item H in subsection (d) of Rule 1300.51 establish the geographic access standards that a plan must meet to demonstrate compliance with the Act for all ZIP Codes in the network service area, except for those ZIP Codes for which the Department has approved an alternative standard of accessibility pursuant to Rule 1300.67.2.1. These geographic access standards shall apply when evaluating a plan’s compliance with the Act in all circumstances where network review is required, including the filings necessitated by Health and Safety Code sections 1351, 1352, 1367.03, 1367.035, 1371.31, 1374.141 and Rules 1300.51, 1300.52, 1300.52.4, and 1300.67.2.1.

(4) ~~(3)~~ When determining compliance with the geographic access standards for the purposes of network adequacy review set forth in the Act, the Department shall rely upon the methodology set forth in the document entitled Geographic Access Measurement Methodology, which is hereby incorporated by reference. The Department shall use the version of this document noticed on the Department’s website at [www.dmhc](http://www.dmhc).ca.gov, on or before January 15th of the reporting year set forth in Rule 1300.67.2.2(b)(18). Where there is a discrepancy in the measurement of driving distance or expected driving time, the Department’s measurements made in accordance with the methodology set forth in the Geographic Access Measurement Methodology shall be the accepted measurement of the driving distance and expected driving time afforded by the plan’s network.

(d) ~~(b)~~ Hours of operation and provision for after-hour services shall be reasonable~~;~~ and the network shall include unscheduled urgent services, as defined in Rule 1300.67.2.2(b), within the network service area.

(e) ~~(c)~~ Emergency health care services shall be available and accessible within the network service area twenty-four hours a day, seven days a week~~;~~.

(f) ~~(d)~~ The ratio of enrollees to staff within a network, including physicians and other health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all covered services will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees~~;~~. The ratio standards established in this section set forth minimum standards of accessibility that a plan must meet in order to establish network adequacy. A plan must arrange for a greater number of providers or additional provider types within its network, if necessary to reasonably assure that all covered services will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollee.

(1) There shall be at least one full-time equivalent (FTE)physician to each one thousand two hundred (1,200) enrollees and there shall be approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, as modified by Health and Safety Code section 1375.9~~;~~.

(2) ~~(1)~~ For the purposes of the network adequacy review conducted pursuant to Health and Safety Code section 1367.035, in addition to the FTE ratio standards within subsections (f) and (f)(1) of this Rule, the Department shall evaluate the FTE ratio of specified network providers to enrollees according to standards established by the Department. A plan that meets the FTE ratio standards set forth within the standards and methodology documents incorporated by reference below shall demonstrate compliance with this provision for the network provider types identified within these documents. ~~the ratio of full-time equivalent non-physician mental health practitioners to enrollees shall be sufficient to meet the standards set forth in the document entitled Counseling Non-Physician Mental Health Professional Ratio Standards and Methodology, which is hereby incorporated by reference, when calculated in accordance with the methodology set forth therein.~~

(A) Ratio standards and the accompanying review methodology for specialist physicians and non-physician mental health professionals shall be set forth in the following documents, hereby incorporated by reference:

(i) Specialist Physician Ratio Standards and Methodology; and

(ii) Counseling Non-Physician Mental Health Professional Ratio Standards and Methodology.

The Department shall use ~~a~~the version of ~~this~~these documents noticed on the Department’s website at [www.dmhc.ca.gov](http://www.dmhc.ca.gov), on or before January 15th of the reporting year set forth in Rule 1300.67.2.2(b)(18).

(B) The Department shall review plans in accordance with the alternative standards and methodologies set forth in the Specialist Physician Ratio Standards and Methodology and the Counseling Non-Physician Mental Health Professional Ratio Standards and Methodology documents, when applicable. The process for requesting alternative accessibility standards set forth in Rule 1300.67.2.1 shall not apply to ratio standards for specialist physicians and non-physician mental health professionals, unless otherwise indicated within the incorporated standards and methodology documents.

(C) For specialty types not specified in the Specialist Physician Ratio Standards and Methodology and the Counseling Non-Physician Mental Health Professional Ratio Standards and Methodology documents, the plan shall ensure the ratio of enrollees to providers within a network such as to reasonably assure that all services will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollee.

(3) ~~(A)~~ The standards set forth in the Specialist Physician Ratio Standards and Methodology and the Counseling Non-Physician Mental Health Professional Ratio Standards and Methodology may also be considered by the Department when evaluating network adequacy 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.

~~(B) For the purposes of alternative ratio standards for non-physician mental health professionals, the alternative accessibility standards methodology set forth in the Counseling Non-Physician Mental Health Professional Ratio Standards and Methodology shall apply. Rule 1300.67.2.1 shall not apply to requests for alternative ratio standards for non-physician mental health professionals.~~

(g) A plan’s network shall include all network provider types of the appropriate specialty
and type necessary to deliver covered services. Within each network, a plan shall provide readily available and accessible physicians, facilities, clinics, mental health providers, and other non-physician medical providers who are appropriately licensed, certified or eligible for certification by the applicable specialty boards, and serve as network providers, as defined in Rule 1300.67.2.2(b)(10).

(1) Each enrollee shall have access to clinically appropriate network providers within the access requirements and network adequacy standards set forth in the Knox-Keene Act and Title 28, including the requirements set forth in this section.

(2) For the purposes of the network adequacy review conducted pursuant to Health and Safety Code section 1367.035, a network that does not contain the provider types set forth in the document entitled, Required Network Provider Types, which is hereby incorporated by reference, may be considered by the Department to not meet the requirement set forth in this subsection. The Department shall use the version of this document noticed on the Department’s website at www.dmhc.ca.gov, on or before January 15th of the reporting year set forth in Rule 1300.67.2.2(b)(18). Where the required network provider type is not available in the network to an individual enrollee, the service is presumed to be unavailable, as defined in Rule 1300.67.2.2(b).

(3) When a hospital or other facility is a network provider, the plan shall make available individual network providers to deliver all covered services available at the facility, including emergency room care, through the following:

(i) Facility-based providers; and

(ii) Providers maintaining medical staff privileges such as hospital admitting privileges, hospital care provision privileges, or emergency medicine privileges, at the facility pursuant to the hospital’s credentialing policies and procedures and Rule 1300.51(d)(H).

~~(e)~~ ~~A plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral;~~

~~(f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments;~~

~~(g) A section of the health education program shall be designated to inform enrollees regarding accessibility of service in accordance with the needs of such enrollees for such information regarding that plan or area;~~

(h) Within each network, the plan shall ensure ~~sufficient~~ the numbers of network providers ~~are~~ accepting new patients is sufficient to reasonably assure that all covered services will be accessible to all enrollees on an appropriate basis without delays detrimental to the health of the enrollee and such as to ensure timely access to care for all enrollees.~~;~~

(1) For the purposes of the network adequacy review conducted pursuant to Health and Safety Code section 1367.035, a plan shall meet standards for network providers that are accepting new patients, as established by the Department, when calculated in accordance with the incorporated standards and methodology documents set forth below.

~~the percent of non-physician mental health practitioners accepting new patients shall be sufficient to meet the standards set forth in the document entitled Counseling Non-Physician Mental Health Professionals Accepting New Patients Standards and Methodology, which is hereby incorporated by reference, when calculated in accordance with the methodology set forth therein.~~

(A) The standards for the percent of primary care physicians accepting new patients and non-physician mental health professionals accepting new patients shall be set forth in the following documents, which are hereby incorporated by reference:

(i) Primary Care Physician Accepting New Patients Standards and Methodology; and

(ii) Counseling Non-Physician Mental Health Professional Accepting New Patients Standards and Methodology.

The Department shall use a version of ~~this~~ these documents noticed on the Department’s website at [www.dmhc.ca.gov](http://www.dmhc.ca.gov), on or before January 15th of the reporting year set forth in Rule 1300.67.2.2(b)(18).

(B) The Department shall review plans in accordance with the alternative standards and methodologies set forth in the Primary Care Physician Accepting New Patients Standards and Methodology and the Counseling Non-Physician Mental Health Professional Accepting New Patients Standards and Methodology documents when applicable. The process for requesting alternative accessibility standards set forth in Rule 1300.67.2.1 shall not apply to the accepting new patients standards, unless otherwise indicated within the standards and methodology document.

~~(A) The standards set forth in Counseling Non-Physician Mental Health Professionals Accepting New Patients Standards and Methodology may also be considered by the Department when evaluating network adequacy for the purposes of licensure pursuant to~~[~~Health and Safety Code sections 1351~~](https://1.next.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000213&cite=CAHSS1351&originatingDoc=IA0D64C60DF8411EEB6C9D34798039C1D&refType=LQ&originationContext=document&transitionType=DocumentItem&ppcid=ff7c99eb65a04060926e35426c3dbf71&contextData=(sc.Search))~~and~~[~~1352~~](https://1.next.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000213&cite=CAHSS1352&originatingDoc=IA0D64C60DF8411EEB6C9D34798039C1D&refType=LQ&originationContext=document&transitionType=DocumentItem&ppcid=ff7c99eb65a04060926e35426c3dbf71&contextData=(sc.Search))~~, and Rules 1300.51, 1300.52, and 1300.52.4.~~

~~(B) For the purposes of alternative standards for non-physician mental health professionals accepting new patients, the alternative accessibility standards methodology set forth in the Counseling Non-Physician Mental Health Professionals Accepting New Patients Standards and Methodology shall apply.~~

(2) The standards set forth in the Primary Care Physician Accepting New Patients Standards and Methodology and the Counseling Non-Physician Mental Health Professional Accepting New Patients Standards and Methodology may also be considered by the Department when evaluating network adequacy 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.

(i) A plan shall arrange for the provision of covered services from non-network providers if the services are unavailable from a network provider, in accordance with the definitions in Rule 1300.67.2.2(b), when medically necessary for the enrollee’s condition.

(1) Where a plan is obligated to provide covered services from a non-network provider, the plan shall provide and arrange coverage from a non-network provider in a manner that meets the access requirements and network adequacy standards set forth in the Knox-Keene Act and Title 28, including the requirements set forth in this section.

(2) A plan shall establish and maintain processes, policies, and procedures to notify enrollees and network providers of the availability of referral to non-network providers.

(3) The requirements set forth in this subsection apply to networks serving all product types, including products that include an out-of-network benefit.

(4) Delivery of services through a non-network provider does not absolve a plan of its obligation to arrange for those services through a network provider within the access requirements and network adequacy standards in the Knox-Keene Act and Title 28, including the requirements set forth in this section.

(j) Each plan shall have a documented system for monitoring and evaluating access to care, including a system for addressing problems that develop. The monitoring system shall consider the plan’s ability to deliver care to enrollees in accordance with the access requirements and network adequacy standards set forth in the Knox-Keene Act and Title 28, including accessibility, availability, continuity of care, network capacity, and timely access requirements.

(1) When identifying network accessibility problems, the plan shall consider enrollee grievances, the unavailability of network providers, shortages of one or more provider types within the network, requests for referrals to non-network providers, delays in access to care, and other indicators of lack of access to covered services for enrollees. The plan shall document any conclusions regarding health plan compliance with these requirements resulting from this review.

(2) For plans that delegate patient care to other health care service plans, provider groups, or other entities, the plan shall have a process for monitoring and evaluating each delegate’s ability to deliver care to enrollees in accordance with the access requirements and network adequacy standards set forth in the Knox-Keene Act and Title 28, including accessibility, availability, continuity of care, network capacity, and timely access requirements.

(k) A section of the health education program shall be designated to inform enrollees regarding accessibility of service in accordance with the needs of such enrollees for such information regarding that plan or area.

~~(i) The definitions set forth in Rule 1300.67.2.2 (b), and the definitions set forth in the Definitions section of the Annual Network Submission Instruction Manual, as incorporated by reference in Rule 1300.67.2.2 (h)(7), shall apply to the plan’s requirement to meet network adequacy with respect to all required filings, including those specified in Health and Safety Code sections 1352, 1367.03, 1367.035, 1371.31, 1374.141 and Rules 1300.51, 1300.52, 1300.52.4, and 1300.67.2.1.~~

(l) Subject to the requirements of this section, a plan shall continue to comply with the standards of accessibility set forth in Item H and Item I of Rule 1300.51.

(m) Nothing in this Rule exempts a health plan from complying with federal and state laws regarding mental health and substance use disorder coverage and parity, including, 42 U.S.C. § 300gg-26, [29 CFR § 2590.712](https://1.next.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000547&cite=29CFRS2590.712&originatingDoc=I6C886820B56411EEB590FF4B157C4E61&refType=LQ&originationContext=document&transitionType=DocumentItem&ppcid=cd618f34ed0548d3b8713facaa616aa7&contextData=(sc.Search)), [45 CFR § 146.136](https://1.next.westlaw.com/Link/Document/FullText?findType=L&pubNum=1000547&cite=45CFRS146.136&originatingDoc=I6C886820B56411EEB590FF4B157C4E61&refType=LQ&originationContext=document&transitionType=DocumentItem&ppcid=cd618f34ed0548d3b8713facaa616aa7&contextData=(sc.Search)), Sections 1374.72 and 1374.76 of the Health and Safety Code, and Rules 1300.74.72, 1300.74.72.01, and 1300.74.721 of this title.

Authority cited: Sections 1343, 1344, 1367.03 and 1367.035, Health and Safety Code. Reference: Sections 1342, 1351, 1352, 1367, 1367.01, 1367.03, 1367.035, 1367.04, 1371.31, 1374.141, 1375.7 and 1386, Health and Safety Code.