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ALL PLAN LETTER

DATE: September 4, 2025

TO: All Health Care Service Plans

FROM: Nathan Nau
Deputy Director, Office of Plan Monitoring

SUBJECT: APL 25-013 – Amendments to Rules 1300.51, 1300.52, 1300.52.4, 1300.67.2.2 and the Incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for Reporting Year 2026 and Continuing Thereafter

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The Department of Managed Health Care (DMHC) issues this All-Plan Letter (APL) to notice new amendments to 28 CCR §§ 1300.51, 1300.52, 1300.52.4, 1300.67.2.2, and the incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for the reporting year (RY) 2026 Annual Network Report submission and continuing thereafter.

The amendments described in this APL and attached documents impact health care service plan (health plan) Annual Network Report submission requirements and the Annual Network Review under Health and Safety Code sections 1367.03 and 1367.035 and Title 28 CCR § 1300.67.2.2.[1] These changes also impact general network filing requirements under Title 28 CCR §§ 1300.51, 1300.52, and 1300.52.4. Amendments are noticed in accordance with sections 1367.03(f)(3) & (5).[2]

As a reminder, rules and instructions related to submission of the Timely Access Compliance Report are released separately, as depicted in Rule 1300.67.2.2. These changes are addressed in APL 25-014 (September 4, 2025).

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[1] The Knox-Keene Act is set forth in California Health and Safety Code sections 1340 et seq. References to "Section" are to sections of the Knox-Keene Act. References to "Rule" refer to the California Code of Regulations, title 28.
[2] This APL applies to all Reporting Plans, Profile-Only Plans, and all health plans required to submit network filings, per the described code sections and Rules.

I. Background

A. Annual Network Reporting Requirements

Health plans are required to submit an Annual Network Report to the DMHC on an annual basis.[3] The DMHC is required to review health plan Annual Network Report submissions for compliance with the Knox-Keene Act (the "Annual Network Review").[4] The requirements for the Annual Network Report submission are set forth in Rule 1300.67.2.2 and incorporated documents. Required Annual Network Report Forms are incorporated in subdivision (h)(7) of this Rule. General reporting instructions and field instructions for the Annual Network Report Forms are set forth within the Annual Network Submission Instruction Manual, also incorporated in Rule 1300.67.2.2(h)(7).

Amendments to annual network reporting methodologies are made in accordance with Senate Bill (SB) 221 (Wiener, Chapter 724, Statutes of 2021) and SB 225 (Wiener, Chapter 601, Statutes of 2022) which provided the DMHC with two exemptions from the Administrative Procedure Act (APA) to develop required reporting methodologies and standards for the Annual Network Report submission and network adequacy review.[5]

B. Previous Amendments to Rule 1300.67.2.2 and Reporting Instructions

Under the APA exemptions to formal rulemaking referenced above, the DMHC has promulgated amendments to Rule 1300.67.2.2 on an annual basis impacting the Annual Network Report submission requirements. As part of those amendments, the DMHC has also updated the Annual Network Report Forms and reporting instructions incorporated by reference in the Rule.[6] Amendments are available on the "Newly Effective Regulations" page of the DMHC's public website.[7]

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[3] Sections 1367.03(f)(3), 1367.035(a), 1371.31, and 1374.141; Rule 1300.67.2.2(h).
[4] Sections 1367.03(f) and 1367.035, and Rule 1300.67.2.2(h).
[5] Sections 1367.03(f)(3) and (5), and 1367.035(a).
[6] See APL 22-024 (October 27, 2022), APL 23-020 (October 26, 2023) and APL 24-019 (October 30, 2024).
[7] Amendments to Rule 1300.67.2.2 and incorporated documents for Annual Network Reporting were noticed through the APLs described in footnote 6 and thereafter filed with the Secretary of State on April 25, 2023 (for RY 2023), March 6, 2024 (for RY 2024), and April 4, 2025 (for RY 2025). Amendments are available on the DMHC's public website, under the titles: 2023-TARR - 1300.67.2.2 Timely Access and Network Reporting Requirements (RY 2023), 2023 GATN - Geographic Access and Tiered Network Regulation (RY 2024) and 2023-NRR - Phase II Network Rule (RY 2025).

C. Amendments for RY 2026 and Subsequent Reporting Years

Amendments noticed in this APL pertain to reporting year (RY) 2026 and will remain in effect for subsequent reporting years, unless further amended at a future date. The RY 2026 Annual Network Report submission has a network capture date of January 15, 2026, unless otherwise indicated in the instructions. Certain report forms also require reporting of data collected throughout the previous measurement year, as described in Rule 1300.67.2.2 and incorporated report form instructions.

D. Stakeholder Review and Frequently Asked Questions

The proposed amendments to Rules 1300.51, 1300.52, 1300.52.4, 1300.67.2.2 and incorporated documents were circulated to stakeholders for feedback on April 25, 2025. The final amendments noticed in this APL reflect stakeholder input. The DMHC has prepared responses to frequently asked questions (FAQ) pertinent to the amendments noticed in this APL. FAQ responses are attached to this APL.

II. Amendments Impacting Network Licensure Filing Requirements

The amendments to network definitions in Rule 1300.67.2.2 noticed via this APL impact all network filings.[8] Updates to network definitions in Rule 1300.67.2.2(b) are incorporated in the network adequacy requirements set forth in Rule 1300.67.2.

Additionally, amendments to Rules 1300.67.2.2, 1300.51, 1300.52 and 1300.52.4 allow the DMHC to require health plans to use the report form templates and instructions for new and ongoing licensure filings. The Annual Network Report Forms are amended for uniformity across programs and for use in network filings, including material modification filings and ten percent change filings submitted through the eFiling portal.

Finally, the DMHC has revised the definitions set forth in Rule 1300.67.2.2 to recognize “combination networks,” which are a modification of the existing definition of “network” to accommodate an industry practice of offering variations in the ancillary networks available to purchasers in connection with an established set of medical, surgical, and mental health providers. To operate a combination network, or if the health plan has identified a current network in operation that would qualify as a combination network, a health plan must file a Notice of Material Modification identifying the affected network and receive an Order of Approval under Section 1352 and Rule 1300.52.4. The health plan will be required to complete the Combination Network Report Form as part of the request for approval, as well as in subsequent annual filings with the DMHC. An existing approved network can continue to operate while a request to convert the network into a combination network is under review. For further information regarding combination

[8] As part of new and ongoing licensure filings, health plans are required to submit all networks to the DMHC for approval and subsequent reviews pursuant to sections 1351 and 1352 and the regulations promulgated thereunder.

networks, please refer to the Frequently Asked Questions (FAQ) Response document attached to this APL.

III. Amendments to Rule 1300.67.2.2 Impacting Annual Network Reporting

By way of this APL, the DMHC provides notice of amendments to Rule 1300.67.2.2 impacting the RY 2026 Annual Network Report submission. The attached amendments to Rule 1300.67.2.2 also include changes impacting the Timely Access Compliance Report. See APL 25-014 for a description of those changes.

The DMHC also amended the incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for RY 2026, per Rule 1300.67.2.2, subsections (h)(7) and (h)(8). The Annual Network Submission Instruction Manual contains required network reporting instructions for health plans to submit an Annual Network Report or complete the network access profile.

Attached to this APL are the DMHC's noticed amendments to Rule 1300.67.2.2 impacting annual network reporting, which include the key changes identified below:

A. Network Definitions

The DMHC added new definitions to Rule 1300.67.2.2, updated existing definitions, and relocated definitions into the Rule that were previously in the Annual Network Submission Instruction Manual. These definitions apply to all provisions in Rule 1300.67.2.2, and to those Rules in which they are incorporated, including Rule 1300.67.2. They must be applied in reference to network adequacy and monitoring requirements set forth in those rules.

1. Network *(updated)*
    - Combination network *(new definition)*
    - Core network *(new definition)*
    - Component network *(new definition)*
2. Network adequacy *(updated)*
3. Network capture date *(updated)*
4. Network provider *(updated)*
5. Network service area *(updated)*
6. Plan-to-plan contract *(updated)*
7. Accepting new patients *(updated)*
8. Limited plan provider *(updated)*

9. Practice address *(updated)*
    - Primary practice address *(new definition)*
    - Secondary practice address *(new definition)*
10. Unscheduled urgent services *(updated)*
11. Urgent care services or urgent care clinic *(relocated and updated)*
    - Telehealth urgent care center *(relocated and updated)*
12. Telehealth network provider *(new definition)*

The **"Provider Type Definitions - Comparison Table**" attached to this APL is provided as a courtesy to health plans, and describes differences between the definitions for Network Provider, Telehealth Network Provider, Limited Plan Provider, and Third-Party Corporate Telehealth Provider. The DMHC invites health plans to review the Table for a "side-by-side" comparison of these provider types.

B. Reporting Requirements

Rule 1300.67.2.2(h)(7) contains updated Annual Network Reporting requirements. Amendments include updates to the type of data to be reported, as well as new and updated report forms incorporated by reference in the Rule. Subsequent sections of this APL further describe changes to reporting requirements depicted in the Annual Network Submission Instruction Manual.

C. Network Access Profile Reporting

Rule 1300.67.2.2(h)(8) contains updated network access profile reporting requirements, impacting both Reporting Plans and Profile-Only Plans, as defined in the Rule. Key updates within the network access profile include the following requirements:

1. Whether the network had enrollment as of the capture date of January 15th of the reporting year;
2. Whether the health plan submitted a 10 percent change filing for the network since the last submission; and
3. The name of the marketed product or product names using the network.

Please refer to updated language in the "Network Access Profile Requirements" section I.C. of the Annual Network Submission Instruction Manual for further details concerning changes to the Network Access Profile reporting.

D. Non-Compliance Findings, Corrective Action, and Enforcement Action

Rules 1300.67.2.2(i), (j), and (k) include amendments clarifying non-compliance determinations for network adequacy reviews. These subsections also include

requirements that health plans timely respond to the DMHC's network adequacy findings and clarify processes for corrective action and the enforcement of the DMHC's non-compliance findings.

IV. Amendments to the Annual Network Submission Instruction Manual

Attached to this APL is the DMHC's noticed Annual Network Submission Instruction Manual (Instruction Manual) for RY 2026 and beyond, for incorporation by reference in Rule 1300.67.2.2(h). The Instruction Manual contains required reporting instructions and definitions for the Annual Network Report submission. It is revised to accommodate new and existing law.

The Instruction Manual updates include revisions to definitions, general instructions, and the field instructions specific to each of the Annual Network Report Forms. A copy of the Instruction Manual will also be available in the Timely Access and Annual Network Reporting Web Portal. Updates to the general instructions clarify the Annual Network Reporting requirements, including updates to Network Access Profile Requirements, Section I.C; Reporting with Standardized Terminology, Section II.C; and Instructions Applicable Only to Reporting Combination Networks, Section III. Below is an overview of the most significant changes:

A. Instruction Manual Definitions

The definitions in Rule 1300.67.2.2 continue to apply to the Annual Network Report submissions and also apply to network adequacy monitoring and the annual network review. Additional definitions within the Instruction Manual have been updated for Annual Network Reporting and Review. The DMHC added or amended the following key reporting definitions in the Definitions section of this Instruction Manual:

1. Particularized hospital services *(updated definition)*
2. Patient location for telehealth providers *(moved)*
3. Residential detox facility *(added)*

B. Key Standardized Terminology Updates

The DMHC has updated standardized terminology within the Appendices of the Instruction Manual, in response to statutory and regulatory requirements. Health plans are expected to update their Annual Network Report submissions in accordance with the updated standardized terms. Health plans are required to report these provider types on the appropriate report form and according to standardized terminology.[9] The

[9] Rule 1300.67.2.2(h)(8)(D).

DMHC will update crosswalk tables within the Timely Access and Annual Network Reporting Web Portal accordingly.

A new standardized terminology table has been added to Appendix B, entitled “Provider Type Category” table. This table will allow health plans to crosswalk provider type category terms for reporting, rather than separately entering these terms in required fields. Additionally, the DMHC added standardized terminology to Appendix B (Provider Types) and Appendix D (Type of License and Certificate) of the Instruction Manual.

V. Amendments to Annual Network Report Forms

Attached to this APL are the noticed updates to Annual Network Report Forms incorporated in Rule 1300.67.2.2(h)(7). The amended report forms for RY 2026 hereby replace the RY 2025 forms previously incorporated in Rule 1300.67.2.2. All fillable Annual Network Report Form templates for RY 2026 and instructions will be available to health plans in the Resources section of the Timely Access and Annual Network Reporting Web Portal (web portal), in accordance with Rule 1300.67.2.2(h)(2) and Section I.B. of the Annual Network Submission Instruction Manual. Report forms provided by the DMHC within the web portal are the only allowable format for a health plan to submit required data for the Annual Network Report.

Refer to Section V. of the of the Annual Network Submission Instruction Manual for the report form field instructions applicable to annual network reporting starting in RY 2026. Amendments to report forms and report form instructions impact the RY 2026 reporting year and subsequent reporting years. Health plans are required to familiarize themselves with the changes in advance of the reporting year. Below is an overview of major changes to report form instructions.

A. New Report Form for Combination Networks

The amendments include a new report form, applicable only to health plans approved by the DMHC to operate a combination network, as defined in Rule 1300.67.2.2(b). In addition to all other required Annual Network Report Forms, health plans operating Combination Networks must complete the Combination Network Report Form (Form No. 40-289), as follows:

1. Combination Network Matrix Report Tab - captures the health plan’s approved core networks and the component networks with which they are combined; and
2. Component Network Enrollment Report Tab - captures enrollment pertaining to component networks.

Section III. of the Instruction Manual provides detailed background on the new required Combination Network Report Form for approved Combination Networks. For Combination Network Report Form instructions, please refer to Section V.L of the Manual.

B. Key Updates to Existing Annual Network Report Form Instructions

The amendments also include updates to existing Annual Network Report Forms. Key updates to existing report forms include the following:

1. Updated Practice Address Reporting:

Practice address reporting requirements are updated within the Annual Network Report Forms, in alignment with updated primary and secondary practice address definitions in Rule 1300.67.2.2(b). A new reporting field has been added for health plans to identify the provider's primary practice address, and any secondary practice addresses. Health plans may only report one primary practice address for the provider. All remaining practice addresses must be reported as secondary practice addresses.

2. Updated Clinical Encounter Data Capture Reporting:

New fields are included in the Annual Network Report Forms to capture clinical encounter data for additional network provider types. Additionally, a new required report tab is included in the Non-Network Provider Arrangements Report Form, entitled the "Past Network Provider Clinical Encounters Report Tab." Health plans must report relevant clinical encounter data for certain network providers who left the network prior to the RY 2026 network capture date of January 15, 2026.

The DMHC may elect not to require clinical encounter data for certain provider types to be reported each reporting year. See the "Elective Reporting and Notice to Health Plans" section below for information as to how health plans will be notified of any change in the status of these fields.

3. Updated Telehealth Reporting:

New fields are included in the Annual Network Report Forms to allow health plans to report telehealth network providers within each of the provider type report forms. Previously, network providers that offered services exclusively via telehealth modalities were reported within the Telehealth Report Form (Form No. 40-271). For RY 2026, health plans are not required to submit a Telehealth Report Form, and instead must submit all required telehealth data within each of the Annual Network Report Forms. See the "Elective Reporting and Notice to Health Plans" section below for information as to how health plans will be notified of any change in the status of the Telehealth Report Form. Third-party corporate telehealth providers must still be reported within the Third-Party Corporate Telehealth Provider Report Form.

4. Updated HCAI ID Reporting:

Previously, only the Hospital and Clinic Report Form included an "HCAI ID" field. As part of the RY 2026 amendments, the "HCAI ID" field is included in additional Annual Network Report Forms, to capture the unique Health Care Access and Information (HCAI) facility identifier of the facilities the health plan reports to the DMHC, or the facilities where the reported network provider practices.

5. Updated Particularized Hospital Services Reporting:

A “Contracted Hospital Services” field and an “Available Services” field is included within the Hospital tab of the Hospital and Clinic Report Form (Form No. 270). These fields seek information regarding whether a health plan is contracted for all hospital services that a reported general acute care hospital offers. If not, the health plan will be required to list the particularized hospital services the health plan makes available at the facility.

6. Updated Fields for Network Filings:

Fields are added to the Annual Network Report Forms to accommodate the use of the form for network filings submitted through the eFiling web portal, and for standardization across programs. This includes fields such as “Provider Participation Status,” “Hospital Accreditation,” and “Available Bed Occupancy Rate” among others.

7. Elective Reporting and Notice to Health Plans:

The DMHC may elect not to require health plans to complete certain new fields for the reporting year for the annual network review submission. The DMHC will provide health plans with notice of changes to data reporting requirements in advance of the reporting year.

VI. Implementation of Network Definitions and Reporting Methodology

Health plans are required to ensure health plan operations comply with the amendments to Rules noticed in this APL and attached documents.[10] To the extent health plans must revise existing policies and procedures on file with the DMHC to bring them into compliance with the new requirements set forth in Rules 1300.51, 1300.52, 1300.52.4, 1300.67.2.2, and the incorporated Annual Network Submission Instruction Manual and Report Forms, health plans must amend all relevant documents on file with the DMHC, pursuant to Section 1352 of the Knox-Keene Act, and Rules 1300.52 and 1300.52.4. Documents on file with the DMHC that the health plan may need to amend include Annual Network Data Collection Policies and Procedures (Exhibit J-19) and Standards of Accessibility (Exhibit I-5-a). Health plans should also review and update all relevant internal policies, procedures, or other documents to ensure compliance.

The DMHC will make available resources to assist health plans in evaluating their policies and procedures for compliance with the current requirements set forth in the Rules and incorporated documents referenced in this APL, prior to the end of 2025. Pursuant to DMHC’s APL 22-026 (November 4, 2022), health plans were previously required to update documents on file with the DMHC to reflect changes to the law enacted in 2022. Since that time, there have been significant amendments to Rule 1300.67.2.2 and the Annual Network Submission Instruction Manual that may impact a health plan’s policies and procedures on file with the DMHC. Health plans should review internal documents and make any updates needed to ensure they comply with regulatory changes.

[10] Rule 1300.67.2.2(h)(5).

Attachments:

Amendments are noticed with edits in underline and strikethrough format:

1. Amendments to Rules 1300.51, 1300.52, and 1300.52.4 – With edits
2. Amendments to Rule 1300.67.2.2 – With edits
3. Annual Network Submission Instruction Manual – Notice of Changes for RY 2026 – With edits
4. Annual Network Submission Instruction Manual – Notice of Changes for RY 2026 – Clean
5. Annual Network Report Forms - Notice of Changes for RY 2026 (With edits):
    - Network Service Area and Enrollment Report Form (Form No. 40-265)
    - PCP and PCP Non-Physician Medical Practitioner Report Form (Form No. 40-266)
    - Specialist and Specialist Non-Physician Medical Practitioner Report Form (Form No. 40-267)
    - Mental Health Professional and Mental Health Facility Report Form (Form No. 40-268)
    - Other Outpatient Provider Report Form (Form No. 40-269)
    - Hospital and Clinic Report Form (Form No. 40-270)
    - Telehealth Report Form (Form No. 40-271)
    - Timely Access and Network Adequacy Grievance Report Form (Form No. 40-272)
    - Out-of-Network Payment Report Form (Form No. 40-273)
    - Third-Party Corporate Telehealth Provider Report Form (Form No. 40-274)
    - Non-Network Arrangements Report Form (Form No. 40-287)
    - Combination Network Report Form (Form No. 40-289)
6. Frequently Asked Questions for Regulatory Amendments Impacting the RY 2026 Annual Network Report Submission
7. Provider Type Definitions – Comparison Table

If you have any questions about this APL or the changes in the incorporated documents, please contact the Office of Plan Monitoring at ANRTeam@dmhc.ca.gov.