# **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 Rule 1300.67.2.2 and Incorporated Documents, as noticed in APL 24-019 (October 30, 2024). This includes Amendments to Rule 1300.67.2.2 and the Incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for Reporting Year 2025.

1. General FAQ Responses:
2. **The network capture date for the Annual Network Report is January 15th of the reporting year. Can a health plan collect network data after January 15th so long as the plan ensures the network data reflects the network as it existed on January 15th?**

The health plan may collect the relevant network data after January 15th, so long as the data submitted for the Annual Network Report reflects the January 15th network capture date, when applicable. For the Annual Network Report, the network data submitted to the DMHC must reflect the health plan’s network as it existed on January 15th of the reporting year, unless otherwise specified in the Rule or reporting instructions. It is the plan’s responsibility to ensure the network data it submits to the DMHC accurately reflects the network as of the applicable network capture date.

1. **In the Annual Network Submission Instruction Manual for RY 2025, Sections III. and IV. of the Manual are the former Timely Access sections. These sections are noted as “Reserved.” Will the Department be releasing Timely Access Reporting Information?**

The RY 2025/MY 2024 Timely Access Submission Instruction Manual and Provider Appointment Availability Survey Manual were issued to health plans in advance of the 2024 measurement year on December 22, 2023. The RY 2025 Annual Network Submission Instruction Manual was recently circulated for stakeholder feedback in anticipation of publication prior to reporting year 2025.

The Timely Access Submission Instruction Manual and the Annual Network Submission Instruction Manual are two separate manuals that provide instructions on how to submit the Timely Access Compliance Report and Annual Network Report, respectively, as set forth in Rules 1300.67.2.2(h)(6) and (7). These two Instruction Manuals were originally a single manual that was incorporated by reference into Rule 1300.67.2.2 (April 1, 2022). The Department revised the manuals into two separate manuals due to timing concerns related to the Timely Access Compliance Report measurement year and amendments to the law. This change is reflected in the amendments to Rule 1300.67.2.2, effective April 25, 2023. For further information, please see APL 23-020 (October 26, 2023) and attached documents.

1. **The DMHC added the following Mental Health Professional License and Certificate Types to Appendix D of the Annual Network Submission Instruction Manual for Reporting Year 2025: associate clinical social worker, associate marriage and family therapist, associate professional clinical counselor, registered psychological associate, and trainee. Why did the DMHC add these terms to its standardized terminology?**

The DMHC added these terms to its standardized terminology in response to feedback, and to better align with the provider types set forth in Section 1374.72(a)(3). Plans are required to report network providers with these licensure and certificate types in the Annual Network Report submission. Plans are not required to report clinical encounter data for mental health professionals with these licensure types at this time.

1. **Why did the DMHC amend Rule 1300.67.2.2(h)(7)(A) and Annual Network Report Forms to require plans to submit non-network provider requests and determinations as part of the Annual Network Report?**

Senate Bill (SB) 221 (Wiener, Chapter 724, Statutes of 2021) set forth the requirement that health plans must ensure they have sufficient numbers of network providers to maintain compliance with the timely access and network adequacy standards established pursuant to Section 1367.03. It further established that if an enrollee’s medically necessary covered service is unavailable within the health plan’s network, the plan must arrange for the provision of the covered service from a provider outside of the plan’s network (i.e. from a non-network provider).

In this current cycle of regulatory updates, the DMHC developed methodologies for the reporting of non-network providers relating to these statutory requirements. In the future, the DMHC may develop network review methodologies to evaluate the sufficiency of network providers, as set forth in Section 1367.03(a)(7).

The Non-Network Provider Arrangements Report Form (Form No. 40-287) includes two tabs: The Non-Network Requests Report Tab, and the Limited Plan Provider Report Tab. Within the Non-Network Requests Report Tab, health plans are required to report non-network provider requests and determinations pertaining to timely access and network adequacy, for each network and county. In the Limited Plan Provider Report Tab, health plans are required to report limited plan providers that the health plan uses to deliver access to care when a network provider is unavailable (unavailable is defined in Rule 1300.67.2.2(b)).

1. **Can the DMHC provide clarification on what qualifies as a non-network provider request and determination?**

The Annual Network Submission Manual for RY 2025 defines “non-network provider request” as follows:

A request that the enrollee access or receive covered services from a provider that is not a network provider, as defined. Such request may be initiated by an enrollee, enrollee’s representative, a provider, or any other source, including through the grievance process.

Instructions for health plans concerning how to report non-network provider request determinations are set forth in the “Determination” field instructions for the Non-Network Requests Report Tab, within Section V.K. of the Annual Network Submission Instruction Manual for RY 2025. The health plan will report whether the plan approved the request, denied the request, or there was a different resolution.

For further instructions regarding how to report non-network provider requests and health plan determinations for RY 2025, see the report form instructions for the Non-Network Requests Report Tab of the Non-Network Provider Arrangements Report Form (Form No. 40-287). These instructions are available in the attached Annual Network Submission Instruction Manual for RY 2025.

1. **Can the DMHC provide more explanation of what qualifies as a non-network provider?**

The Annual Network Submission Instruction Manual for Reporting Year 2025 defines “non-network provider” as follows: “An individual provider, an entity or a facility, as set forth in section 1345(i), that does not meet the definition of network provider in Rule 1300.67.2.2(b)(10).” In other words, a non-network provider is any provider that does not meet all the network contracting and other requirements of the Knox-Keene Act as described in the definition of network provider in Rule 1300.67.2.2(b)(10). One key component of a network provider under the definition is that the provider must be available to provide covered services to all plan enrollees in all product lines using the designated network. Network providers must also meet all contracting requirements in the Knox-Keene Act and be available to enrollees through regularly established in-network referral and authorization processes.

One example of a non-network provider is a provider that does not have any contractual relationship with the plan. Another example of a non-network provider is a provider made available to an enrollee through a single-case agreement, letter of intent, or a contract agreement that does not meet all contractual requirements of with the Knox-Keene Act and implementing regulations. Examples of Knox-Keene Act contracting requirements are set forth in subsection (b)(10)(B)(ii) and (iii) of the definition of network provider.

Another example of a non-network provider is a “limited plan provider” which is a new defined term set forth in Rule 1300.67.2.2(b). Such providers are sometimes referred to as “rainy day” providers by health plans. A limited plan provider is a provider who would meet the criteria for "network provider" defined in Rule 1300.67.2.2(b), **except** the provider is not accessible to some or all enrollees in all product lines using the network without limitations other than established in-network referral or authorization processes; or processes for changing provider groups consistent with the Knox-Keene Act in networks where enrollees are assigned to a provider group. For instance, in a network where enrollees are assigned to a provider group, the enrollees may not be permitted to switch into the provider group where the limited plan provider practices. Or there may be a different referral or authorization process required for an enrollee to see a limited plan provider.

While limited plan providers cannot be used to meet established network adequacy standards, health plans are required to report limited plan providers to the DMHC if the plan uses the provider to deliver access to care when a network provider is unavailable, as defined in Rule 1300.67.2.2(b). The DMHC may review limited plan providers in this context.

For more information concerning the definition of network provider, please refer to Rule 1300.67.2.2(b)(10).

1. Changes to Report Forms FAQ Responses:
2. **What types of non-network provider requests are plans required to report on the Non-Networks Request Report Tab of the Non-Network Provider Arrangements Report Form?**

In response to stakeholder feedback, the DMHC revised the Non-Network Provider Arrangement Report Form to limit the scope of the non-network provider requests health plans are required to report on the Non-Network Requests Report Tab. For Reporting Year 2025, health plans will only be required to report non-network requests that pertain to the following reasons:

* Provider not accepting new patients
* Timely access to provider
* Specialized procedure/area of expertise
* Geographic accessibility of provider
* Provider type specialty or covered service unavailable

See the instructions for the Non-Network Requests Report Tab in the Annual Network Submission Instruction Manual for further information.

1. **The DMHC made changes to the Network Service Area and Enrollment Report Form for Reporting Year 2025. Within the updated report form, when is a health plan required to report the individual ZIP Codes that are part of the network service area?**

For Reporting Year 2025, the DMHC has added a new field, entitled “Full or Partial County” to the Network Service Area Report Tab. For each county within a health plan’s network service area, a health plan must report whether the network is approved to operate in the entire county (“full”) or only a portion of the county (“partial”). By indicating the plan’s network is approved for the full county, the plan is affirming that the network was approved by the DMHC to operate in every ZIP Code within the county pursuant to sections 1351 and 1352, and the regulations promulgated thereunder. By indicating the network is approved for a partial county, the plan is affirming that the network is approved to operate in one or more ZIP Codes within the county, but not the complete county.

If a health plan reports a county as a “full” county for the network, then the health plan is not required to list all of the corresponding ZIP Codes for that county. If a health plan reports a county as a “partial” county for the network, the plan must list each ZIP Code the DMHC approved the network to operate in for the identified county. The DMHC made this change to simplify network service area reporting, and to better align a health plan’s network service area reporting in licensure filings (eFiling) with the Annual Network Report submission.

1. **The DMHC added the “Population Age Served” field to several provider report forms for Reporting Year 2025, which requires plans to specify whether an individual provider serves adult enrollees, pediatric enrollees, or both. Can the DMHC clarify the cutoffs between the different age groups? Additionally, how does this new field interact with current requirements to report pediatric physicians, and to report specialty types for non-physician mental health professionals?**

The field instructions for the “Population Age Served” field include instructions concerning the ages of the patient population pertaining to the population served. Providers that serve enrollees ages 18 and older are reported as serving an adult population, and providers that serve enrollees ages 17 and younger are reported as serving a pediatric population. Providers that serve both age populations are reported as serving both populations.

Physicians who meet the requirements for a pediatric specialty are reported according to their pediatric specialty type in the “Specialty” field. Mental health professionals who have an area of expertise in treating children or adolescents should be identified as such in the “Specialty/Area of Expertise” field. Separate from the provider’s specialty type or area of expertise, the “Population Age Served” field will capture which providers limit their practice to treating only adults, or only pediatric patients, and which providers treat both.

1. **Why did the DMHC add the “HCAI ID” field to the Hospital Report Tab of the Hospital and Clinic Report Form (Form No. 40-270)?**

The field for “HCAI ID” within the Hospital Report Tab captures the unique identifier established by the California Department of Health Care Access and Information (HCAI) identifying facilities used in the Licensed Facility Information System (LFIS).

The DMHC is collecting this data to evaluate enrollee access to various hospital services in health plan networks, including emergency room services, specialized services, and the services included in the new definition of “particularized hospital services” in the Annual Network Submission Instruction Manual for Reporting Year 2025.

1. **Will the DMHC provide plans with a list of HCAI’s licensed facilities so that plans will be able to find each hospital’s unique HCAI identifier?**

The DMHC will be releasing technical guidance to health plans for the Reporting Year 2025 Report Forms, which will include technical instructions for the “HCAI ID” field. The DMHC will provide the URL for HCAI’s Licensed Facility Information System (LFIS), which plans can use to look up the HCAI identifier for each hospital in the plan’s network.
The LFIS is accessible from the following URL: https://lfis.hcai.ca.gov/. Since the LFIS is available for public use, the DMHC will not provide plans with a list of HCAI’s licensed facilities.

1. **The DMHC added the term “mental health rehabilitation center” to its standardized terminology for the reporting of mental health facilities. Could the DMHC please define mental health rehabilitation center?**

A mental health rehabilitation center (MHRC) is a facility licensed by the Department of Health Care Services (DHCS). DHCS defines an MHRC as “a 24-hour program which provides intensive support and rehabilitative services designed to assist persons, 18 years or older, with mental disorders who would have been placed in a state hospital or another mental health facility to develop skills to become self-sufficient and capable of increasing levels of independence and functioning.” For more information, consult the DHCS website at https://www.dhcs.ca.gov/mental-health-rehabilitation-centers.

1. Changes to Regulatory Definitions FAQ Responses:
2. **Where have the definitions previously in the Annual Network Submission Instruction Manual been moved to?**

For Reporting Year 2025, the DMHC moved several definitions previously included in the Definitions section of the Annual Network Submission Instruction Manual into Rule 1300.67.2.2(b). These definitions are applicable to both the Annual Network Report submission instructions incorporated in Rule 1300.67.2.2(h)(7), as well as monitoring requirements and the DMHC’s Annual Network Review.

1. **The Instruction Manual references several definitions stated in Rule 1300.67.2.2. Can the DMHC restate these definitions within the Annual Network Submission Instruction Manual in their entirety, instead of referencing the Rule?**

Due to the potential risk of inconsistent language, rather than restate definitions now included in Rule 1300.67.2.2(b), the Annual Network Submission Instruction Manual incorporates these definitions by reference.

1. **The DMHC revised the definition for “accepting new patients,” and moved the definition from the Annual Network Submission Instruction Manual, into Rule 1300.67.2.2(b). Can the DMHC provide further clarification on what counts as a current patient for purposes of this definition?**

In response to stakeholder feedback, the DMHC further revised the definition of “accepting new patients” to clarify that the provider must be available to deliver care to enrollees in the network who are not currently patients or are not assigned to the network provider. Please see the complete definition in the attached Rule 1300.67.2.2(b) for the updated language and additional criteria.

1. **Why has the DMHC updated the definition of practice address?**

The DMHC revised the definition of “practice address” and “practice location or locations” to emphasize that the practice address must be the physical location where the provider is actively delivering in-person health care services. Occasionally, a provider may have more than one practice location; however, health plans should not report a provider address as a practice address unless the individual provider reported is physically present at the location, providing in-person health care services to network enrollees.

In response to recent stakeholder feedback, the DMHC simplified the definition to remove any barriers to the reporting of legitimate practice addresses for network providers. However, due to the large volume of practice addresses reported for many providers in past measurement years, in subsequent reporting years the DMHC will continue to evaluate this definition, and reporting instructions that require health plans to demonstrate that the practice addresses reported are current and accurate. Please see the complete definition in the attached Rule 1300.67.2.2(b) for the updated language.

1. **Why has the DMHC updated the definition of specialty and subspecialty?**

In response to recent stakeholder feedback, the DMHC revised the definition of “specialty” and “subspecialty” to clarify the requirements for reporting and review. A provider’s specialty and/or subspecialty is the primary specialty or subspecialty type(s) the provider currently practices in the network, and for which the provider has been credentialed by or on behalf of the health plan. Specialty must be consistent with board certification where applicable, and when not applicable, consistent with required education, experience and training, and subject to the Plan’s quality assurance program.

1. **Must the Plan only report in the “Specialty” field those specialties for which the physician is board certified?**

A plan must report a physician’s specialty based on how the physician has been credentialed by the plan. This may be based on board certification when applicable; and when not applicable, it shall be consistent with required education, experience and training and subject to the Plan’s quality assurance program. Health plans are required to report physician specialties in accordance with the standardized terminology provided by the DMHC in the Appendix B of the Instruction Manual. That terminology is based on the specialty terminology established by the American Board of Medical Specialties for the purposes of administering board certification.