§ 1300.65.1. Cancellations, Rescissions, or Nonrenewals for Reasons Other than Nonpayment of Premiums.

(a) General Requirements

(1) Applicability. This section shall apply to all cancellations for reasons other than for nonpayment of premiums.

(2) The plan shall send a Notice of Cancellation, Rescission, or Nonrenewal for all cancellations other than cancellations due to the nonpayment of premium. At a minimum, this Notice shall contain the information set forth in California Code of Regulations, title 28, section 1300.65.1(b)(1). The Notice of Cancellation, Rescission, or Nonrenewal shall be sent to the enrollee, subscriber, or group contract holder:

(A) At least 30 days before the cancellation, rescission, or nonrenewal for fraud or intentional misrepresentation of material fact pursuant to Health and Safety Code sections 1365(a)(2) or 1389.21, subject to limitations imposed by Health and Safety Code section 1389.21.

(B) At least 30 days before the cancellation, rescission, or nonrenewal for a cancellation or nonrenewal pursuant to Health and Safety Code sections 1365(a)(3), (4) or (7).

(C) At least 180 days before the discontinuation or termination of a contract if the cancellation or nonrenewal is due to the plan ceasing to provide or arrange for the provision of health benefits for new plan contracts in the individual or group market in this state pursuant to Health and Safety Code section 1365(a)(5). A notice sent pursuant to this subdivision shall also be sent concurrently to the Director.

(D) At least 90 days before the withdrawal of a health benefit plan from the market pursuant to Health and Safety Code section 1365(a)(6). A notice sent pursuant to this subdivision shall also be sent concurrently to the Director.

(3) The plan shall send a Notice of Cancellation, Rescission, or Nonrenewal to each subscriber in a group contract unless:

(A) The plan contract requires the group contract holder to promptly send any such Notice to each subscriber; and

(B) The plan sends the Notice to the group contract holder designated in the plan contract.

(4) The plan shall send a Notice of End of Coverage for all cancellations. This Notice shall be sent to the enrollee, subscriber, or group contract holder after the date coverage ended, and no later than five (5) calendar days after the date coverage ended. At a minimum, this Notice shall contain the information set forth in California Code of Regulations, title 28, section 1300.65.1(b)(2).

(5) When required pursuant to Health and Safety Code section 1373.96(m), notice as to the availability of the right to request completion of covered services shall be part of, accompany, or be sent simultaneously with both the Notice of Cancellation, Rescission, or Nonrenewal and the Notice of End of Coverage.

(b) Elements of Notices:

(1) Notice of Cancellation, Rescission, or Nonrenewal

The Notice of Cancellation, Rescission, or Nonrenewal shall comply with all applicable federal and state requirements, and shall include all of the following:

(A) The title "Notice of Cancellation, Rescission, or Nonrenewal" displayed in 20-point bolded font at the top of the first page of the notice;

(B) The name and contact information for the enrollee, subscriber, or group contract holder;

(C) For all contracts issued in the individual market, the names of all enrollees affected by the notice;

(D) The date of the notice;

(E) Reason for the cancellation, rescission, or nonrenewal;

(F) Effective date of the cancellation, rescission, or nonrenewal, expressed as a month, day and year;

(G) The notice of grievance rights in accordance with Health and Safety Code section 1365(b) as set forth in California Code of Regulations, title 28, section 1300.65.5; and

(H) Any notice required under Health and Safety Code section 1366.50.

(2) Notice of End of Coverage

The Notice of End of Coverage shall comply with all applicable federal and state requirements, and shall include all of the following:

(A) The title "Notice of End of Coverage" displayed in 20-point bolded font at the top of the first page of the notice;

(B) The name and contact information for the enrollee, subscriber, or group contract holder;

(C) For all contracts issued in the individual market, the names of all enrollees affected by the notice;

(D) The date of the notice;

(E) The effective date of cancellation, rescission, or nonrenewal, expressed as a month, day and year;

(F) The reason for cancellation, rescission, or nonrenewal;

(G) The notice of grievance rights in accordance with Health and Safety Code section 1365(b) as set forth in California Code of Regulations, title 28, section 1300.65.5;

(H) Any notice required under Health and Safety Code section 1366.50; and

(I) The following statement: "To learn about new coverage or whether your coverage can be reinstated, contact [health plan] at [contact information]."

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1365, 1366.50, 1373.96 and 1389.21, Health and Safety Code.

HISTORY:

1. Amendment of subsection (a) filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
2. Change without regulatory effect amending form filed 5-24-99 pursuant to section 100, title 1, California Code of Regulations (Register 99, No. 22).
3. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
4. Change without regulatory effect amending subsection (a) filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).
5. Amendment filed 12-22-2014; operative 1-1-2015 pursuant to Government Code section 11343.4(b)(3) (Register 2014, No. 52).
6. Repealer and new section filed 7-30-2019; operative 10-1-2019 (Register 2019, No. 31).

§ 1300.65.2. Cancellations or Nonrenewals for Nonpayment of Premiums.

(a) General Requirements

(1) Applicability. This section shall apply to all cancellations and nonrenewals for nonpayment of premiums pursuant to Health and Safety Code section 1365(a)(1)(A), unless an enrollee, subscriber, or group contract holder is entitled to a longer grace period pursuant to state or federal law.

(2) Grace Period

(A) The grace period may not begin sooner than the day after the last date of paid coverage. Grace period is defined in California Code of Regulations, title 28, section 1300.65(a)(9).

(B) A plan shall provide coverage pursuant to the terms of the contract during the entire grace period. The term "Grace Period" does not include the "Federal Grace Period," as defined in California Code of Regulations, title 28, section 1300.65(a)(8), which applies to individuals receiving APTC pursuant to the PPACA, section 1401 (26 U.S.C. § 36B).

(3) Notices

(A) Upon determining that an enrollee, subscriber, or group contract holder has failed to make a premium payment by the due date, the plan shall send a Notice of Start of Grace Period to the enrollee, subscriber, or group contract holder, notifying the recipient that a payment delinquency has triggered a grace period starting from the day the Notice of Start of Grace Period is dated. This Notice shall, at minimum, contain the information set forth in California Code of Regulations, title 28, section 1300.65.2(b)(1).

(B) The plan shall send a Notice of Start of Grace Period to each subscriber in a group contract unless:

(i) The plan contract requires the group contract holder to promptly send any such Notice to each subscriber; and

(ii) The plan sends the Notice to the group contract holder designated in the plan contract.

(C) A plan shall not delegate the responsibility for sending the Notice of Start of Grace Period to a group contract holder for each subscriber in the group unless the plan has complied with California Code of Regulations, title 28, section 1300.65.2(a)(3)(B).

(D) In the case where a plan has delegated the responsibility for sending the Notice of Start of Grace Period to a group contract holder, the Notice of Start of Grace Period to the group contract holder triggers the 30-day grace period. Any subsequent notice to the subscribers in the group does not restart the 30-day grace period.

(E) For the purposes of this section, all plans shall notify an enrollee, subscriber, or group contract holder when the plan has cancelled, rescinded, or not renewed health coverage in one of the following two ways:

(i) Send a written notice of termination to the enrollee, subscriber, or group contract holder, when required pursuant to California Code of Regulations, title 10, section 6506(e)(1). This notice shall include the notice of grievance rights set forth in California Code of Regulations, title 28, section 1300.65.5, and any notice required under Health and Safety Code section 1366.50; or

(ii) Send the Notice of End of Coverage. This Notice shall be sent after the date coverage ends, and no later than five calendar days after the date coverage ended. At a minimum, this Notice shall contain the information set forth in California Code of Regulations, title 28, section 1300.65.2(b)(2).

(4) Notwithstanding California Code of Regulations, title 28, section 1300.65(a)(14), a plan may implement a premium payment threshold policy, as defined in California Code of Regulations, title 28, section 1300.65(a)(21).

(5) In the event the plan, after compliance with all timing and notice requirements of this section, fails to receive all outstanding premium amounts from the enrollee, subscriber, or group contract holder on or before the last day of the grace period, as specified in the Notice of Start of Grace Period, coverage may be cancelled prospectively only after the expiration of the entire grace period.

(6) The plan shall continue the enrollee, subscriber, and/or group contract holder's coverage uninterrupted pursuant to the plan contract upon payment of all outstanding premium amounts at any time before the expiration of the grace period.

(7) The enrollee, subscriber, or group contract holder is financially responsible for any and all premiums and any copayments, coinsurance, or deductible amounts obligated under the plan contract, including those incurred for services received during the grace period.

(b) Elements of Notices

(1) Notice of Start of Grace Period

The Notice of Start of Grace Period shall comply with all applicable federal and state requirements, and shall include all of the following:

(A) The title "Notice of Start of Grace Period" displayed in 20-point bolded font at the top of the first page of the notice;

(B) The name and contact information for the enrollee, subscriber, or group contract holder;

(C) For all contracts issued in the individual market, the names of all enrollees affected by the notice;

(D) The date of the notice, expressed as a month, day and year;

(E) A statement indicating the specific date the grace period begins;

(F) The dollar amount past due. This amount shall indicate the amounts owed by month if more than one month is past due;

(G) The date of the last day of paid coverage, expressed as a month, day and year;

(H) The name of the plan;

(I) An explanation of the grace period and the specific date the grace period expires, expressed as a month, day and year;

(J) The telephone number for the plan's customer service; and

(K) A statement explaining the consequence of losing coverage, including, financial responsibility for the payment of claims incurred and the obligations of the subscriber.

(2) Notice of End of Coverage

The Notice of End of Coverage shall comply with all applicable federal and state requirements, and shall include all of the following:

(A) The title "Notice of End of Coverage" displayed in 20-point bolded font at the top of the first page of the notice;

(B) The name and contact information for the enrollee, subscriber, or group contract holder;

(C) For all contracts issued in the individual market, the names of all enrollees affected by the notice;

(D) The date of the notice;

(E) The effective date of cancellation, expressed as a month, day and year;

(F) The reason for cancellation;

(G) The notice of grievance rights in accordance with Health and Safety Code section 1365(b) and California Code of Regulations, title 28, section 1300.65.5;

(H) Any notice required under Health and Safety Code section 1366.50; and

(I) The following statement: "To learn about new coverage or whether your coverage can be reinstated, contact [health plan] at [contact information]."

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1365 and 1366.50, Health and Safety Code.

HISTORY:

1. New section filed 12-22-2014; operative 1-1-2015 pursuant to Government Code section 11343.4(b)(3) (Register 2014, No. 52).
2. Repealer and new section filed 7-30-2019; operative 10-1-2019 (Register 2019, No. 31).

§ 1300.65.3. Cancellations or Nonrenewals for Nonpayment of Premiums: APTC Enrollee.

(a) General Requirements

(1) Applicability. This section shall apply to all cancellations and nonrenewals for nonpayment of premiums for an enrollee who is receiving the APTC through the PPACA, section 1401 (26 U.S.C. § 36B), pursuant to Health and Safety Code section 1365(a)(1)(A).

(2) Federal Grace Period

(A) To qualify for the federal grace period, as defined in California Code of Regulations, title 28, section 1300.65(a)(8), an APTC enrollee shall have paid at least one full month's premium before the nonpayment of premiums.

(B) The federal grace period begins the first day after the last day of paid coverage and lasts for three full consecutive months.

(C) Notwithstanding California Code of Regulations, title 28, section 1300.65(a)(14), a QHP Issuer may implement a premium payment threshold policy, as defined in California Code of Regulations, title 28, section 1300.65(a)(21).

(D) Upon determining that an APTC enrollee has failed to make a premium payment by the due date, the QHP Issuer shall send a "Notice of Start of Federal Grace Period" to the APTC enrollee, notifying the recipient that a payment delinquency has triggered a 3-month federal grace period starting from the first day after the last day of paid coverage.

(E) The Notice of Start of Federal Grace Period sent to the APTC enrollee shall not be mailed or dated on or before the premium due date for which the APTC enrollee is receiving the Notice. The Notice of Start of Federal Grace Period must be sent on or before the fifth (5th) business day after the start of the federal grace period. However, in the event a QHP Issuer learns of a payment delinquency between the last day of paid coverage and the fifteenth (15th) day of the first month of the federal grace period, due to the discovery of insufficient funds, a rejected credit card payment, or a similar event, the QHP Issuer shall send the Notice of Start of Federal Grace Period within five (5) calendar days of learning of the payment delinquency. A Suspension QHP Issuer that fails to send the Notice of Start of Federal Grace Period by the applicable deadline(s) shall not suspend the APTC enrollee's coverage during the second and third months of the federal grace period.

(3) Suspension of Coverage

(A) Suspension of coverage during months two and three of the federal grace period is optional for the plan.

(B) A Non-Suspension QHP Issuer shall not take or threaten action that causes or suggests that the APTC enrollee's coverage may be suspended. A Non-Suspension QHP Issuer shall:

(i) Provide its APTC enrollees with the 3-month federal grace period,

(ii) Provide coverage to the APTC enrollee as required by the plan contract during the 3-month federal grace period,

(iii) Pay all claims for covered health care services rendered during the 3-month federal grace period, notwithstanding California Code of Regulations, title 28, section 1300.65.3(a)(5)(A), and

(iv) Not hold an APTC enrollee financially responsible for the costs of claims for covered health care services rendered during the 3-month federal grace period, even if cancellation occurs for nonpayment of premium. An APTC enrollee remains responsible for payment of outstanding premiums and any applicable deductibles, copayments, and coinsurance, pursuant to the APTC enrollee's Evidence of Coverage, accrued during the 3-month federal grace period, even if cancellation occurs for nonpayment of premium.

(C) To suspend an enrollee during months two and three of the federal grace period, a Suspension QHP Issuer shall:

(i) Comply with any and all notice requirements to the enrollee related to suspension of coverage;

(ii) Make any necessary system adjustments by day 1 of the second month of the federal grace period to the QHP Issuer's real time eligibility and verification system to accurately reflect the APTC enrollee's suspension of coverage; and

(iii) Reinstate the APTC enrollee, retroactive to the last day of the first month, if the APTC enrollee pays all outstanding premium amounts before the end of the federal grace period.

(D) During the first month of the federal grace period, the Suspension QHP Issuer shall:

(i) Provide coverage to the APTC enrollee as required by the plan contract; and

(ii) If the APTC enrollee does not pay outstanding premium amounts by day 15 of the first month of the federal grace period, the Suspension QHP Issuer shall send a Notice of Suspension to the APTC enrollee, and shall send a separate Notice of Suspension to providers. Both notices shall be sent no earlier than day 16 of the first month of the federal grace period but no later than the end of the first month of the federal grace period.

(E) During months two and three of the federal grace period, the Suspension QHP Issuer shall:

(i) Suspend or pend claims for services rendered to the APTC enrollee; and

(ii) Make any necessary system adjustments by day 1 of the second month of the federal grace period to the Suspension QHP Issuer's real time eligibility and verification system to accurately reflect the APTC enrollee's suspension of coverage. For the purposes of this subdivision, the QHP Issuer shall use only the terms "coverage pending," "coverage suspended," or "inactive pending investigation" so as to clearly communicate the status of the APTC enrollee.

(F) During the suspension of coverage, the APTC enrollee:

(i) Remains responsible for making all delinquent and ongoing premium payments; and

(ii) May submit a grievance pursuant to Health and Safety Code section 1365(b).

(G) The Notice of Suspension shall be given to the APTC enrollee's assigned group, assigned network provider, any provider with an outstanding prior authorization to provide services to the APTC enrollee, and any network provider that submitted claims for the APTC enrollee in the two months prior to the start of the APTC enrollee's federal grace period.

(i) This notice requirement is in addition to the provider's ability to verify APTC enrollee eligibility for coverage with the QHP Issuer.

(ii) This notice requirement does not replace a provider's responsibility to verify eligibility for coverage of an APTC enrollee with the QHP Issuer before providing health care services.

(iii) In the event the Suspension QHP Issuer does not provide the notice to the APTC enrollee's providers or does not update its real time eligibility and verification system by day 1 of the second month of the federal grace period, and providers provide health care services to the APTC enrollee, the Suspension QHP Issuer shall be responsible for paying the claim costs of the APTC enrollee that would have been covered under the plan contract notwithstanding the Suspension of Coverage.

(4) Reinstatement of Coverage

(A) In the event that an APTC enrollee does not pay all outstanding premium amounts before the next premium due date, the QHP Issuer shall bill the APTC enrollee in the same form and manner of billing as if the APTC enrollee were not in the federal grace period, and include in the billing statement the total premium amounts owing at the end of the billing cycle.

(B) Upon payment of all outstanding premium amounts at any time before the expiration of the federal grace period, the QHP Issuer shall reinstate the APTC enrollee's coverage pursuant to the plan contract and immediately update its real time eligibility and verification system to reflect an "active" status.

(C) If an APTC enrollee with coverage through a Suspension QHP Issuer pays all outstanding premium amounts before the end of the federal grace period, the Suspension QHP Issuer shall be liable for the claims covered under the APTC enrollee's Evidence of Coverage less any applicable deductibles, copayments, or coinsurance, from the date of suspension of coverage through the date of reinstatement. The Suspension QHP Issuer shall reimburse the APTC enrollee for any medical expenses incurred pursuant to this subdivision within 30 days of receipt of the complete claim, as defined in California Code of Regulations, title 28, section 1300.71(a)(2).

(5) Cancellation or Nonrenewal Following Federal Grace Period

If the APTC enrollee fails to pay outstanding premium amounts on or before the last day of the federal grace period, the QHP Issuer shall cancel or not renew the APTC enrollee's health care coverage.

(A) The effective date of cancellation for an APTC enrollee canceled or not renewed by a Suspension QHP Issuer or by a Non-Suspension QHP Issuer shall be the day after the last day of the first month of the 3-month federal grace period pursuant to 45 Code of Federal Regulations part 155.430(d)(4).

(B) For the purposes of this section, all plans shall notify an enrollee, subscriber, or group contract holder when the plan has cancelled, rescinded, or not renewed health coverage in one of the following two ways:

(i) Send a written notice of termination to the enrollee, subscriber, or group contract holder, when required pursuant to California Code of Regulations, title 10, section 6506(e)(1). This notice shall include the notice of grievance rights set forth in California Code of Regulations, title 28, section 1300.65.5, and any notice required under Health and Safety Code section 1366.50, or

(ii) Send the Notice of End of Coverage. This Notice shall be sent after the date coverage ends, and no later than five calendar days after the date coverage ended. At a minimum, this Notice shall contain the information set forth in California Code of Regulations, title 28, section 1300.65.3(b)(4).

(b) Notice Requirements

(1) Notice of Start of Federal Grace Period to APTC Enrollee

The Notice of Start of Federal Grace Period to the APTC Enrollee shall comply with all applicable federal and state requirements, and shall include all of the following:

(A) The title "Notice of Start of Federal Grace Period" displayed in 20-point bolded font at the top of the notice;
(B) The name and contact information for the APTC enrollee;
(C) The names of all APTC enrollees affected by the notice;
(D) The date of the notice;
(E) The date of the first day of the federal grace period, expressed as a month, day and year;
(F) The dollar amount past due. This amount shall indicate the amounts owed by month if more than one month is past due;
(G) The date of the last day of paid coverage, expressed as a month, day and year;
(H) The name of the QHP Issuer;
(I) An explanation of the three-month federal grace period and the date the federal grace period expires;
(J) The telephone number for the QHP Issuer's customer service; and
(K) A statement explaining the consequence of losing coverage, including financial responsibility for the payment of claims incurred and the obligations of the subscriber.

(2) Notice of Suspension to APTC Enrollee

The Notice of Suspension to the APTC enrollee shall comply with all applicable federal and state requirements, and shall include all of the following:
(A) The title "Notice of Suspension" displayed in 20-point bolded font at the top of the first page of the notice;
(B) The name and contact information for the APTC enrollee;
(C) The names of all APTC enrollees affected by the notice;
(D) The date of the notice;
(E) A statement indicating the start date of the federal grace period;
(F) The dollar amount past due. This amount shall indicate the amounts owed by month if more than one month is past due;
(G) Date of the last day of paid coverage, expressed as a month, day and year;
(H) The name of the QHP Issuer;
(I) An explanation of the three-month federal grace period and the date the federal grace period expires;
(J) An explanation of the suspension of coverage during the second and third months of the federal grace period and the start and end dates of the suspension of coverage;
(K) An explanation that the APTC enrollee must pay the total outstanding premium in order to exit the federal grace period and prevent coverage from ending;
(L) The telephone number for the QHP Issuer's customer service;
(M) Consequence of losing coverage, including financial responsibility for the payment of claims incurred and the obligations of the APTC enrollee; and
(N) The notice of grievance rights in accordance with Health and Safety Code section 1365(b) and California Code of Regulations, title 28, section 1300.65.5.

(3) Notice of Suspension to APTC Enrollee's Provider(s)

The Notice of Suspension to the APTC Enrollee's Provider(s) shall comply with all applicable federal and state requirements, and shall include all of the following:
(A) The title "Notice of Suspension to APTC Enrollee's Provider" displayed in 20-point bolded font at the top of the notice;
(B) The names of all APTC enrollees affected by the notice;
(C) The date of the notice;
(D) The name of the Suspension QHP Issuer for the APTC enrollee;

(E) An explanation of the suspension of coverage during the second and third months of the federal grace period, and the start and end dates of the suspension of coverage; and

(F) The Suspension QHP Issuer's customer service telephone number for providers.

(4) Notice of End of Coverage

The Notice of End of Coverage shall comply with all applicable federal and state requirements, and shall include all of the following:

(A) The title "Notice of End of Coverage" displayed in 20-point bolded font at the top of the notice;

(B) The name and contact information for the APTC enrollee;

(C) The names of all APTC enrollees affected by the notice;

(D) The date of the notice;

(E) The end of coverage effective date, expressed as a month, day and year;

(F) The reason for end of coverage;

(G) The notice of grievance rights in accordance with Health and Safety Code section 1365(b) and California Code of Regulations, title 28, section 1300.65.5;

(H) Any notice required under Health and Safety Code section 1366.50; and

(I) The following statement: "To learn about new coverage or whether your coverage can be reinstated, contact [health plan] at [contact information]."

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1365, Health and Safety Code; and Code of Federal Regulations, title 45, part 156.270.

HISTORY:

1. New section filed 7-30-2019; operative 10-1-2019 (Register 2019, No. 31).

§ 1300.65.4. Grievance Form for Cancellations, Rescissions, and Non-renewals of an Enrollment or Subscription.

(a) Grievances to the Director pursuant to Health and Safety Code section 1365(b) may be made electronically, verbally, or in writing signed by the enrollee, subscriber, or group contract holder (or their legal representative).

(b) An enrollee, subscriber, or group contract holder is not required to use a specific form to submit a written grievance to the Director pursuant to Health and Safety Code section 1365(b)(1). An enrollee, subscriber, or group contract holder may submit a written grievance using any form that, at a minimum, contains the information enumerated in California Code of Regulations, title 28, section 1300.65.4(d), and addressed to:

DEPARTMENT OF MANAGED HEALTH CARE
HELP CENTER
980 9TH STREET, SUITE 500
SACRAMENTO, CA 95814

(c) The plan shall make readily available to its members a form that, at a minimum, contains the information enumerated in California Code of Regulations, title 28, section 1300.65.4(d).

(d) An enrollee, subscriber, or group contract holder may submit a written grievance using a form that, at a minimum, contains fields for, or notice of, the following information:

(1) Full name of enrollee, subscriber, or group contract holder filing the grievance;

(2) Name and identification number(s) of all enrollees affected;

(3) Name of parent or guardian, if filing for minor child enrollee;

(4) Date of birth;

(5) Gender, as follows:

Gender: ☐ Male ☐ Female ☐ Other _____

(6) Mailing address;

(7) Daytime phone number;

(8) Evening phone number;

(9) Email address;

(10) Health plan name;

(11) Health plan membership number;

(12) Medical group name, if applicable;

(13) Employer, if applicable;

(14) Medi-Cal identification number, if applicable;

(15) Medicare or Medicare Advantage identification number, if applicable;

(16) Date enrollee received notice that coverage was or will end;

(17) Date enrollee filed a grievance with an entity other than the Department, if applicable;

(18) Copies of plan notice(s) and correspondence(s) received, if any;

(19) Copies of enrollee correspondence(s) sent, if any;

(20) Copies of proof of payment for the last paid coverage period;

(21) A Medical Release, if necessary, as follows:

MEDICAL RELEASE

I request that the Department of Managed Health Care (DMHC) make a decision about my problem with my plan. I request that the DMHC review my Cancellation of Health Coverage Grievance Form to determine if my grievance qualifies for the DMHC's Consumer Complaint process. I allow my providers, past and present, and my plan to release my medical records and information to review this issue. These records may include medical, mental health, substance abuse, HIV, diagnostic imaging reports, and other records related to my grievance. These records may also include non-medical records and any other information related to my grievance. I allow the DMHC to review these records and information and send them to my plan. My permission will end one year from the date below, except as allowed by law. For example, the law allows the DMHC to continue to use my information internally. I can end my permission sooner if I wish. All the information that I have provided on this sheet is true.

Enrollee, Legal Guardian, or Parent Signature: _____

Date: _____

Please see the instruction sheet for mailing or faxing information.

(22) An Authorized Assistant Form, if necessary, as follows:

AUTHORIZED ASSISTANT FORM

If you want to give another person permission to assist you with your grievance, complete Parts A and B below.

If you are a parent or legal guardian submitting this grievance for a child under the age of 18, you do not need to complete this form.

If you are filing this grievance for an enrollee who cannot complete this form because the enrollee is either incompetent or incapacitated, and you have legal authority to act for this enrollee, please complete Part B only. Also attach a copy of the power of attorney for health care decisions or other documents that say you can make decisions for the enrollee.

PART A: ENROLLEE

I allow the person named below in Part B to assist me in my grievance filed with the DMHC. I allow the DMHC staff to share information about my medical condition(s) and care with the person named below. This information may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information.

I understand that only information related to my grievance will be shared.

My approval of this assistance is voluntary and I have the right to end it. If I want to end it, I must do so in writing.

Enrollee Signature:_____ Date:_____

PART B: PERSON ASSISTING ENROLLEE

Name of Person Assisting (print): _____

Signature of Person Assisting: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Relationship to Enrollee: _____

Daytime Phone Number: _____

Evening Phone Number: _____

Email Address (if available): _____

My power of attorney for health care decisions or other legal document is attached: _____ (check if applicable)

(23) An Instruction Sheet, as follows:

GRIEVANCE/COMPLAINT FORM INSTRUCTION SHEET

If you have questions, call the Help Center at 1-888-466-2219 or TDD at 1-877-688-9891. This call is free.

How to File:

1. File online at www.HealthHelp.ca.gov. [This is the fastest way.]

   OR

   Fill out and sign the Cancellation of Health Care Coverage Grievance Form.

2. If you want someone to help you with your grievance, complete the Authorized Assistant Form.
3. Include documents requested on the Cancellation of Health Care Coverage Grievance Form, such as notices from your health plan, billing statements, and proof of payment.
4. If you are not submitting online, please mail or fax your form and any supporting documents to:

   DEPARTMENT OF MANAGED HEALTH CARE
   HELP CENTER
   980 9TH STREET, SUITE 500
   SACRAMENTO, CA 95814-2725
   FAX: 916-255-5241

What Happens Next?

The Help Center will send you a letter telling you if your grievance has been accepted. If your grievance is accepted, a decision about your issue will be made within 30 days. You will be notified in writing of the decision.

(24) The Information Practices Act of 1977 Notice, as follows:

INFORMATION PRACTICES ACT OF 1977 NOTICE

The Information Practices Act of 1977 (California Civil Code section 1798.17) requires the following notice.

- California's Knox-Keene Act gives the DMHC the authority to regulate health plans and investigate the grievances of health plan members.
- The DMHC's Help Center uses your personal information to investigate your problem with your health plan.
- You provide the DMHC this information voluntarily. You do not have to provide this information. However, if you do not, the DMHC may not be able to investigate your grievance.
- The DMHC may share your personal information, as needed, with the plan and providers to investigate your grievance.
- The DMHC may also share your information with other government agencies as required or allowed by law.
- You have a right to see your personal information. To do this, contact the DMHC Records Request Coordinator, DMHC, Office of Legal Services, 980 9th Street Suite 500, Sacramento CA 95814-2725, or call 916-322-6727.

(25) Explanation of reason for filing the grievance; and

(26) Signature of enrollee.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1365, Health and Safety Code.

HISTORY:

1. New section filed 7-30-2019; operative 10-1-2019 (Register 2019, No. 31).

§ 1300.65.5. Notice of Right of Enrollee to Submit a Grievance.

The following language regarding the right of an enrollee, subscriber, or group contract holder to submit a grievance to the Department of Managed Health Care must appear in at least 12-point font when required by a section in this Article:

RIGHT TO SUBMIT GRIEVANCE REGARDING CANCELLATION, RESCISSION, OR NONRENEWAL OF YOUR PLAN ENROLLMENT, SUBSCRIPTION, OR CONTRACT.

If you believe your health care coverage has been, or will be, improperly cancelled, rescinded, or not renewed, you have the right to file a grievance with the plan and/or the Department of Managed Health Care.

OPTION (1) — YOU MAY SUBMIT A GRIEVANCE TO YOUR PLAN.

- You may submit a grievance to [plan] by calling [plan phone number], online at [plan website], or by mailing your written grievance to [plan address].
- You may want to submit your grievance to [plan] first if you believe your cancellation, rescission, or nonrenewal is the result of a mistake. Grievances should be submitted as soon as possible.
- [Plan] will resolve your grievance or provide a pending status within three (3) calendar days. If you do not receive a response from the plan within three (3) calendar days, or if you are not satisfied in any way with the plan's response, you may submit a grievance to the Department of Managed Health Care as detailed under Option 2 below.

OPTION (2) — YOU MAY SUBMIT A GRIEVANCE DIRECTLY TO THE DEPARTMENT OF MANAGED HEALTH CARE.

- You may submit a grievance to the Department of Managed Health Care without first submitting it to the plan or after you have received the plan's decision on your grievance.
- You may submit a grievance to the Department of Managed Health Care online at:

  WWW.HEALTHHELP.CA.GOV
- You may submit a grievance to the Department of Managed Health Care by mailing your written grievance to:

  HELP CENTER
  DEPARTMENT OF MANAGED HEALTH CARE
  980 NINTH STREET, SUITE 500
  SACRAMENTO, CALIFORNIA 95814-2725
- You may contact the Department of Managed Health Care for more information on filing a grievance at:

  PHONE: 1-888-466-2219
  TDD: 1-877-688-9891
  FAX: 1-916-255-5241

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1365 and 1368, Health and Safety Code.

HISTORY:
1. New section filed 7-30-2019; operative 10-1-2019 (Register 2019, No. 31).

§ 1300.66. Deceptive Plan Names.

(a) A change of plan name is a "material modification" of the plan within the meaning of subdivision (b) of Section 1352 of the Act.

(b) A plan name will be considered deceptive if it suggests the quality of care furnished by the plan, or that full benefits are provided for health care or a specialized area of health care, or that the cost of benefits to members of the plan is lower than the cost of similar benefits purchased elsewhere, and in any such case the express or implied representation contained in the plan name is demonstrably untrue or is not supported by substantial evidence, at all times while such name is used by the plan. Nothing in this subsection limits or

restricts the Director from a determination that a plan or solicitor firm name is deceptive for reasons other than those stated herein.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1366, Health and Safety Code.

HISTORY:

1. Change without regulatory effect amending subsection (b) and adding Note filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

ARTICLE 7
Standards

Section

§ 1300.67. Scope of Basic Health Care Services.

The basic health care services required to be provided by a health care service plan to its enrollees shall include, where medically necessary, subject to any copayment, deductible, or limitation of which the Director may approve:

(a) Physician services, which shall be provided by physicians licensed to practice medicine or osteopathy in accordance with applicable California law. There shall also be provided consultation with and referral by physicians to other physicians.

(1) The plan may also include, when provided by the plan, consultation and referral (physician or, if permitted by law, patient initiated) to other health

professionals who are defined as dentists, nurses, podiatrists, optometrists, physician's assistants, clinical psychologists, social workers, pharmacists, nutritionists, occupational therapists, physical therapists and other professionals engaged in the delivery of health services who are licensed to practice, are certified, or practice under authority of the plan, a medical group, or individual practice association or other authority authorized by applicable California law.

(b) Inpatient hospital services, which shall mean short-term general hospital services, including room with customary furnishings and equipment, meals (including special diets as medically necessary), general nursing care, use of operating room and related facilities, intensive care unit and services, drugs, medications, biologicals, anesthesia and oxygen services, diagnostic laboratory and x-ray services, special duty nursing as medically necessary, physical therapy, respiratory therapy, administration of blood and blood products, and other diagnostic, therapeutic and rehabilitative services as appropriate, and coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early rehospitalization.

(c) Ambulatory care services, (outpatient hospital services) which shall include diagnostic and treatment services, physical therapy, speech therapy, occupational therapy services as appropriate, and those hospital services which can reasonably be provided on an ambulatory basis. Such services may be provided at a hospital, any other appropriate licensed facility, or any appropriate facility which is not required by law to be licensed, if the professionals delivering such services are licensed to practice, are certified, or practice under the authority of the plan, a medical group, or individual practice association or other authority authorized by applicable California law.

(d) Diagnostic laboratory services, diagnostic and therapeutic radiological services, and other diagnostic services, which shall include, but not be limited to, electrocardiography and electroencephalography.

(e) Home health services, which shall include, where medically appropriate, health services provided at the home of an enrollee as prescribed or directed by a physician or osteopath licensed to practice in California. Such home health services shall include diagnostic and treatment services which can reasonably be provided in the home, including nursing care, performed by a registered nurse, public health nurse, licensed vocational nurse or licensed home health aide.

(1) Home health services may also include such rehabilitation, physical, occupational or other therapy, as the physician shall determine to be medically appropriate.

(f) Preventive health services (including services for the detection of asymptomatic diseases), which shall include, under a physician's supervision,

(1) reasonable health appraisal examinations on a periodic basis;

(2) a variety of voluntary family planning services;

(3) prenatal care;

(4) vision and hearing testing for persons through age 16;

(5) immunizations for children in accordance with the recommendations of the American Academy of Pediatrics and immunizations for adults as recommended by the U.S. Public Health Service;

(6) venereal disease tests;

(7) cytology examinations on a reasonable periodic basis;

(8) effective health education services, including information regarding personal health behavior and health care, and recommendations regarding

the optimal use of health care services provided by the plan or health care organizations affiliated with the plan.

(g)(1) Emergency health care services which shall be available and accessible to enrollees on a twenty-four hour a day, seven days a week, basis within the health care service plan area. Emergency health care services shall include ambulance services for the area served by the plan to transport the enrollee to the nearest twenty-four hour emergency facility with physician coverage, designated by the Health Care Service Plan.

(2) Coverage and payment for out-of-area emergencies or urgently needed services involving enrollees shall be provided on a reimbursement or fee-for-service basis and instructions to enrollees must be clear regarding procedures to be followed in securing such services or benefits. Emergency services defined in section 1317.1 include active labor. "Urgently needed services" are those services necessary to prevent serious deterioration of the health of an enrollee, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the enrollee returns to the plan's service area. "Urgently needed services" includes maternity services necessary to prevent serious deterioration of the health of the enrollee or the enrollee's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee returns to the plan's service area.

(h) Hospice services as set forth in Section 1300.68.2.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1317.1, 1345 and 1367, Health and Safety Code.

HISTORY:

1. Amendment of subsection (c) filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
2. Change without regulatory effect amending introductory paragraph filed 12-22-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 51).
3. New subsection (h) filed 6-26-2001; operative 7-26-2001 (Register 2001, No. 26).
4. Redesignation and amendment of former subsection (g) as new subsections (g)(1)-(2) filed 9-16-2003; operative 10-16-2003 (Register 2003, No. 38).

§ 1300.67.003. State Medical Loss Ratio Annual Report.

(a) Every health care service plan ("health plan") required to submit the Federal Medical Loss Ratio ("MLR") Annual Reporting Form (CMS form-10418) to the federal Department of Health and Human Services ("DHHS") shall also file the MLR Annual Reporting Form with the Department of Managed Health Care ("Department").

(b) The MLR Annual Report Form shall be filed with the Department no later than July 31 of the year following the end of the MLR reporting year. The MLR reporting year is the calendar year during which health coverage is provided by a health plan. All terms used in the MLR Annual Reporting Form instructions will have the same meaning as used in 45 CFR Part 158, the Public Health Service Act (42 U.S.C. Sec. 300g-18), and Health and Safety Code section 1367.003.

(c) If a financial examination pursuant to Health and Safety Code section 1382 and Title 28 California Code of Regulations section 1300.82 is necessary to verify the health plan's representations in the MLR Annual Report, the Department shall give the health plan a 30-day prior notification of the commencement of the financial examination.

(d) The health plan shall have 30 days from the date of notification to electronically submit all requested records, books and papers authorized in Health and Safety Code section 1381(a) to the Department.

(e) The Director may extend the time for a health plan to comply with subsection (d) upon a finding of good cause.

NOTE: Authority Cited: Section 1344, Health and Safety Code. Reference: Sections 1367.003 and 1381, Health and Safety Code.

HISTORY:

1. New section filed 10-7-2013; operative 1-1-2014 (Register 2013, No. 41).

§ 1300.67.005. Essential Health Benefits.

(a) All health plans that offer individual and small group contracts subject to Health and Safety Code Section 1367.005 shall comply with the requirements of this section.

(b) In addition to any other requirements set forth in the Knox-Keene Health Care Service Plan Act of 1975 (hereinafter the "Act'), to demonstrate compliance with Health and Safety Code Section 1367.005 and this section, health plans shall electronically file through the Department's Efile application the Essential Health Benefits Filing Worksheet (EHB Filing Worksheet) no later than the date that qualified health plan product filings are required to be submitted, and thereafter as necessary for new or amended plan contracts.

(c) The EHB Filing Worksheet shall include:

(1) The benefits specified in Health and Safety Code Section 1367.005 and the federal Patient Protection and Affordable Care Act (PPACA) at section 1302(b) (42 U.S.C. §18022) and 45 Code of Federal Regulations (CFR) parts 156.100 and 156.115;

(2) Pursuant to Health and Safety Code Section 1367.005(a)(2)(A)(v), any "other health benefits" covered by the base-benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, in the first quarter of 2014, which are not otherwise required to be covered under the Act;

(3) Required benefits for pediatric vision and dental care, for individuals until at least the end of the month in which the enrollee turns 19 years of age, consistent with benefits described in Health and Safety Code Section 1367.005(a)(4) - (5); and

(4) Prescription drug benefits required by Health and Safety Code Section 1367.005(d) and 45 CFR part 156.122, including the plan's prescription drug list and/or formulary. The EHB Filing Worksheet shall include a certification that the plan's drug list meets or exceeds the prescription drug formulary requirements specified in 45 CFR part 156.122, subparagraph (a)(1).

(d) "Other health benefits" are essential health benefits and are required to be covered as follows:

(1) Acupuncture services that are typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain.

(2) Nonemergency ambulance and psychiatric transport services inside the service area if:

(A) The plan or plan-contracted physician determines the enrollee's condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide; and

(B) The use of other means of transportation would endanger the enrollee's health.

(C) These services must be covered only when the vehicle transports the enrollee to or from covered services.

(3) Chemical dependency services, which shall be in compliance with federal parity requirements set forth in the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), as follows:

(A) Inpatient detoxification – Hospitalization for medical management of withdrawal symptoms, including room and board, physician services, drugs, dependency recovery services, education, and counseling.

(B) Outpatient evaluation and treatment for chemical dependency:

(i) Day-treatment programs;

(ii) Intensive outpatient programs;

(iii) Individual and group chemical dependency counseling; and

(iv) Medical treatment for withdrawal symptoms.

(C) Transitional residential recovery services – Chemical dependency treatment in a nonmedical transitional residential recovery setting. This setting provides counseling and support services in a structured environment.

(D) Chemical dependency services exclusion - Services in a specialized facility for alcoholism, drug abuse, or drug addiction are not required to be covered except as otherwise specified above.

(4) Special contact lenses to treat aniridia (missing iris) or aphakia,(absence of the crystalline lens of the eye) as follows:

(A) Aniridia: Up to two medically necessary contact lenses per eye (including fitting and dispensing) in any 12-month period, whether provided by the plan during the current or a previous 12-month contract period.

(B) Aphakia: Up to six medically necessary aphakic contact lenses per eye (including fitting and dispensing) per calendar year for enrollees, whether provided by the plan under the current or a previous contract in the same calendar year.

(5) Durable medical equipment for home use.

(A) In addition to durable medical equipment otherwise required to be covered by the Act, the plan shall cover durable medical equipment for use in the enrollee's home (or another location used as the enrollee's home). Durable medical equipment for home use is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use in the home.

(B) The plan may limit coverage to the standard equipment or supplies that adequately meet the enrollee's medical needs. Coverage includes repair or replacement of covered equipment. The plan may decide whether to rent or purchase the equipment, and may select the vendor. The enrollee may be required to return the equipment to the plan or pay the fair market price of the equipment or any unused supplies when they are no longer medically necessary.

(C) The plan shall cover durable medical equipment for home use, substantially equal to the following:

(i) Standard curved handle or quad cane and replacement supplies

(ii) Standard or forearm crutches and replacement supplies

(iii) Dry pressure pad for a mattress

(iv) IV pole

(v) Enteral pump and supplies

(vi) Bone stimulator

(vii) Cervical traction (over door)

(viii) Phototherapy blankets for treatment of jaundice in newborns

(ix) Dialysis care equipment as follows:

a. The plan shall cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis.

b. The following dialysis care services are not required to be covered:

1. Comfort, convenience, or luxury equipment, supplies and features

2. Nonmedical items, such as generators or accessories to make home dialysis equipment portable for travel

(6) Mental Health Services in addition to services required under the Act, as follows:

(A) Mental Health Services for Mental Disorders Other than SMI and SED. In addition to the coverage required under Health and Safety Code sections 1374.72 and 1374.73, the plan shall cover any mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM IV). All coverage of mental health services must comply with federal mental health parity requirements, as set forth in the MHPAEA:

(B) The plan is not required to cover services for conditions the DSM IV identifies as something other than a "mental disorder," such as relational problems (e.g. couples counseling or family counseling).

(C) Outpatient mental health services. The plan shall cover the following services when provided by licensed health care professionals acting within the scope of their license:

(i) Individual and group mental health evaluation and treatment;

(ii) Psychological testing when necessary to evaluate a mental disorder; and

(iii) Outpatient services for the purpose of monitoring drug therapy.

(D) Inpatient psychiatric hospitalization. Coverage shall include room and board, drugs, and services of physicians and other providers who are licensed health care professionals acting within the scope of their license.

(E) Intensive psychiatric treatment programs as follows:

(i) Short-term hospital-based intensive outpatient care (partial hospitalization);

(ii) Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program;

(iii) Short-term treatment in a crisis residential program in a licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis; and

(iv) Psychiatric observation for an acute psychiatric crisis.

(7) Organ Donation Services for actual or potential living donors, in addition to transplant services of organs, tissue, or bone marrow required under the Act, as follows:

(A) Coverage for donation-related services for a living donor, or an individual identified by the plan as a potential donor, whether or not the donor is an enrollee. Services must be directly related to a covered transplant for the enrollee, which shall include services for harvesting the organ, tissue, or bone marrow and for treatment of complications, pursuant to the following guidelines:

(i) Services are directly related to a covered transplant service for an enrollee or are required for evaluating potential donors, harvesting the organ, bone marrow, or stem cells, or treating complications resulting from the evaluation or donation, but not including blood transfusions or blood products.

(ii) Donor receives covered services no later than 90 days following the harvest or evaluation service;

(iii) Donor receives services inside the United States, with the exception that geographic limitations do not apply to treatment of stem cell harvesting;

(iv) Donor receives written authorization for evaluation and harvesting services;

(v) For services to treat complications, the donor either receives non-emergency services after written authorization, or receives emergency services the plan would have covered if the enrollee had received them; and

(vi) In the event the enrollee's plan membership terminates after the donation or harvest, but before the expiration of the 90 day time limit for services to treat

complications, the plan shall continue to pay for medically necessary services for donor for 90 days following the harvest or evaluation service.

(B) The plan is not required to cover:

(i) Treatment of donor complications related to a stem cell registry donation;

(ii) HLA blood screening for stem cell donations, for anyone other than the enrollee's siblings, parents, or children;

(iii) Services related to post-harvest monitoring for the sole purpose of research or data collection; or

(iv) Services to treat complications caused by the donor failing to come to a scheduled appointment or leaving a hospital before being discharged by the treating physician.

(8) Ostomy and urological supplies substantially equal to the following:

(A) Ostomy supplies: adhesives; adhesive remover; ostomy belt; hernia belts; catheter; skin wash/cleaner; bedside drainage bag and bottle; urinary leg bags; gauze pads; irrigation faceplate; irrigation sleeve; irrigation bag; irrigation cone/catheter; lubricant; urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; gloves; stoma caps; colostomy plug; ostomy inserts; urinary and ostomy pouches; barriers; pouch closures; ostomy rings; ostomy face plates; skin barrier; skin sealant; and waterproof and non-waterproof tape.

(B) Urological supplies: adhesive catheter skin attachment; catheter insertion trays with and without catheter and bag; male and female external collecting devices; male external catheter with integral collection chamber; irrigation tubing sets; indwelling catheters; foley catheters; intermittent catheters; cleaners; skin sealants; bedside and leg drainage bags; bedside bag drainage bottle; catheter leg straps; irrigation tray; irrigation syringe; lubricating gel; sterile individual packets; tubing and connectors; catheter clamp or plug; penile clamp; urethral clamp or compression device; waterproof and non-waterproof tape; and catheter anchoring device.

(C) Incontinence supplies for hospice patients: disposable incontinence underpads; adult incontinence garments.

(D) Ostomy and urological supplies required under this section do not include supplies that are comfort, convenience, or luxury equipment or features.

(9) Prosthetic-and orthotic services and devices in addition to those services and devices required to be covered under the Act.

(A) Coverage includes fitting and adjustment of these devices, their repair or replacement (unless due to loss or misuse), and services to determine whether the enrollee needs a prosthetic or orthotic device. If the plan covers a replacement device, the enrollee pays the cost sharing the enrollee would pay for obtaining that device.

(B) The plan shall cover the prosthetic and orthotic services and devices substantially equal to the following:

(i) Enteral and Parenteral Nutrition: enteral formula and additives, adult and pediatric, including for inherited diseases of metabolism; enteral feeding supply kits; enteral nutrition infusion pump; enteral tubing; gastrostomy/jejunostomy tube and tubing adaptor; nasogastric tubing; parenteral nutrition infusion pump; parenteral nutrition solutions; stomach tube; and supplies for self-administered injections;

(ii) Up to three brassieres required to hold a breast prosthesis every 12 months;

(iii) Compression burn garments and lymphedema wraps and garments; and

(iv) Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect.

(10) Skilled nursing facility services as follows:

(A) For up to 100 days per benefit period (including any days covered under the prior subscriber contract issued by the plan to the enrollee or enrollee's group) of skilled inpatient services in a skilled nursing facility. The skilled inpatient services must be customarily provided by a skilled nursing facility, and above the level of custodial or intermediate care.

(B) A benefit period begins on the date the enrollee is admitted to a hospital or skilled nursing facility at a skilled level of care. A benefit period ends on the date the enrollee has not been an inpatient in a hospital or skilled nursing facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required to commence a benefit period.

(C) The following services are covered as part of the skilled nursing services:

(i) Physician and nursing services;

(ii) Room and board;

(iii) Drugs prescribed by a physician as part of the plan of care in the plan skilled nursing facility in accord with the plan's drug formulary guidelines if they are administered in the skilled nursing facility by medical personnel;

(iv) Durable medical equipment in accord with the plan's durable medical equipment formulary if skilled nursing facilities ordinarily furnish the equipment;

(v) Imaging and laboratory services that skilled nursing facilities ordinarily provide;

(vi) Medical social services;

(vii) Blood, blood products, and their administration;

(viii) Medical supplies;

(ix) Behavioral health treatment for pervasive developmental disorder or autism; and

(x) Respiratory therapy.

(11) Procedures for the prenatal diagnosis of fetal genetic disorders including tests for specific genetic disorders for which genetic counseling is available.

(12) Rehabilitative/habilitative health care services and devices.

(A) Coverage shall be in accordance with subdivisions (a)(3) and (p)(1) of section 1367.005, and as follows:

(i) Individual and group outpatient physical, occupational, and speech therapy related to pervasive developmental disorder or autism;

(ii) All other individual and group outpatient physical, occupational, and speech therapy;

(iii) Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day treatment program, a skilled nursing facility; and in an inpatient hospital (including treatment in an organized multidisciplinary rehabilitation program).

(B) The plan shall include in its Evidence of Coverage and Schedule of Benefits a disclaimer that limits for rehabilitative and habilitative service shall not be combined.

(13) Coverage in connection with a clinical trial in accordance with section 1370.6, and as follows:

(A) The plan would have covered the services if they were not related to a clinical trial.

(B) The enrollee is eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the

course of the condition is interrupted), as determined in one of the following ways:

(i) a plan provider makes this determination;

(ii) the enrollee provides the plan with medical and scientific information establishing this determination;

(C) If any plan providers participate in the clinical trial and will accept the enrollee as a participant in the clinical trial, the enrollee must participate in the clinical trial through a plan provider unless the clinical trial is outside the state where the enrollee lives; or

(D) The clinical trial is an approved clinical trial, meaning it is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:

(i) The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;

(ii) The study or investigation is a drug trial that is exempt from having an investigational new drug application, or

(iii) The study or investigation is approved or funded by at least one of the following:

(I) The National Institutes of Health;

(II) The Centers for Disease Control and Prevention;

(III) The Agency for Health Care Research and Quality;

(IV) The Centers for Medicare & Medicaid Services;

(V) A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs;

(VI) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or

(VII) The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements: (1) It is comparable to the National Institutes of Health system of peer review of studies and investigations and (2) it assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

(e) In the event the list of "other health benefits" in subdivision (d) omits benefits otherwise required pursuant to Health and Safety Code Section 1367.005, the provisions of Health and Safety Code Section 1367.005 shall control.

(f) If a stand-alone dental plan described in the PPACA at section 1311(d)(2)(B)(ii) (42 U.S.C. §18031(d)(2)(B)(ii)) is offered on the California Health Benefit Exchange (Exchange), then, pursuant to the PPACA section 1302(b)((4)(F) (42 U.S.C. §18022(b)(4)(F)), health plan contracts offered in the Exchange may, but are not required to, omit coverage of pediatric dental care benefits described in Health and Safety Code Section 1367.005(a)(5). A health plan shall not omit coverage of the pediatric dental EHB for health plan contracts sold outside the Exchange.

(g) The worksheet shall be in the following form:

CALIFORNIA ESSENTIAL HEALTH BENEFITS FILING WORKSHEET

For Individual Plan Subscriber Contracts and Evidence of Coverage ("EOC"), Small Group Plan EOCs, or Combined Individual or Small Group EOC/ Disclosure Forms ("DF")

This EHB Worksheet requires plans to record how their coverage, as disclosed in EOCs, Subscriber Contracts, and DFs, complies with EHB requirements set forth in Health and Safety Code section 1367.005. The alignment of certain provisions of the Act with federal EHB categories is not meant to be legally definitive, but is offered as a way to organize required benefits as plans frequently organize them within their EOCs. Note that some benefits may be listed under multiple federal EHB categories because benefits and categories overlap in many plan EOCs. The plans must utilize the boxes in the third column to identify where the required EHB is located in plan documents and supply the necessary information to describe the benefit. For the purposes of the EHB Worksheet, "Section" refers to a provision of the Health and Safety Code and "Rule" refers to a section of Title 28 of the California Code of Regulations.

Federal Essential Health Benefits Categories ("EHB")	Benefits required pursuant to § 1367.005(a)	[ ] Individual EOC, Subscriber Contract [ ] Group EOC, Subscriber Contract [ ] Combined Individual or Group DF/EOC [ ] Qualified Health Plan in the Exchange [ ] Multi-State Plan Check all that apply. In the space below, please provide page number and section number or heading in plan documents that describe the required EHB.
#1: Ambulatory Patient Services	Section 1345(b)(2) Rule 1300.67(b-c) **Ambulatory Care Services** Section 1345(b)(1) Rule 1300.67(a) **Outpatient Physician Services** Section 1345(b)(4) Rule 1300.67(e) Section 1367.005(a)(2)(C) **Home Health Services** Section 1345(b)(2) Rule 1300.67(c) **Outpatient Physical, Occupational, and Speech Therapy** Section 1370.6 **Cancer Clinical Trials** Benchmark Plan EHB Rule 1300.67.005(d)(13) **Other Clinical Trials**	

Federal Essential Health Benefits Categories ("EHB")	Benefits required pursuant to § 1367.005(a)	[ ] Individual EOC, Subscriber Contract [ ] Group EOC, Subscriber Contract [ ] Combined Individual or Group DF/EOC [ ] Qualified Health Plan in the Exchange [ ] Multi-State Plan Check all that apply. In the space below, please provide page number and section number or heading in plan documents that describe the required EHB.
	Section 1373(b) **Sterilization Services**	
	Benchmark Plan EHB Rule 1300.67.005(d)(1) **Acupuncture Services**	
	Benchmark Plan EHB Rule 1300.67.005(d)(8) **Ostomy, Urinary Supplies**	
#2: Emergency Services	Section 1345(b)(6) Rule 1300.67(g)(1) **Emergency Services**	
	Section 1371.5 Rule 1300.67(g)(1) **Emergency Response Ambulance Services**	
	Section 1345(b)(6) Rule 1300.67(g)(2) **Out of Area Coverage and Urgently Needed Services**	
#3: Hospitalization	Section 1345(b)(2) Rule 1300.67(b-c) **Inpatient Hospital Services**	
	Section 1345(b)(7) Section 1368.2 Rule 1300.67(h) **Hospice Services**	
	Section 1367.635 **Mastectomies and Lymph Node Dissections**	
	Section 1367.63 **Reconstructive Surgery**	

Federal Essential Health Benefits Categories ("EHB")	Benefits required pursuant to § 1367.005(a)	[ ] Individual EOC, Subscriber Contract [ ] Group EOC, Subscriber Contract [ ] Combined Individual or Group DF/EOC [ ] Qualified Health Plan in the Exchange [ ] Multi-State Plan Check all that apply. In the space below, please provide page number and section number or heading in plan documents that describe the required EHB.
	Section 1367.6 **Breast Cancer Coverage, Including Surgery**	
	Section 1367.68 **Jawbone Surgery**	
	Section 1367.71 **Dental Anesthesia**	
	Section 1373(b) **Sterilization Services**	
	Section 1374.17 **Organ Transplant Services for HIV**	
	Benchmark Plan EHB Rule 1300.67.005(d)(2) **Ambulance and Psychiatric Transport Services—Nonemergency**	
	Benchmark Plan EHB Rule 1300.67.005(d)(7) **Organ Donation Services**	
	Benchmark Plan EHB Rule 1300.67.005(d)(10) **Skilled Nursing Facility Services**	
#4: Maternity and Newborn Care	Section 1345(b)(1-2) Rule 1300.67(a-b) **Inpatient Maternity Care**	
	Section 1345(b)(5) Rule 1300.67(f)(3) **Prenatal Care**	
	Rule 1300.67(g)(2) **Urgently Needed Services, Including Maternity Services**	

Federal Essential Health Benefits Categories ("EHB")	Benefits required pursuant to § 1367.005(a)	[ ] Individual EOC, Subscriber Contract [ ] Group EOC, Subscriber Contract [ ] Combined Individual or Group DF/EOC [ ] Qualified Health Plan in the Exchange [ ] Multi-State Plan Check all that apply. In the space below, please provide page number and section number or heading in plan documents that describe the required EHB.
	Section 1367.62 **Maternity Hospital Stay**	
	Section 1367.54 **Alpha-Fetoprotein Testing**	
	Section 1373.4 **Inpatient Hospital and Ambulatory Maternity Services**	
	45 CFR 147.130 HRSA Guidelines for Women's Preventive Services **Breastfeeding Support, Supplies, Counseling**	
	Benchmark Plan EHB Section 1367.7 Rule 1300.67.005(d)(11): **Prenatal Diagnosis of Genetic Disorders of the Fetus**	
5: Mental Health and Substance Use Disorder Services, Including Behavioral Health Treatment	Section 1345(b)(1) Rule 1300.67(a) Section 1374.72 Section 1367.005(a)(2)(D) **Mental Health Services**	
	Section 1374.73 Section 1367.005(a)(2)(D) Benchmark Plan EHB Rule 1300.67.005(d)(12)(A) **Behavioral Health Treatment ("BHT") for PDD or Autism**	
	Benchmark Plan EHB Section 1367.005(a)(2)(D) Rule 1300.67.005(d)(6) **Mental Health Services for Mental Disorders Other than SMI and SED**	

Federal Essential Health Benefits Categories ("EHB")	Benefits required pursuant to § 1367.005(a)	[ ] Individual EOC, Subscriber Contract [ ] Group EOC, Subscriber Contract [ ] Combined Individual or Group DF/EOC [ ] Qualified Health Plan in the Exchange [ ] Multi-State Plan Check all that apply. In the space below, please provide page number and section number or heading in plan documents that describe the required EHB.
	Section 1367.005(a)(2)(D) Benchmark Plan EHB: Rule 1300.67.005(d)(3) **Chemical Dependency Services**	
#6: Prescription Drugs	Section 1367.25 **Coverage for Contraceptive Methods** Section 1367.45 **Coverage for Approved AIDS Vaccine** Section 1370.6 **Cancer Clinical Trials** EHB Benchmark Plan Rule 1300.67.005(d)(13) **Other Clinical Trials** Section 1367.21 **Off Label Drug Use** Section 1367.002 Section 1367.06 **Pediatric Asthma Services** Section 1374.56 **Phenylketonuria Services** Section 1367.215 **Pain Management Medication for Terminally Ill** Section 1367.22 **Coverage for Previously Approved Prescription** Section 1367.24 **Prescription Authorization Process for Non Formulary Drugs**	

Federal Essential Health Benefits Categories ("EHB")	Benefits required pursuant to § 1367.005(a)	[ ] Individual EOC, Subscriber Contract [ ] Group EOC, Subscriber Contract [ ] Combined Individual or Group DF/EOC [ ] Qualified Health Plan in the Exchange [ ] Multi-State Plan Check all that apply. In the space below, please provide page number and section number or heading in plan documents that describe the required EHB.
	Rule 1300.67.24 **Outpatient Prescription Drug Coverage, Limitations and Exclusions**	
#7: Rehabilitative and Habilitative Services and Devices	Section 1345(b)(2) Rule 1300.67(c) Benchmark Plan EHB Rule 1300.67.005(d)(12) **Outpatient Physical, Occupational, and Speech Therapy**	
	Section 1374.73 Section 1367.005(a)(3) Benchmark Plan EHB Rule 1300.67.005(d)(12)(A) **Behavioral Health Treatment ("BHT") for PDD or Autism**	
	Section 1345(b)(4) Rule 1300.67(e) Section 1367.005(a)(2)(C) **Home Health Services**	
	Section 1367.61 **Prosthetics for Laryngectomy**	
	Section 1367.18 **Orthotic and Prosthetic Devices and Services**	
	Section 1367.6 Section 1367.635 **Prosthetic Devices Incident to Mastectomy**	
	Benchmark Plan EHB Rule 1300.67.005(d)(4) **Contact Lenses to Treat Aniridia and Aphakia**	

Federal Essential Health Benefits Categories ("EHB")	Benefits required pursuant to § 1367.005(a) Benchmark Plan EHB Rule 1300.67.005(d)(5) **Additional Durable Medical Equipment Required to be Covered** Benchmark Plan EHB Rule 1300.67.005(d)(9) **Additional Prosthetic-Orthotics Devices Required to be Covered**	[ ] Individual EOC, Subscriber Contract [ ] Group EOC, Subscriber Contract [ ] Combined Individual or Group DF/EOC [ ] Qualified Health Plan in the Exchange [ ] Multi-State Plan Check all that apply. In the space below, please provide page number and section number or heading in plan documents that describe the required EHB.
#8: Laboratory Services	Section 1345(b)(3) Rule 1300.67(d) **Diagnostic Laboratory and Therapeutic Radiologic Services** Section 1367.65 **Mammography Services** Section 1367.46 Rule 1300.67.24 **Coverage for HIV Testing** Section 1367.54 **Alpha-Fetoprotein Testing** Section 1367.6 **Breast Cancer Screening** Section 1367.64 **Prostate Cancer Screening** Section 1367.66 **Cervical Cancer Screening** Section 1367.665 **Cancer Screening Tests** Section 1367.67 **Osteoporosis Services**	

Federal Essential Health Benefits Categories ("EHB")	Benefits required pursuant to § 1367.005(a)	[ ] Individual EOC, Subscriber Contract [ ] Group EOC, Subscriber Contract [ ] Combined Individual or Group DF/EOC [ ] Qualified Health Plan in the Exchange [ ] Multi-State Plan Check all that apply. In the space below, please provide page number and section number or heading in plan documents that describe the required EHB.
	Section 1367.9 **Diethylstilbestrol Services**	
	Benchmark Plan EHB Section 1367.7 Rule 1300.67.005(d)(11): **Prenatal Diagnosis of Genetic Disorders of the Fetus**	
#9: Preventive and Wellness Services and Chronic Disease Management	Section 1345(b)(5) Rule 1300.67(f) Section 1367.002 45 CFR 147.130 75 Fed Reg 41726, 41728 HRSA Guidelines for Women's Preventive Services **Preventive Health Services**	
	Section 1367.06 **Pediatric Asthma Services**	
	Section 1367.35 **Comprehensive Pediatric Preventive Services**	
	Section 1367.6 **Breast Cancer Screening**	
	Section 1367.64 **Prostate Cancer Screening**	
	Section 1367.665 **General Cancer Screening**	
	Section 1367.66 **Cervical Cancer Screening**	
	Section 1367.51 **Diabetes Equipment and Supply Services**	
	Section 1367.65 **Mammography Services**	

Federal Essential Health Benefits Categories ("EHB")	Benefits required pursuant to § 1367.005(a) Section 1367.46 Rule 1300.67.24 **Coverage for HIV Testing** Section 1367.67 **Osteoporosis Services** Section 1367.9 **Diethylstilbestrol Services**	[ ] Individual EOC, Subscriber Contract [ ] Group EOC, Subscriber Contract [ ] Combined Individual or Group DF/EOC [ ] Qualified Health Plan in the Exchange [ ] Multi-State Plan Check all that apply. In the space below, please provide page number and section number or heading in plan documents that describe the required EHB.
#10: Pediatric Services, Including Oral and Vision Care	Section 1367.005(a)(5) Benefits for pediatric oral care covered under the dental benefit received by children under the Medi-Cal program as of 2014, pursuant to the Medi-Cal Dental Program Provider Handbook in effect during the first quarter of 2014, including coverage pursuant to the Early Periodic Screening, Diagnosis, and Treatment benefit pursuant to 42 U.S.C. Section 1396d(r), and provision of medically necessary orthodontic care provided pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009. **Oral Care** Section 1367.005(a)(4) BCBS Association, 2014 FEP BlueVision — High Option, including but not limited to low vision benefits. **Vision Care** Section 1345(b)(5) Rule 1300.67(f)(4) **Pediatric Vision and Hearing Services**	

Federal Essential Health Benefits Categories ("EHB")	Benefits required pursuant to § 1367.005(a) Section 1345(b)(5) Rule 1300.67(f)(5) **Pediatric Immunization Services** Section 1367.002 Section 1367.06 **Pediatric Asthma Services** Section 1367.002 Section 1367.35 **Comprehensive Pediatric Preventive Services**	[ ] Individual EOC, Subscriber Contract [ ] Group EOC, Subscriber Contract [ ] Combined Individual or Group DF/EOC [ ] Qualified Health Plan in the Exchange [ ] Multi-State Plan Check all that apply. In the space below, please provide page number and section number or heading in plan documents that describe the required EHB.

PRESCRIPTION DRUG BENEFITS

Directions for Plan Completion of Prescription Drug EHB-Benchmark Plan Benefits Chart

To demonstrate compliance with the prescription drug essential health benefits required under the PPACA at section 1302(b) (42 U.S.C. §18022) and at 45 CFR §156.122, please complete the form below indicating the number of prescription drugs offered by the Plan in each class and category of prescription drugs listed below. Plans must make whatever modifications are necessary to their current formularies so that the number of prescription drugs they cover equal or exceed the number listed in the "EHB Submission Count" column. Please attach the Plan's prescription drug list and/or formulary to this worksheet.

The plan must demonstrate it provides at least the greater of one (1) drug per category and class or the same number of drugs provided by the base-benchmark plan as indicated in the EHB Submission Count column, pursuant to 45 Code of Federal Regulations part 156.122, subparagraph (a). (78 Fed. Reg. 12834, 12867, February 25,2013.)

CATEGORY	*CLASS*	*EHB SUBMISSION COUNT*	*PLAN SUBMISSION COUNT*
ANALGESICS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	10	
ANALGESICS	OPIOID ANALGESICS, LONG-ACTING	3	
ANALGESICS	OPIOID ANALGESICS, SHORT-ACTING	7	
ANESTHETICS	LOCAL ANESTHETICS	2	
ANTI-ADDICTION/ SUBSTANCE ABUSE TREATMENT AGENTS	ALCOHOL DETERRENTS/ANTI-CRAVING	3	
ANTI-ADDICTION/ SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID DEPENDENCE TREATMENTS	1	
ANTI-ADDICITION/ SUBSTANCE ABUSE TREATMENT AGENTS	OPIOID REVERSAL AGENTS	1	
ANTI-ADDICTION/ SUBSTANCE ABUSE TREATMENT AGENTS	SMOKING CESSATION AGENTS	0	
ANTI-INFLAMMATORY AGENTS	GLUCOCORTICOIDS	20	
ANTI-INFLAMMATORY AGENTS	NONSTEROIDAL ANTI-INFLAMMATORY DRUGS	9	
ANTIBACTERIALS	AMINOGLYCOSIDES	5	
ANTIBACTERIALS	ANTIBACTERIALS, OTHER	14	
ANTIBACTERIALS	BETA-LACTAM, CEPHALOSPORINS	7	
ANTIBACTERIALS	BETA-LACTAM, OTHER	2	
ANTIBACTERIALS	BETA-LACTAM, PENICILLINS	5	
ANTIBACTERIALS	MACROLIDES	3	
ANTIBACTERIALS	QUINOLONES	6	
ANTIBACTERIALS	SULFONAMIDES	4	
ANTIBACTERIALS	TETRACYCLINES	4	
ANTICONVULSANTS	ANTICONVULSANTS, OTHER	3	
ANTICONVULSANTS	CALCIUM CHANNEL MODIFYING AGENTS	2	
ANTICONVULSANTS	GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS	3	
ANTICONVULSANTS	GLUTAMATE REDUCING AGENTS	3	
ANTICONVULSANTS	SODIUM CHANNEL AGENTS	4	
ANTIDEMENTIA AGENTS	ANTIDEMENTIA AGENTS, OTHER	1	
ANTIDEMENTIA AGENTS	CHOLINESTERASE INHIBITORS	2	
ANTIDEMENTIA AGENTS	N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST	1	
ANTIDEPRESSANTS	ANTIDEPRESSANTS, OTHER	6	
ANTIDEPRESSANTS	MONOAMINE OXIDASE INHIBITORS	2	
ANTIDEPRESSANTS	SEROTONIN/NOREPINEPHRINE REUPTAKE INHIBITORS	9	

CATEGORY	*CLASS*	*EHB SUBMISSION COUNT*	*PLAN SUBMISSION COUNT*
ANTIDEPRESSANTS	TRICYCLICS	9	
ANTIEMETICS	ANTIEMETICS, OTHER	9	
ANTIEMETICS	EMETOGENIC THERAPY ADJUNCTS	3	
ANTIFUNGALS	NO USP CLASS	9	
ANTIGOUT AGENTS	NO USP CLASS	5	
ANTIMIGRAINE AGENTS	ERGOT ALKALOIDS	2	
ANTIMIGRAINE AGENTS	PROPHYLACTIC	2	
ANTIMIGRAINE AGENTS	SEROTONIN (5-HT) 1B/1D RECEPTOR AGONISTS	3	
ANTIMYASTHENIC AGENTS	PARASYMPATHOMIMETICS	3	
ANTIMYCOBACTERIALS	ANTIMYCOBACTERIALS, OTHER	2	
ANTIMYCOBACTERIALS	ANTITUBERCULARS	8	
ANTINEOPLASTICS	ALKYLATING AGENTS	4	
ANTINEOPLASTICS	ANTIANDROGENS	3	
ANTINEOPLASTICS	ANTIANGIOGENIC AGENTS	3	
ANTINEOPLASTICS	ANTIESTROGENS/MODIFIERS	2	
ANTINEOPLASTICS	ANTIMETABOLITES	5	
ANTINEOPLASTICS	ANTINEOPLASTICS, OTHER	4	
ANTINEOPLASTICS	AROMATASE INHIBITORS, 3RD GENERATION	3	
ANTINEOPLASTICS	ENZYME INHIBITORS	3	
ANTINEOPLASTICS	MOLECULAR TARGET INHIBITORS	13	
ANTINEOPLASTICS	MONOCLONAL ANTIBODIES	0	
ANTINEOPLASTICS	RETINOIDS	2	
ANTIPARASITICS	ANTHELMINTICS	3	
ANTIPARASITICS	ANTIPROTOZOALS	10	
ANTIPARASITICS	PEDICULICIDES/SCABICIDES	2	
ANTIPARKINSON AGENTS	ANTICHOLINERGICS	3	
ANTIPARKINSON AGENTS	ANTIPARKINSON AGENTS, OTHER	2	
ANTIPARKINSON AGENTS	DOPAMINE AGONISTS	4	
ANTIPARKINSON AGENTS	DOPAMINE PRECURSORS/L-AMINO ACID DECARBOXYLASE INHIBITORS	2	
ANTIPARKINSON AGENTS	MONOAMINE OXIDASE B (MAO-B) INHIBITORS	2	
ANTIPSYCHOTICS	1ST GENERATION/TYPICAL	10	
ANTIPSYCHOTICS	2ND GENERATION/ATYPICAL	5	
ANTIPSYCHOTICS	TREATMENT-RESISTANT	1	
ANTISPASTICITY AGENTS	NO USP CLASS	3	
ANTIVIRALS	ANTI-CYTOMEGALOVIRUS (CMV) AGENTS	1	
ANTIVIRALS	ANTI-HEPATITIS B (HBV) AGENTS	5	
ANTIVIRALS	ANTI-HEPATITIS C (HBC) AGENTS	7	
ANTIVIRALS	ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS	5	
ANTIVIRALS	ANTI-HIV AGENTS, NUCLEOSIDE AND		

CATEGORY	*CLASS*	*EHB SUBMISSION COUNT*	*PLAN SUBMISSION COUNT*
	NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS	12	
ANTIVIRALS	ANTI-HIV AGENTS, INTEGRASE INHIBITORS	2	
ANTIVIRALS	ANTI-HIV AGENTS, OTHER	3	
ANTIVIRALS	ANTI-HIV AGENTS, PROTEASE INHIBITORS	9	
ANTIVIRALS	ANTI-INFLUENZA AGENTS	4	
ANTIVIRALS	ANTIHERPETIC AGENTS	3	
ANXIOLYTICS	ANXIOLYTICS, OTHER	3	
ANXIOLYTICS	SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)	5	
ANXIOLYTICS	BENZODIASEPINES	0	
BIPOLAR AGENTS	BIPOLAR AGENTS, OTHER	6	
BIPOLAR AGENTS	MOOD STABILIZERS	5	
BLOOD GLUCOSE REGULATORS	ANTIDIABETIC AGENTS	7	
BLOOD GLUCOSE REGULATORS	GLYCEMIC AGENTS	1	
BLOOD GLUCOSE REGULATORS	INSULINS	6	
BLOOD PRODUCTS/ MODIFIERS/VOLUME EXPANDERS	ANTICOAGULANTS	3	
BLOOD PRODUCTS/ MODIFIERS/VOLUME EXPANDERS	BLOOD FORMATION MODIFIERS	4	
BLOOD PRODUCTS/ MODIFIERS/VOLUME EXPANDERS	COAGULANTS	0	
BLOOD PRODUCTS/ MODIFIERS/VOLUME EXPANDERS	PLATELET MODIFYING AGENTS	6	
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC AGONISTS	4	
CARDIOVASCULAR AGENTS	ALPHA-ADRENERGIC BLOCKING AGENTS	4	
CARDIOVASCULAR AGENTS	ANGIOTENSIN II RECEPTOR ANTAGONISTS	1	
CARDIOVASCULAR AGENTS	ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS	3	
CARDIOVASCULAR AGENTS	ANTIARRHYTHMICS	9	
CARDIOVASCULAR AGENTS	BETA-ADRENERGIC BLOCKING AGENTS	7	
CARDIOVASCULAR AGENTS	CALCIUM CHANNEL BLOCKING AGENTS	5	
CARDIOVASCULAR AGENTS	CARDIOVASCULAR AGENTS, OTHER	2	

CATEGORY	*CLASS*	*EHB SUBMISSION COUNT*	*PLAN SUBMISSION COUNT*
CARDIOVASCULAR AGENTS	DIURETICS, CARBONIC ANHYDRASE INHIBITORS	2	
CARDIOVASCULAR AGENTS	DIURETICS, LOOP	3	
CARDIOVASCULAR AGENTS	DIURETICS, POTASSIUM-SPARING	2	
CARDIOVASCULAR AGENTS	DIURETICS, THIAZIDE	4	
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES	2	
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS	4	
CARDIOVASCULAR AGENTS	DYSLIPIDEMICS, OTHER	3	
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL	2	
CARDIOVASCULAR AGENTS	VASODILATORS, DIRECT-ACTING ARTERIAL/VENOUS	3	
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES	3	
CENTRAL NERVOUS SYSTEM AGENTS	ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES	1	
CENTRAL NERVOUS SYSTEM AGENTS	CENTRAL NERVOUS SYSTEM AGENTS, OTHER	2	
CENTRAL NERVOUS SYSTEM AGENTS	FIBROMYALGIA AGENTS	1	
CENTRAL NERVOUS SYSTEM AGENTS	MULTIPLE SCLEROSIS AGENTS	3	
DENTAL AND ORAL AGENTS	NO USP CLASS	6	
DERMATOLOGICAL AGENTS	NO USP CLASS	50	
ENZYME REPLACEMENT/ MODIFIERS	NO USP CLASS	2	
GASTROINTESTINAL AGENTS	ANTISPASMODICS, GASTROINTESTINAL	2	
GASTROINTESTINAL AGENTS	GASTROINTESTINAL AGENTS, OTHER	6	
GASTROINTESTINAL AGENTS	HISTAMINE2 (H2) RECEPTOR ANTAGONISTS	3	
GASTROINTESTINAL AGENTS	IRRITABLE BOWEL SYNDROME AGENTS	1	
GASTROINTESTINAL AGENTS	LAXATIVES	1	
GASTROINTESTINAL AGENTS	PROTECTANTS	2	
GASTROINTESTINAL AGENTS	PROTON PUMP INHIBITORS	2	

CATEGORY	*CLASS*	*EHB SUBMISSION COUNT*	*PLAN SUBMISSION COUNT*
GENITOURINARY AGENTS	ANTISPASMODICS, URINARY	2	
GENITOURINARY AGENTS	BENIGN PROSTATIC HYPERTROPHY AGENTS	5	
GENITOURINARY AGENTS	GENITOURINARY AGENTS, OTHER	4	
GENITOURINARY AGENTS	PHOSPHATE BINDERS	2	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (ADRENAL)	NO USP CLASS	23	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PITUITARY)	NO USP CLASS	4	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PROSTAGLANDINS)	NO USP CLASS	1	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/MODIFIERS)	ANABOLIC STEROIDS	1	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/MODIFIERS)	ANDROGENS	4	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/MODIFIERS)	ESTROGENS	2	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTERONE AGONISTS/ ANTAGONISTS	0	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/MODIFIERS)	PROGESTINS	5	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/MODIFIERS)	SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS	1	

CATEGORY	*CLASS*	*EHB SUBMISSION COUNT*	*PLAN SUBMISSION COUNT*
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (THYROID)	NO USP CLASS	2	
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)	NO USP CLASS	1	
HORMONAL AGENTS, SUPPRESSANT (PARATHYROID)	NO USP CLASS	2	
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)	NO USP CLASS	5	
HORMONAL AGENTS, SUPPRESSANT (THYROID)	ANTITHYROID AGENTS	3	
IMMUNOLOGICAL AGENTS	ANDIOEDEMA (HAE) AGENTS	1	
IMMUNOLOGICAL AGENTS	IMMUNE SUPPRESSANTS	14	
IMMUNOLOGICAL AGENTS	IMMUNIZING AGENTS, PASSIVE	0	
IMMUNOLOGICAL AGENTS	IMMUNOMODULATORS	11	
INFLAMMATORY BOWEL DISEASE AGENTS	AMINOSALICYLATES	2	
INFLAMMATORY BOWEL DISEASE AGENTS	GLUCOCORTICOIDS	5	
INFLAMMATORY BOWEL DISEASE AGENTS	SULFONAMIDES	1	
METABOLIC BONE DISEASE AGENTS	NO USP CLASS	6	
OPHTHALMIC AGENTS	OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS	2	
OPHTHALMIC AGENTS	OPHTHALMIC AGENTS, OTHER	14	
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-ALLERGY AGENTS	2	
OPHTHALMIC AGENTS	OPHTHALMIC ANTI-INFLAMMATORIES	6	
OPHTHALMIC AGENTS	OPHTHALMIC ANTIGLAUCOMA AGENTS	12	
OTIC AGENTS	NO USP CLASS	5	
RESPIRATORY TRACT AGENTS/PULMONARY AGENTS	ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS	5	
RESPIRATORY TRACT AGENTS/PULMONARY AGENTS	ANTIHISTAMINES	5	
RESPIRATORY TRACT AGENTS/PULMONARY AGENTS	ANTILEUKOTRIENES	1	
RESPIRATORY TRACT AGENTS/PULMONARY AGENTS	BRONCHODILATORS, ANTICHOLINERGIC	2	

CATEGORY	*CLASS*	*EHB SUBMISSION COUNT*	*PLAN SUBMISSION COUNT*
RESPIRATORY TRACT AGENTS/PULMONARY AGENTS	PHOSPHDIESTERASE INHIBITORS, AIRWAYS DISEASE	3	
RESPIRATORY TRACT AGENTS/PULMONARY AGENTS	BRONCHODILATORS, SYMPATHOMIMETIC	5	
RESPIRATORY TRACT AGENTS/PULMONARY AGENTS	CYCSTIC FIBROSIS AGENTS	3	
RESPIRATORY TRACT AGENTS/PULMONARY AGENTS	MAST CELL STABILIZERS	1	
RESPIRATORY TRACT AGENTS/PULMONARY AGENTS	PULMONARY ANTIHYPERTENSIVES	5	
RESPIRATORY TRACT AGENTS/PULMONARY AGENTS	RESPIRATORY TRACT AGENTS, OTHER	1	
SKELETAL MUSCLE RELAXANTS	NO USP CLASS	2	
SLEEP DISORDER AGENTS	GABA RECEPTOR MODULATORS	1	
SLEEP DISORDER AGENTS	SLEEP DISORDERS, OTHER	1	
THERAPEUTIC NUTRIENTS/MINERALS/ ELECTROLYTES	ELECTROLYTE/MINERAL MODIFIERS	4	
THERAPEUTIC NUTRIENTS/MINERALS/ ELECTROLYTES	ELECTROLYTE/MINERAL REPLACEMENT	3	
THERAPEUTIC NUTRIENTS/MINERALS/ ELECTROLYTES	VITAMINS	0	

NOTE: Authority cited: Sections 1341, 1344, 1346 and 1367.005, Health and Safety Code. Reference: Section 1367.005, Health and Safety Code.

HISTORY:

1. New section filed 7-5-2013 as an emergency; operative 7-5-2013 (Register 2013, No. 27). A Certificate of Compliance must be transmitted to OAL by 1-2-2014 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 12-16-2013 as an emergency, including amendment of subsection (c)(4) and subsection (g) — worksheet; operative 1-2-2014 (Register 2013, No. 51). A Certificate of Compliance must be transmitted to OAL by 4-2-2014 or emergency language will be repealed by operation of law on the following day.
3. Editorial correction restoring inadvertently deleted portions of Filing Worksheet (Register 2014, No. 16).
4. Certificate of Compliance as to 12-16-2013 order transmitted to OAL 3-4-2014 and filed 4-14-2014 (Register 2014, No. 16).
5. Amendment filed 11-28-2016 as an emergency; operative 11-28-2016 (Register 2016, No. 49). A Certificate of Compliance must be transmitted to OAL by 5-30-2017 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 11-28-2016 order transmitted to OAL 5-16-2017 and filed 6-27-2017 (Register 2017, No. 26).

§ 1300.67.01. COVID-19 Diagnostic Testing. [Repealed]

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Sections 1367, 1367.01 and 1367.03, Health and Safety Code.

HISTORY:

1. New section filed 7-17-2020 as an emergency; operative 7-17-2020 (Register 2020, No. 29). A Certificate of Compliance must be transmitted to OAL by 1-13-2021 or emergency language will be repealed by operation of law on the following day.
2. Emergency filed 7-17-2020 and operative 7-17-2020 extended 60 days pursuant to Executive Order N-40-20 and an additional 60 days pursuant to Executive Order N-66-20 (Register 2020, No. 35). A Certificate of Compliance must be transmitted to OAL by 5-14-2021 or emergency language will be repealed by operation of law on the following day.
3. Repealed by operation of Government Code section 11346.1(g) (Register 2023, No. 2).

§ 1300.67.02. Transfer of Enrollees Pursuant to a Public Health Order.

(a) Applicability. This section applies to a health plan offering group or individual health care coverage that includes hospital, medical, or surgical benefits, including a grandfathered health plan as defined in section 1251(e) of the Patient Protection and Affordable Care Act. This section does not apply to Medi–Cal managed care health plans with a contract entered into pursuant to Chapter 7 (commencing with section 14000), Chapter 8 (commencing with section 14200), or Chapter 8.75 (commencing with section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

(b) Definitions. The following definitions apply for the purposes of this section:

(1) Covered public health order—Means an order issued by the State Public Health Officer pursuant to Division 112 (commencing with section 131000) of the Health and Safety Code, or during a local health emergency as defined in section 101080 of the Health and Safety Code or a state of emergency or local emergency as defined in section 8558 of the Government Code, that directs or allows hospitals or other health care facilities to transfer patients to other health care facilities in response to, or otherwise as a result of, the COVID–19 pandemic. This specifically includes an order issued to allocate or preserve health care resources in the face of increased demand for health care resources related to COVID–19 during a California state of emergency.

(2) Transferring facility—Means the health care facility from which an enrollee is transferred as directed or allowed by a covered public health order.

(3) Receiving facility—Means the health care facility that receives an enrollee transferred from a transferring facility as directed or allowed by a covered public health order.

(c) When a health care facility transfers an enrollee pursuant to a covered public health order, the following applies:

(1) The enrollee's health plan shall not require prior authorization or prior notice, or impose any other requirements that delay or prevent the transfer of the enrollee.

(2) The health plan shall cover the medically necessary costs of moving the enrollee between the transferring facility and the receiving facility.

(3) The health plan shall reimburse the receiving facility for all medically necessary services provided to the enrollee during the first 72 hours the enrollee is treated at the receiving facility, regardless of whether the receiving facility has a contract with the health plan.

(4) Within 72 hours of receiving the enrollee, the receiving facility shall notify the enrollee's health plan that the facility is treating the enrollee received pursuant to a covered public health order.

(5) After the first 72 hours, the health plan shall continue to reimburse the receiving facility for all medically necessary services provided to the enrollee at the receiving facility if:

(A) within 72 hours of receiving the enrollee, the receiving facility notified the health plan that the facility is treating the enrollee: and

(B) the health plan does not disapprove the facility's request to continue providing medically necessary care to the enrollee. If the health plan disapproves the receiving facility's request to continue providing medically necessary care to the enrollee, the health plan shall reimburse the receiving facility for medically necessary services the receiving facility provides the enrollee up to the time the health plan effectuates the enrollee's transfer or the enrollee is discharged from the receiving facility.

(6) If the health plan has a contract with the receiving facility, the health plan shall reimburse the receiving facility per the terms of that contract.

(7) If the health plan does not have a contract with the receiving facility, the health plan shall reimburse the receiving facility for the reasonable and customary value of the services the enrollee receives at the receiving facility.

(8) "Reasonable and customary value" has the same meaning as defined in section 1300.71(a)(3)(B) of this title.

(d) An enrollee transferred pursuant to a covered public health order shall be liable for no more than the cost the enrollee would have incurred if the enrollee had remained in a contracting health facility. For the purpose of this section, contracting health facility has the meaning in subdivision (f)(1) section 1371.9.

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Sections 1367, 1367.01 and 1367.03.

HISTORY:

1. New section filed 1–15–2021 as an emergency; operative 1–15–2021 (Register 2021, No. 3). Expiration of emergency extended 60 days (Executive Order N–40–20) and an additional 60 days (N–71–20). A Certificate of Compliance must be transmitted to OAL by 11–12–2021 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 10–28–2021 as an emergency; operative 11–13–2021 (Register 2021, No. 44). A Certificate of Compliance must be transmitted to OAL by 2–11–2022 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 10–28–2021 order, including new subsection (c)(4) and subsection renumbering, transmitted to OAL 1–5–2022 and filed 1–26–2022; amendments operative 1–26–2022 pursuant to Government Code section 11343.4(b)(3) (Register 2022, No. 4).

§ 1300.67.04. Language Assistance Programs.

(a) Application.

(1) Every health care service plan, including specialized health care service plans (plans), shall comply with the requirements of this section. The requirements of this section shall not apply to plan contracts for the provision of services to Medi-Cal enrollees or to contracts between plans and the federal government for the provision of services to Medicare enrollees.

(2) If a plan has both Medi-Cal and non-Medi-Cal lines of business, then the plan will be in compliance with the requirements of this section as to its non-Medi-Cal lines of business if:

(A) The Medi-Cal standards for providing language assistance services, including standards for timeliness and proficiency of interpreters, are equivalent to or exceed the standards set forth in Section 1367.04 of the Act and this section;

(B) The plan applies the Medi-Cal standards for language assistance programs to the plan's non-Medi-Cal lines of business; and

(C) The Department of Managed Health Care (Department) determines, as described in Section 1367.04(h)(3) of the Act, that the plan is in compliance with the Medi-Cal standards.

(3) A plan that seeks the Department's determination of compliance as provided in subsection (a)(2) shall request such determination as part of its filing pursuant to subsection (e)(2) and provide documentation sufficient to support and verify the request to the Department's satisfaction. The Department's determination pursuant to subsection (a)(2) shall apply only to the enrollees in a plan's non-Medi-Cal lines of business to which the plan actually applies the plan's Medi-Cal program standards.

(b) Definitions.

(1) Demographic profile means, at a minimum, identification of an enrollee's preferred spoken and written language, race and ethnicity.

(2) Interpretation: the act of listening to something spoken or reading something written in one language (source language) and orally expressing it accurately and with appropriate cultural relevance into another language (target language).

(3) Limited English Proficient or LEP Enrollee: an enrollee who has an inability or a limited ability to speak, read, write, or understand the English language at a level that permits that individual to interact effectively with health care providers or plan employees.

(4) Point of Contact: an instance in which an enrollee accesses the services covered under the plan contract, including administrative and clinical services, and telephonic and in-person contacts.

(5) Threshold Language(s): the language(s) identified by a plan pursuant to Section 1367.04(b)(1)(A) of the Act.

(6) Translation: replacement of a written text from one language (source language) with an equivalent written text in another language (target language).

(7) Vital Documents: the following documents, when produced by the plan (plan-produced documents) including when the production or distribution is delegated by a plan to a contracting health care service provider or administrative services provider:

(A) Applications;

(B) Consent forms, including any form by which an enrollee authorizes or consents to any action by the plan;

(C) Letters containing important information regarding eligibility and participation criteria;

(D) Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal;

(E) Notices advising LEP enrollees of the availability of free language assistance and other outreach materials that are provided to enrollees;

(F) A plan's explanation of benefits or similar claim processing information that is sent to an enrollee if the document requires a response from the enrollee; and

(G) Subject to subsection (c)(2)(F)(ii), the enrollee disclosures required by Section 1363(a)(1), (2) and (4) of the Act.

(c) Language Assistance Program Requirements.

Every plan shall develop and implement a language assistance program, which shall comply with the requirements and standards established by Section 1367.04 of the Act and this section. The language assistance program shall be documented in written policies and procedures, and shall address, at a minimum, the following four elements: standards for enrollee assessment; standards for providing language assistance services; standards for staff training; and standards for compliance monitoring.

(1) Enrollee Assessment. Every health care service plan and specialized health care service plan shall assess its enrollee population to develop a demographic profile and to survey the linguistic needs of individual enrollees. In assessing its enrollee population each plan shall, at a minimum:

(A) Develop a demographic profile of the plan's enrollee population for the purposes of calculating threshold languages and reporting to the Department pursuant to Section 1367.07 of the Act. All plans shall apply statistically valid methods for population analysis in developing the demographic profile and plans may utilize a variety of methods for collecting demographic data for this purpose, including census data, client utilization data from third parties, data from community agencies and third party enrollment processes;

(B) Survey its enrollees in a manner designed to identify the linguistic needs of each of the plan's enrollees, and record the information provided by a responding enrollee in the enrollee's file. Plans may utilize existing processes and methods to distribute the linguistic needs survey, including but not limited to, existing enrollment and renewal processes, subscriber newsletters, mailings and other communication processes. A plan may demonstrate compliance with the survey requirement by distributing to all subscribers, including all individual subscribers under group contracts, a disclosure explaining, in English and in the plan's threshold languages, the availability of free language assistance services and how to inform the plan and relevant providers regarding the preferred spoken and written languages of the subscriber and other enrollees under the subscriber contract; and

(C) Collect, summarize and document enrollee demographic profile data in a manner that enables the plan to maintain confidentiality of personal information and to disclose the information to the Department on request for regulatory purposes and to contracting providers on request for lawful purposes, including language assistance purposes and health care quality improvement purposes. This section is not intended to limit or expand existing law regarding confidentiality of medical records.

(2) Providing Language Assistance Services. Every plan shall develop language assistance program policies and procedures, which shall describe, at a minimum, the information outlined below.

(A) All points of contact where the need for language assistance may be reasonably anticipated.

(B) The types of resources needed to provide effective language assistance to the plan's enrollees.

(C) The plan's processes for informing enrollees of the availability of language assistance services at no charge to enrollees, and how to access language assistance services. At a minimum, these processes shall include the following:

(i) Processes to promote effective identification of LEP enrollee language assistance needs at points of contact, to ensure that LEP enrollees are informed at points of contact that interpretation services are available at no cost to the LEP enrollee, and to facilitate individual enrollee access to interpretation services at points of contact.

(ii) Processes for including the notice required by Section 1367.04(b)(1)(B)(v) with all vital documents, all enrollment materials and all correspondence, if any, from the plan confirming a new or renewed enrollment. If documents are distributed in an LEP enrollee's preferred written language the notice need not be included.

(iii) Processes for including statements, in English and in threshold languages, about the availability of free language assistance services and how to access them, in or with brochures, newsletters, outreach and marketing

materials and other materials that are routinely disseminated to the plan's enrollees.

(D) Processes to ensure the plan's language assistance program conforms with the requirements of section 1300.68(b)(3) and (7) of these regulations, including standards to ensure that LEP enrollees receive information regarding their rights to file a grievance and seek an independent medical review in threshold languages and through oral interpretation.

(i) All plans shall ensure that grievance forms and procedures in threshold languages are made readily available to enrollees and to contracting providers for distribution to enrollees upon request.

(ii) All plans shall inform contracting providers that informational notices explaining how enrollees may contact their plan, file a complaint with their plan, obtain assistance from the Department and seek an independent medical review are available in non-English languages through the Department's web site. The notice and translations can be obtained online at www.hmohelp.ca.gov for downloading and printing. In addition, hard copies may be requested by submitting a written request to: Department of Managed Health Care, Attention: HMO Help Notices, 980 9th Street, Suite 500, Sacramento, CA 95814.

(E) Processes to ensure that contracting providers are informed regarding the plan's standards and mechanisms for providing language assistance services at no charge to enrollees, and to ensure that LEP language needs information collected by the plan is made available to contracting providers.

(F) Processes and standards for providing translation services, including, but not limited to:

(i) A list of the threshold languages identified by the plan;

(ii) A list of the types of standardized and enrollee-specific vital documents that must be translated and the applicable standards for making translated vital documents available to subscribers and enrollees. Plans need not translate subscriber contracts, evidences of coverage and other large disclosure forms and enrollee handbooks in their entirety, but may excerpt from large documents the disclosures specified at subsection (b)(7)(G) for translation in a format that permits cost-effective and timely production and distribution, so long as there is no loss of accuracy or meaning by doing so. A plan may demonstrate compliance regarding translation of the disclosures specified at subsection (b)(7)(G) if the plan provides a standardized matrix that lists the major categories of health care services covered under the plan's subscriber contracts, together with the corresponding copayments and coinsurance, and exclusions and limitations, and disclosing any applicable deductibles and lifetime maximums, using the same sequence as the uniform matrix described at Section 1363(b)(1) of the Act.

(iii) A description of how the plan will provide or arrange for the provision of translation of vital documents at no charge to enrollees in accordance with the requirements of Section 1367.04 of the Act and this section. This subsection is not intended to prohibit or discourage a plan from providing translation of vital documents into a greater number of languages than the threshold languages;

(iv) A requirement that non-English translations of vital documents must meet the same standards required for English language versions of those documents; and

(v) A requirement that, with respect to vital documents that are not standardized, but which contain enrollee-specific information, a plan shall provide the English version together with the Department-approved written notice of the availability of interpretation and translation services and, if a translation is requested, the plan shall provide the requested translation in accordance with the requirements of Section 1367.04 of the Act and this section.

(G) Processes and standards for providing individual enrollee access to interpretation services at points of contact at no charge, including, but not limited to:

(i) A list of the non-English languages likely to be encountered among the plan's enrollees.

(ii) A requirement that the plan shall provide LEP enrollees with interpretation services for information contained in plan-produced documents.

(iii) A requirement that qualified interpretation services be offered to LEP enrollees, at no cost to the enrollee, at all points of contact, including when an enrollee is accompanied by a family member or friend that can provide interpretation services. The offer of a qualified interpreter, and the enrollee's refusal if interpretation services are declined, shall be documented in the medical record or plan file, as applicable.

(iv) When an enrollee needs interpretation services at a point of contact that occurs in a hospital, facility or provider office subject to federal or state law that requires the hospital, facility or provider office to provide interpretation services, the plan is not relieved of its obligation to comply with the requirements of Section 1367.04 of the Act or this section. Full service plans shall have reasonable processes in place to ensure that LEP enrollees can obtain the plan's assistance in arranging for the provision of timely interpretation services at all points of contact as defined at subsection (b)(4). This subsection does not prohibit a plan from incorporating into its language assistance program a contracting hospital's language assistance program if: the hospital's language assistance program provides access to interpretation services consistent with the requirements of Section 1367.04 of the Act and this section; the plan monitors for deficiencies in delivery of interpretation services by the hospital; and the plan takes appropriate corrective action to address hospital deficiencies in delivery of interpretation services to the plan's enrollees. This subsection is not intended to limit or expand any existing state or federal law.

(v) A description of the arrangements the plan will make to provide or arrange for the provision of timely interpretation services at no charge to LEP enrollees at all points of contact where language assistance is needed. For purposes of this subsection "timely" means in a manner appropriate for the situation in which language assistance is needed. Interpretation services are not timely if delay results in the effective denial of the service, benefit, or right at issue. A plan's language assistance program shall specify quality assurance standards for timely delivery of language assistance services for emergency, urgent and routine health care services, and shall include standards for coordinating interpretation services with appointment scheduling.

(vi) The range of interpretation services that will be provided to enrollees as appropriate for the particular point of contact. The range of services may include, but is not limited to:

(aa) Arranging for the availability of bilingual plan or provider staff who are trained and competent in the skill of interpreting;

(bb) Hiring staff interpreters who are trained and competent in the skill of interpreting;

(cc) Contracting with an outside interpreter service for trained and competent interpreters;

(dd) Arranging formally for the services of voluntary community interpreters who are trained and competent in the skill of interpreting; and

(ee) Contracting for telephone, videoconferencing or other telecommunications supported language interpretation services.

(vii) As used in this section, "trained and competent in the skill of interpreting," "qualified interpretation services" and "qualified interpreter"

means that the interpreter meets the plan's proficiency standards established pursuant to subsection (c)(2)((H).

(H) The plan's policies and standards for ensuring the proficiency of the individuals providing translation and interpretation services. A plan may develop and apply appropriate criteria for ensuring the proficiency of translation and interpretation services or may adopt certification by an association acceptable to the Department at the time of certification. A plan's language assistance proficiency standards shall require:

(i) A documented and demonstrated proficiency in both English and the other language;

(ii) A fundamental knowledge in both languages of health care terminology and concepts relevant to health care delivery systems; and

(iii) Education and training in interpreting ethics, conduct and confidentiality. The Department will accept plan standards for interpreter ethics, conduct, and confidentiality that adopt and apply, in full, the standards promulgated by the California Healthcare Interpreters Association or the National Council on Interpreting in Healthcare.

(3) Staff training.

Every plan shall implement a system to provide adequate training regarding the plan's language assistance program to all plan staff who have routine contact with LEP enrollees. The training shall include instruction on:

(A) Knowledge of the plan's policies and procedures for language assistance;

(B) Working effectively with LEP enrollees;

(C) Working effectively with interpreters in person and through video, telephone and other media, as may be applicable; and

(D) Understanding the cultural diversity of the plan's enrollee population and sensitivity to cultural differences relevant to delivery of health care interpretation services.

(4) Compliance Monitoring.

(A) Every plan shall monitor its language assistance program, including delegated programs, and make modifications as necessary to ensure compliance with Section 1367.04 of the Act and this section.

(d) In reviewing a plan's proposed language assistance program, the Department will evaluate the totality of the plan's language assistance program to determine whether the program as a whole provides meaningful access for LEP enrollees, and may consider relevant operational and demographic factors, including but not limited to:

(1) Whether the plan is a full service plan or specialized health care service plan;

(2) The nature of the points of contact;

(3) The frequency with which particular languages are encountered;

(4) The type of provider network and methods of health care service delivery;

(5) The variations and character of a plan's service area;

(6) The availability of translation and interpretation services and professionals;

(7) The variations in cost of language assistance services and the impact on affordability of health care coverage; and

(8) A plan's implementation of best practices and utilization of existing and emerging technologies to increase access to language assistance services, such as video interpreting programs, language translation software, collaborating with other plans to share a pool of interpreters, and other methods and technologies.

(9) Specialized dental, vision, chiropractic, acupuncture and employee assistance program plans that demonstrate adequate availability and accessibility of qualified bilingual contracted providers and office staff to provide

meaningful access to LEP enrollees, will be in compliance with the requirements of subsection (c)(2)(G)(iii) and (v). For the purposes of this subsection, specialized dental, vision, chiropractic, acupuncture and employee assistance program plans may demonstrate adequate availability and accessibility of competent and qualified bilingual providers and office staff if:

(A) The plan identifies within its provider directories those contracting providers who are themselves bilingual or who employ other bilingual providers and/or office staff, based on language capability disclosure forms signed by the bilingual providers and/or office staff, attesting to their fluency in languages other than English;

(B) The plan requires all contracting providers to provide quarterly updates regarding any changes in the language capabilities of currently employed providers and/or office staff by submitting new language capability disclosure forms, and the plan updates its provider directories accordingly, and consistent with Section 1367.26 of the Act; and

(C) The plan's quality assurance audits of contracting providers confirm and document the accuracy of provider language capability disclosure forms and attestations.

(e) Implementation.

(1) Within one year of the effective date of this section, every plan shall complete the initial enrollee assessment required by Section 1367.04 of the Act and this section. Every plan shall update its assessment of enrollee language needs and enrollee demographic profile at least once every three years following the initial assessment.

(2) By July 1,2008, every plan shall file, in accordance with Section 1352 of the Act, an amendment to its quality assurance program providing its written language assistance program policies and procedures, together with information and documents sufficient to demonstrate compliance with the requirements and standards of Section 1367.04 of the Act and this section. The filing shall include the plan's Section 1367.04(b)(1)(B)(v) notices. All materials filed with the Department that contain documents in non-English languages shall include the following minimum supporting documentation:

(i) The English version of each non-English document

(ii) An attestation by the translator or, if applicable, by an authorized officer of the organization providing translator services, outlining the qualifications of the translator making the translation and affirming that the non-English translation is an accurate translation of the English version.

(3) By January 1,2009 every plan shall have established and implemented a language assistance program in compliance with the requirements of Section 1367.04 of the Act and this section.

(4) Every contract between a health care provider and a plan, including a specialized plan, that is issued, amended, delivered or renewed on or after January 1,2009, shall require compliance with the plan's language assistance program standards developed pursuant to Section 1367.04 of the Act and this section.

(A) A plan shall retain financial responsibility for the implementation of the language assistance program required by Section 1367.04 of the Act and this section, except to the extent that delegated financial responsibility has been separately negotiated and specifically documented in written contracts. This subsection does not create an exception to Section 1367 of the Act and delegation shall not constitute a waiver of the plan's obligation to provide language assistance services required by Section 1367.04 of the Act and this section.

(B) Delegation to contracting providers of any part of the plan's obligation to provide language assistance services required by Section 1367.04 of the Act and this section constitutes a material change to a provider contract subject to the requirements of Section 1375.7 of the Act.

(f) The Department will periodically review plan compliance with the standards and requirements of Section 1367.04 of the Act and this section by methods that may include, but are not limited to, the medical survey process, reviews of consumer grievances and complaints to the Department's HMO Help Center, and provider complaints submitted to the Department's provider complaint line. The Department may also periodically request that plans submit information and data regarding enrollee language needs and demographic profile.

NOTE: Authority cited: Sections 1344 and 1367.04, Health and Safety Code. Reference: Sections 1259, 1342, 1363, 1365.5, 1367, 1367.04, 1367.07, 1368, 1368.01, 1370 and 1375.7, Health and Safety Code.

HISTORY:

1. New section filed 1-24-2007; operative 2-23-2007 (Register 2007, No. 4).

§ 1300.67.05. Acts of War Exclusions.

(a) No health care service plan contract executed or amended on or after the effective date of this regulation shall limit or exclude health care services based on a determination that the need for the health care service arose as a result of an Act of War.

(1) The term "contract" includes but is not limited to health care service plan contracts with subscribers and health care service providers.

(2) The term "Act of War" includes any act or conduct, or the prevention of an act or conduct, resulting from war, declared or undeclared, terrorism, or warlike action by any individual, government, military, sovereign group, terrorist or other organization.

(b) This regulation does not preclude a health plan from coordinating coverage of benefits with other entities.

(c) Nothing in this section shall prevent the Director from finding any exclusion or limitation of health care service or other services covered by the contract objectionable on grounds other than those set forth herein.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1345 and 1367, Health and Safety Code.

HISTORY:

1. New section filed 2-14-2002 as an emergency; operative 2-14-2002 (Register 2002, No. 7). A Certificate of Compliance must be transmitted to OAL by 6-14-2002 or emergency language will be repealed by operation of law on the following day.
2. Certificate of Compliance as to 2-14-2002 order, including amendment of subsection (a), transmitted to OAL 6-6-2002 and filed 7-17-2002 (Register 2002, No. 29).
3. Editorial correction of subsection (a) (Register 2002, No. 35).

§ 1300.67.1. Continuity of Care.

Within each service area of a plan, basic health care services shall be provided in a manner which provides continuity of care, including but not limited to:

(a) The availability of primary care physicians, who will be responsible for coordinating the provision of health care services to each enrollee;

(b) The encouragement of each enrollee to select a primary physician;

(c) The maintenance and ready availability of medical records, with sharing within the plan of all pertinent information relating to the health care of each enrollee;

(d) The maintenance of staff, including health professionals, administrative and other supporting staff, directly or through an adequate referral system, sufficient to assure that health care services will be provided on a timely and appropriate basis to enrollees;

(e) An adequate system of documentation of referrals to physicians or other health professionals. The monitoring of the follow up of enrollees' health care documentation shall be the responsibility of the health care service plan and associated health professionals.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1367, Health and Safety Code.

HISTORY:

1. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.67.1.3. Block Transfer Filings.

(a) Definitions. As used in this section:

(1) "Affected Enrollee" means enrollees of the plan who are assigned to a Terminated Provider Group or a Terminated Hospital.

(2) "Alternate Hospital" means a hospital that will provide services to plan enrollees in place of a Terminated Hospital.

(3) "Block Transfer" means a transfer or redirection of two thousand (2,000) or more enrollees by a plan from a Terminated Provider Group or Terminated Hospital to one or more contracting providers that takes place as a result of the termination or non-renewal of a Provider Contract.

(4) "Enrollee Transfer Notice" means a written notice that is sent to enrollees who are assigned to a Terminated Provider group or Terminated Hospital.

(5) "Provider Contract" means a contract between a plan and one or more health care providers, through which the plan arranges to provide health care services for its enrollees.

(6) "Provider Group" means a medical group, an independent practice association, or any other similar organization providing services to enrollees of a plan who are assigned to that provider group.

(7) "Receiving Provider Group" means a provider group that will provide services to Affected Enrollees in place of the current Provider Group.

(8) "Terminated Hospital" means a general acute care hospital that will no longer maintain a Provider Contract with the plan following the termination or non-renewal of a Provider Contract.

(9) "Terminated Provider" means either a Terminated Provider Group or a Terminated Hospital.

(10) "Terminated Provider Group" means a Provider Group that will no longer maintain a Provider Contract with the plan following the termination or non-renewal of a Provider Contract.

(b) For any proposed Block Transfer, a plan shall file with the Department a Block Transfer filing that includes, at minimum, all the items of information described in this subsection (b). The Block Transfer filing must be submitted to the Department at least seventy-five (75) days prior to the termination or non-renewal of any Provider Contract with a Terminated Provider Group or a Terminated Hospital. The Block Transfer filing must be submitted in an electronic format developed by the Department and made available at the Department's website at www.hmohelp.ca.gov and must include, at minimum, all of the following information as appropriate for the type of provider involved:

(1) A form of the written notice that the plan intends to send to Affected Enrollees. The Enrollee Transfer Notice must include:

(A) The name of the Terminated Provider Group or Terminated Hospital. The plan may also add the name of the assigned physician, where appropriate.

(B) A brief explanation of why the transfer is necessary due to the termination of the contract between the plan and the Terminated Provider.

(C) The date of the pending contract termination and transfer.

(D) An explanation to the Affected Enrollee outlining the Affected Enrollee's assignment to a new Provider Group, options for selecting a physician within a new Provider Group, and applicable timeframes to make a new Provider Group selection. The explanation must include a notification to the Affected Enrollee that he or she may select a different network provider by contacting the plan as outlined in the plan's written continuity of care policy and evidence of coverage or disclosure form.

(E) A statement that the plan will send the Affected Enrollee a new member information card with the name, address and telephone number of the Receiving Provider Group and assigned physician by a specified later date, which will occur prior to the date of the contract termination. Alternatively, the plan may notify the Affected Enrollee of the name, address and telephone number of the new Provider Group and assigned physician, or Alternate Hospital, to which the Affected Enrollee will be assigned in the absence of a selection made by the enrollee.

(F) A statement that the Affected Enrollee may contact the plan's customer service department to request completion of care for an ongoing course of treatment from a Terminated Provider. This statement may include either a statement outlining the specific conditions set forth in California Health and Safety Code section 1373.96(c), or an explanation to the Affected Enrollee that his or her eligibility is conditioned upon certain factors as outlined in the plan's written continuity of care policy and evidence of coverage or disclosure form.

(G) The telephone number through which the Affected Enrollee may contact the plan for a further explanation of his or her rights to completion of care, including the plan's written continuity of care policy; and a link that an Affected Enrollee may use to obtain of a downloadable copy of the policy from the plan's website.

(H) A statement informing any enrollee of a point of service product that the Affected Enrollee may be required to pay a larger portion of costs if he or she continues to use his or her current providers, if applicable to the particular Block Transfer.

(I) The following statement in at least 8-point font:

> "If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated time period. Please contact your HMO's customer service department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number 1-888-HMO-2219, or at a TDD number for the hearing impaired at 1-877-688-9891, or online at www.hmohelp.ca.gov."

The statement may be modified to include the health care service plan's name in place of the phrase "your HMO's."

(J) The plan shall require all contracted providers to include the statutory language required by California Health and Safety Code section 1373.65(f) in all communications to Affected Enrollees that concern the termination of a provider or a Block Transfer.

(K) Compliance with all applicable language assistance statues and regulations, including Section 1367.04 and any regulations based upon Section 1367.04.

(2) For a Terminated Hospital contract the plan shall also submit the following information:

(A) A brief explanation of the cause of the hospital redirection including whether the contract termination or non-renewal was initiated by the plan, the hospital, or by a contracting Provider Group.

(B) A copy of the notice of termination sent or received by the plan.

(C) If the contract termination will affect 50,000 or more enrollees, the relevant portions of the Provider Contract(s) that relate to continuity of care and transition of care.

(D) Either of the following two options:

1. a list of counties in which Affected Enrollees reside and the corresponding number of Affected Enrollees for each county, or

2. a list of the zip codes in which Affected Enrollees reside and the corresponding number of Affected Enrollees for each zip code.

(E) The number of Affected Enrollees assigned to the Terminated Hospital, and the number to be reassigned to each Alternate Hospital, classified by type of product (for example, commercial, Medi-Cal, Healthy Families, etc.)

(F) The number of Affected Enrollees within a 15-mile radius of the Terminated Hospital.

(G) The date that the plan anticipates it will mail the Enrollee Transfer Notification.

(H) The proposed date or dates of transfer of Affected Enrollees. If the plan intends to transfer Affected Enrollees on various dates, please explain the reason for the different transfer dates.

(I) If additional governmental departments or agencies require approval of enrollee notices regarding the transfer, provide copies of each proposed notice as well as an explanation of the status of each required approval.

(J) The identity of the Terminated Hospital and Alternate Hospital including the contract renewal or termination date for each Alternate Hospital.

(K) A listing identifying any services that are available at the Terminated Hospital that are not available at an Alternate Hospital. The plan must discuss the arrangements it has made to ensure that enrollees have an opportunity to receive those services.

(L) Based upon the data made public on the Office of Statewide Health Planning and Development's website, for each of the proposed Alternate Hospitals, provide the available bed occupancy rate for the most recently completed calendar year. If the rate is at 80% or higher, please provide justification as to the sufficiency of the Alternate Hospital's capacity to serve additional plan enrollees.

(M) The number of bed days utilized by plan enrollees at the Terminated Hospital for the most recently completed calendar year.

(N) An analysis showing the driving distance between the proposed Alternate Hospital and the Terminated Hospital.

(O) Of the primary care providers to whom Affected enrollees are currently assigned, the number and percentage of primary care providers with active admitting privileges at the Alternate Hospital(s) and the number of Affected Enrollees assigned to these primary; care providers and the number and percentage of primary care providers without active admitting privileges at the Alternate Hospital(s) and the number of Affected Enrollees assigned to these primary care providers.

(P) Explain the procedure by which an Affected Enrollee who is assigned to a primary care provider who does not have active admitting privileges to the Alternate Hospital(s) will receive needed hospital care.

(Q) Of the specialists available to Affected Enrollees with active admitting privileges at the Terminated Hospital, the number and percentage with active admitting privileges at the Alternate Hospital(s). If any of these specialists will be unable to admit to the Alternate Hospital(s), disclose the specialty involved, how many specialists of that specialty, if any, will still be available to admit the Alternate Hospital(s) and explain how Affected Enrollees will receive care for that specialty at a proposed Alternate Hospital if there are an insufficient number of remaining specialists with active admitting privileges.

(R) A disclosure of any anticipated increase in costs that will be incurred by Affected Enrollees of the plan's point of service products resulting from termination of the current hospital's contract if they continue to use the Terminated Provider.

(S) Confirmation that the plan's continuity of care program, as filed with the Department, will be implemented for any Affected Enrollees.

(3) For a Provider Group contract termination, the plan shall also submit the following information:

(A) A brief explanation of the cause or circumstances of the Provider Contract termination or non-renewal, including whether the contract termination or non-renewal was initiated by the plan or the Provider Group. If the Provider Contract termination is due to a provider closure, specify whether the provider closure is due to a bankruptcy, an insolvency, a sale, ceasing business operations or the closure of a specific office site.

(B) A copy of the notice of termination sent or received by the plan.

(C) If the contract termination will affect 50,000 or more enrollees, the relevant portions of the Provider Contract(s) that relate to continuity of care and transition of care.

(D) Either of the following two options:

(i) a list of counties in which Affected Enrollees reside and the corresponding number of Affected Enrollees for each county, or

(ii) a list of the zip codes in which Affected Enrollees reside and the corresponding number of Affected Enrollees for each zip code.

(E) A listing, classified by type of product (for example, commercial, Medi-Cal, Healthy Families, etc.) that specifies the number of Affected Enrollees assigned to the Terminated Provider.

(F) The date that the plan anticipates it will mail the Enrollee Transfer Notice.

(G) The proposed date or dates of transfer. If the plan intends to transfer Affected Enrollees on various dates, please explain the reason for the different transfer dates.

(H) The plan's estimate of the percentage of Affected Enrollees who will remain with the same primary care provider after the transfer to a Receiving Provider Group.

(I) If additional governmental departments or agencies require approval of enrollee notices regarding the transfer, please provide copies of each proposed notice as well as an explanation of the status of each required approval.

(J) A matrix of proposed Receiving Provider Groups that includes the following information:

1. the identity of the Receiving Provider Group(s), including its Risk Bearing Organization (RBO) number as assigned by the Department,

2. the number of Affected Enrollees being transferred to each Receiving Provider Group listed by type of product. If the plan gives the Affected Enrollees the choice of selecting a new provider, then the plan must provide the number of Affected Enrollees to be transferred to each receiving Provider Group by default if no selections are made by the Affected Enrollees,

3. a listing of all hospitals to which Receiving Provider Groups refer Affected Enrollees, if different from the Terminated Provider Group.

(K) Confirmation that the plan's continuity of care program, as filed with the Department, will be implemented for any Affected Enrollees.

(c) Timing of Notice Requirements. For any termination or non-renewal of a Provider Contract, a plan shall mail to all Affected Enrollees an Enrollee Transfer Notice that has been approved by the Department.

(1) The Enrollee Transfer Notice must be mailed to each Affected Enrollee at least sixty (60) days prior to the date of termination or non-renewal.

(d) Notice Mailing Requirements. The plan shall send an Enrollee Transfer Notice to Affected Enrollees as follows:

(1) For Affected Enrollees enrollees who are Block Transferred from a Terminated Provider Group — the plan shall send the notice to all Affected Enrollees assigned to the Terminated Provider Group.

(2) For Affected Enrollees who are block transferred from a Terminated Hospital — the plan shall send the notice to all Affected Enrollees who reside within 15 miles of the Terminated Hospital.

(e) If, for any reason, a plan is unable to send all Enrollee Transfer Notice required pursuant to subsection 1300.67.1.3(c) of Title 28, California Code of Regulations, at least sixty (60) days prior to the termination or non-renewal of a Provider Contract, the plan shall submit to the Department an application for a waiver of the 60-day requirement. The application for waiver must include an explanation of the plan's reasons for being unable to meet the 60-day notice requirement and its proposal to minimize any disruption that may be caused to Affected Enrollees by the reduced notice. A waiver application may be based upon the sudden closure of a contracted provider, a notice-timing conflict with another jurisdictional agency, or other circumstances for which good-cause exists. If the Department does not approve or disapprove the waiver request within seven (7) days of its receipt of the request, the waiver will be deemed to have been approved by the Department.

(f) If, after sending Enrollee Transfer Notices a plan reaches an agreement to renew or enter into a new Provider Contract or to not terminate their Provider Contract with a Terminated Provider to which the plan had assigned enrollees, then the plan shall promptly inform the Department and convey an additional enrollee notification, either by telephone or in writing, to each Affected Enrollee. The additional enrollee notification must include:

(1) A brief explanation of the fact that the plan has reached an agreement with the Affected Enrollee's previously assigned provider.

(2) An explanation to the enrollee regarding options for either returning to the previously assigned provider, keeping the newly assigned provider, or select another participating provider from the plan's contracting provider list.

(3) An explanation to the Affected Enrollee of the procedure by which the enrollee may contact the plan to express his or her desire to return to the previously assigned provider.

(4) If the additional enrollee notice is given in writing, then the notice must include the following statement in at least 8-point font:

> "If you have any questions regarding this notice please contact [Plan Name] customer service department. If you have further concerns about your provider network, you are encouraged to contact the Department of Managed Health Care by telephone at its toll-free number 1-888-HMO-2219, or at TDD number for the hearing impaired at 1-877-688-9891, or online at www.hmohelp.ca.gov."

(5) Compliance with all applicable language assistance statutes and regulations, including Section 1367.04 and any regulations based upon Section 1367.04.

NOTE: Authority cited: Sections 1342, 1344 and 1346, Health and Safety Code. Reference: Sections 1367.04 and 1373.65, Health and Safety Code.

HISTORY:

1. New section filed 8-22-2005; operative 9-21-2005 (Register 2005, No. 34).

§ 1300.67.2. Accessibility of Services.

Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;

(a) The location of facilities providing the primary 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.

(b) Hours of operation and provision for after-hour services shall be reasonable;

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

(d) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be at least one full-time equivalent 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, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees;

(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.

Subject to subsections (a) and (b) of this section, a plan may rely on the standards of accessibility set forth in Item H of Section 1300.51 and in Section 1300.67.2.

§ 1300.67.2.1. Geographic Accessibility Standards.

Subject to subsections (a) and (b) of this section, a plan may rely, for the purposes of satisfying the requirements for geographic accessibility, on the standards of accessibility set forth in Item H of Section 1300.51 and in Section 1300.67.2.

(a) If, given the facts and circumstances with regard to any portion of its service area, a plan's standards of accessibility adopted pursuant to Item H of Section 1300.51 and/or Section 1300.67.2 are unreasonably restrictive, or the service area is within a county with a population of 500,000 or fewer, and is

within a county that, as of January 1,2002, has two or fewer full service health care service plans in the commercial market, the plan may propose alternative standards of accessibility for that portion of its service area. The plan shall do so by including such alternative standards in writing in its plan license application or in a notice of material modification. The plan shall also include a description of the reasons justifying the less restrictive standards based on those facts and circumstances. If the Department rejects the plan's proposal, the Department shall inform the plan of the Department's reason for doing so.

(b) If, in its review of a plan license application or a notice of material modification, the Department believes the accessibility standards set forth in Item H of Section 1300.51 and/or Section 1300.67.2 are insufficiently prescribed or articulated or are inappropriate given the facts and circumstances with regard to a portion of a plan's service area, the Department shall inform the plan that the Department will not allow application of those standards to that portion of the plan's service area. The Department shall also inform the plan of the Department's reasons for rejecting the application of those standards.

(c) The facts and circumstances to be included in a discussion of the reasons justifying the standards of accessibility proposed by the plan pursuant to subsection (a) or (b) of this section shall include, to the extent relevant, but shall not necessarily be limited to the following:

(1) whether the plan contract involved is a group health care service plan contract or an individual health care service plan contract;

(2) whether the plan contract is a full-service health care service plan contract or a specialized health care service plan contract, and if the latter, whether emergency services need not be covered;

(3) the uniqueness of the services to be offered;

(4) whether the portion of the service area involved is urban or rural;

(5) population density in the portion of the service area, including whether the service area is within a county with a population of 500,000 or fewer;

(6) whether, as of January 1,2002, the county containing the service area had two or fewer full service health care service plans providing coverage to the entire county in the commercial market;

(7) the distribution of enrollees in the portion of the service area;

(8) the availability and distribution of primary care physicians;

(9) the availability and distribution of other types of providers;

(10) the existence of exclusive contracts in the provider community or other barriers to entry;

(11) patterns of practice in the portion of the service area;

(12) driving times;

(13) waiting times for appointments;

(14) whether the plan or any other health care service plan currently has significant operations in that portion of the service area; and

(15) other standards of accessibility that the Director deems necessary or appropriate in the public interest and consistent with the intent and purpose of the Act as applied to specific facts or circumstances.

(d) At least 30 days before a health care service plan files a notice of material modification of its license with the department in order to withdraw from a county with a population of 500,000 or fewer, the health care service plan shall hold a public meeting at a time and place reasonably calculated to facilitate attendance by affected enrollees in the county from which it intends to withdraw, and shall do all of the following:

(1) Provide notice announcing the public meeting at least 30 days prior to the public meeting to all affected enrollees, health care providers with which it contracts, the members of the board of supervisors of the affected county, the

members of the city councils of cities in the affected county, and the members of the Legislature who represent the affected county.

(2) Provide notice announcing the public meeting at least 15 days prior to the public meeting in a newspaper of general circulation within the affected county.

(3) At the public meeting, allow testimony, which may be limited to a certain length of time by the health care service plan, of all interested parties.

(4) File with the department for review, no less than 30 days prior to the date of mailing or publication, the notices required under subparagraphs (1) and (2).

(e) The department may require a health care service plan that has filed to withdraw from a portion of a county with a population of fewer than 500,000 to hold a hearing for affected enrollees.

(f) A representative of the department shall attend the public meeting described in this section.

NOTE: Authority cited: Sections 1344, 1351 and 1366.1, Health and Safety Code. Reference: Sections 1366.1, 1367 and 1367.2, Health and Safety Code.

HISTORY:

1. New section filed 11-30-98; operative 11-30-98 pursuant to Government Code section 11343.4(d) (Register 98, No. 49).
2. Change without regulatory effect amending subsection (a) filed 4-4-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 14).
3. Change without regulatory effect amending subsection (c) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
4. Amendment of section heading, section and Note filed 6-10-2004; operative 7-10-2004 (Register 2004, No. 24).

§ 1300.67.2.2. Timely Access to Non–Emergency Health Care Services and Annual Timely Access and Network Reporting Requirements.

(a) Application.

(1) A health care service plan that provides or arranges for the provision of hospital or physician services, including a specialized mental health plan that provides physician or hospital services, or provides mental health services pursuant to a contract with a full–service plan, shall comply with the requirements of this section.Aspecialized mental health plan includes a plan only licensed to provide the services set forth in subsection (a)(3) of Health and Safety Code section 1374.72.

(2) A specialized dental, vision, chiropractic, or acupuncture plan shall comply with this subsection and subsections (c)(1), (c)(3), (c)(4), (c)(7), (c)(9), (c)(10), (d)(1), (g)(1), (h)(1)(B), (h)(5), (h)(9), (i) and (j) of this Rule. These specialized plans shall comply with the network access profile requirements in subsections (h)(2) and (h)(8) of this Rule, and documents incorporated within this Rule, as specified. Dental plans shall also comply with subsection (c)(6).

(3) The obligation of a plan to comply with this section shall not be waived if the plan delegates to its provider groups or other contracting entities any services or activities that the plan is required to perform. A plan's implementation of this section shall be consistent with the Health Care Providers' Bill of Rights, and a material change in the obligations of a plan's network providers shall be considered a material change to the provider contract, within the meaning of subsections (b) and (h)(2) of section 1375.7 of the Knox–Keene Act. (4) This section confirms requirements for plans to provide or arrange for the provision of health care services in a timely manner, and establishes additional metrics for measuring and monitoring the adequacy of a plan's network to provide

enrollees with timely access to needed health care services. This section does not:

(A) Establish professional standards of practice for health care providers;

(B) Establish requirements for the provision of emergency services; or

(C) Create a new cause of action or a new defense to liability for any person.

(5) All reports and information submitted by the plan pursuant to this section shall be timely, accurate and complete.

(6) A plan that uses a tiered network shall demonstrate compliance with the standards established by section 1367.03 of the Knox–Keene Act and this Rule based on providers available at the lowest cost–sharing tier.

(b) Definitions.

For purposes of this section, the following definitions apply.

(1) "Advanced access" means the provision, by a network provider, or by the provider group to which an enrollee is assigned, of appointments with a primary care physician, or other qualified primary care provider such as a nurse practitioner or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the enrollee prefers not to accept the appointment offered within the same or next business day.

(2) "Appointment waiting time" means the time from the initial request to the plan or a provider for covered health care services by an enrollee, an enrollee's representative or the enrollee's treating provider to the earliest date offered for the appointment for services. Appointment waiting time is inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its network providers. A grievance, as defined in Rule 1300.68(a)(1), regarding a delay or difficulty in obtaining an appointment for a covered health care service may constitute an initial request for an appointment for covered health care services.

(3) "Preventive care" means health care provided for prevention and early detection of disease, illness, injury, or other health conditions and, in the case of a full–service plan includes all of the following health care services required by sections 1345(b)(5), 1367.002, 1367.3 and 1367.35 of the Knox–Keene Act, and Rule 1300.67(f).

(4) "Measurement year" means the time periods within which a plan shall collect the required information for the Timely Access Compliance Report and the Annual Network Report.

(A) The Timely Access Compliance Report measurement year is January 1 to December 31 of the year immediately preceding the year in which the information set forth in subsection (h)(6), (h)(7)(A)(iv), and (h)(7)(C) of this Rule is required to be submitted to the Department, pursuant to subsection (h)(1) of this Rule.

(B) The Annual Network Report measurement year is the year in which the information set forth in subsection (h)(7) of this Rule is required to be submitted to the Department, pursuant to subsection (h)(1) of this Rule, except as otherwise indicated in subsections (h)(7)(A)(iv) and (h)(7)(C) of this Rule.

(5) "Network" means a discrete set of network providers, as defined in subsection (b)(10) of this Rule, the plan has designated to deliver all covered services for a specific network service area, as defined in subsection (b)(11) of this Rule.

(6) "Network adequacy" means the sufficiency of a plan's network to ensure the delivery of all covered services, on an ongoing basis, in a manner that meets the network accessibility, availability, and capacity requirements set forth in the Knox–Keene Act, including subsection (a)(5) of section 1371.31, subsections

(d) and (e) of section 1367 and section 1375.9, and Rules 1300.51, 1300.67.2, subsection (c)(7) of this Rule, and 1300.67.2.1.

(7) "Network capture date" means the date the plan shall capture all data for each network required to be reported pursuant to subsections (h)(6)(B)(i)a.–e. and (h)(7)(A)(i)–(iii) of this Rule, for the Timely Access Compliance Report and the Annual Network Report. The following network capture dates apply:

(A) For the Annual Network Report, the network capture date is January 15 of the Annual Network Report measurement year, as set forth in subsection (b)(4)(B) of this Rule.

(B) For the Timely Access Compliance Report, the network capture date is a date selected by the plan that occurs on or after January 15 of the Timely Access Compliance Report measurement year as set forth in subsection (b)(4)(A) of this Rule, but no later than the date the plan begins conducting the Provider Appointment Availability Survey, set forth in subsection (f) of this Rule. The network capture date selected by the plan shall:

(i) Allow the plan to adhere to all requirements in the PAAS Manual;

(ii) Be a date as close to administration of the survey as practicable; and

(iii) Ensure the information in the plan's Provider Appointment Availability Survey Contact List is accurate and representative of the network at the time the survey is administered.

(8) "Network identifier" is the fixed identifier assigned to each network by the Department.

(9) "Network name" is the name used by the plan to identify a specific network in plan communications and submissions to the Department.

(10) "Network provider" means any provider as defined in subsection (i) of section 1345 of the Knox–Keene Act, located inside or outside of the network service area of a designated network, meeting all of the following criteria:

(A) The provider is available to provide covered services to all plan enrollees in all product lines using the designated network.

(B) The provider is one or more of the following:

(i) An employee of the plan;

(ii) An individual health professional or health facility contracted directly with the plan consistent with the Knox–Keene Act and implementing regulations, including the contractual requirements for providers within sections 1348.6, 1367(h), 1367.04, 1367.27, 1367.62, 1373.65(f), 1375.7, 1379 and subsection (d) of section 1351;

(iii)An individual health professional or health facility contracted with the plan through an association, provider group, or other entity, consistent with the Knox–Keene Act and implementing regulations, including the contractual requirements for providers within sections 1348.6, 1367(h), 1367.04, 1367.27, 1367.62, 1373.65(f), 1375.5, 1379, and subsection (d) of 1351;

(iv) An individual health professional or health facility designated to deliver covered services to enrollees in the network through a plan–to–plan contract, as defined in subsection (b)(13); or

(v) An individual health professional or health facility required to be part of the plan's network under any of the following circumstances; a. a corrective action plan submitted to the Department by the plan or its delegated entity; b. as required by the Department pursuant to section 1373.65 of the Knox–Keene Act; or c. as otherwise required by order of the Department.

(C) The provider is accessible to enrollees of the designated network without limitations other than established:

(i) In–network referral or authorization processes; or

(ii) Processes for changing provider groups consistent with section 1373.3 of the Knox–KeeneAct, in networks where enrollees are assigned to a provider group.

(D) A network provider shall not include:

(i) Providers made available through single–case agreements, letters of intent, or contract agreements that do not include the provider contracting requirements of the Knox–Keene Act as described in subsection (b)(10)(B)(ii) and (iii) of this Rule;

(ii) For any line–of–business that includes an out–of–network benefit (e.g., preferred provider organization (PPO) or point–of–service (POS)), providers who are available to enrollees only at non–participating or out–of–network cost–share levels; or

(iii) Noncontracting individual health professionals, as defined in subsection (f)(5) of section 1371.9 of the Knox–Keene Act.

(11) "Network service area" means 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. "Population points" shall mean a representation of where people live and work in the state of California based on United States Census Bureau population data and United States Postal Service (USPS) delivery route data, and made available annually by the Department on the web portal accessible at www.dmhc.ca.gov.

(12) "Patterns of non–compliance," with respect to the standards set forth in subsection (c) of this Rule, means any of the following:

(A) For purposes of the Provider Appointment Availability Survey: Fewer than 70% of the network providers, as calculated on the Provider Appointment Availability Survey Results Report Form, for a specific network had a non–urgent or urgent appointment available within the time–elapsed standards set forth in subsection (c)(5)(A)–(F) for the measurement year. A pattern of non–compliance shall be identified using the information reported to the Department in the "Rate of Compliance Urgent Care Appointments (All Provider Survey Types)" field and the "Rate of Compliance Non–UrgentAppointments (All Provider Survey Types)" field in the Summary of Rate of Compliance Tab of the Results Report Form.

(B) The Department receives information establishing that the plan was unable to deliver timely, available, or accessible health care services to enrollees. The Department may consider any of the following factors in evaluating whether each instance identified is part of a pattern of non–compliance that is reasonably related:

(i) Each instance is a violation of the same standard set forth in subsection (c) of this Rule;

(ii) Each instance involves the same network;

(iii) Each instance involves the same provider group, or subcontracted plan;

(iv) Each instance involves the same provider type;

(v) Each instance involves the same network provider;

(vi) Each instance occurs in the same region. For purposes of this subsection, a region is a county in which a network provider practices, and the counties next to or adjoining that county;

(vii) The number of enrollees in the health plan's network and the total number of instances identified as part of a pattern; (viii) Whether each instance occurred within the same twelve–month period; or

(ix) Whether each instance involves the same category of health care services.

(13) "Plan–to–plan contract" means an arrangement between two plans, in which the subcontracted plan makes network providers available to primary

plan enrollees, and may be responsible for other primary plan functions. Plan–to–plan contracts include administrative service agreements, management service agreements or other contracts between a primary and subcontracted plan.

(A) "Primary plan" means a licensed plan that holds a contract with a group, individual subscriber, or a public agency, to arrange for the provision of health care services.

(B) "Subcontracted plan" means a licensed plan or specialized plan that is contracted to allow a primary plan's enrollees access to the subcontracted plan's network providers. The contract may be between the primary plan and the subcontracted plan or between two subcontracted plans.

(14) "Product line" means the combination of the plan's product and the type of market segment (e.g., individual, large group, small group, government) in which the product is licensed to be offered. "Product" means a discrete package of health care benefits the plan is licensed to offer using a particular line of business (e.g., health maintenance organization (HMO), PPO, POS, and exclusive provider organization (EPO)) within a network service area.

(15) "Provider group" has the meaning set forth in subsection (g) of section 1373.65 of the Knox–Keene Act. (16) "Provider Survey Types" means the following five types of network providers required to be surveyed in the Provider Appointment Availability Survey Manual, pursuant to subsection (f) of this section:

(A) Primary care providers;

(B) Non–physician mental health care providers;

(C) Specialist physicians;

(D) Psychiatrists; and

(E) Ancillary service providers.

(17) "Reporting plan" means a full–service or mental health plan that is licensed to contract with a group, individual subscriber, or a public agency, to arrange for the provision of health care services and has one or more networks approved by the Department as of January 15th of the applicable measurement year. A reporting plan shall submit the reports set forth in subsection (h) of this section on behalf of itself or on behalf of a subcontracted plan through a plan–to–plan contract.

(18) "Reporting year" means the calendar year in which the plan's Timely Access Compliance Report and Annual Network Report is submitted to the Department.

(19) "Triage" or "screening" means the assessment of an enrollee's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage an enrollee who may need care, for the purpose of determining the urgency of the enrollee's need for care.

(20) "Triage or screening waiting time" means the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage an enrollee who may need care.

(21) "Urgent care" means health care for a condition which requires prompt attention, consistent with subsection (h)(2) of section 1367.01 of the Knox–Keene Act.

(c) Standards for Timely Access to Care.

(1) A plan shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. A plan shall establish and maintain

networks, policies, procedures, and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.

(2) A plan shall ensure that all plan and provider processes necessary to obtain covered health care services, including the processes required under section 1367.01 of the Knox–Keene Act, are completed in a manner that assures the provision of covered health care services to an enrollee in a timely manner appropriate for the enrollee's condition and in compliance with the requirements of this Rule.

(3) If it is necessary for a provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice, and consistent with the objectives of section 1367.03 of the Knox–Keene Act and the requirements of this Rule.

(4) Interpreter services required by section 1367.04 of the Knox–Keene Act and Rule 1300.67.04 shall be coordinated by the plan, its delegated network provider, or other delegated entity with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment without imposing delay on the scheduling of the appointment. This subsection does not modify the requirements established in Rule 1300.67.04 or approved by the Department pursuant to Rule 1300.67.04 for a plan's language assistance program.

(5) In addition to ensuring compliance with the clinical appropriateness standard set forth in subsection (c)(1) of this Rule, a plan shall ensure that its network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the following timeframes:

(A) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in subsection (c)(5)(H) of this Rule;

(B) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in subsection (c)(5)(H) of this Rule;

(C) Non–urgent appointments for primary care: within ten business days of the request for appointment, except as provided in subsection (c)(5)(H) and in subsection (c)(5)(I) of this Rule;

(D) Non–urgent appointments with specialist physicians: within fifteen business days of the request for appointment, except as provided in subsection (c)(5)(H) and in subsection (c)(5)(I) of this Rule;

(E) Non–urgent appointments with a non–physician mental health care provider or substance use disorder provider: within ten business days of the request for appointment, except as provided in subsection (c)(5)(H) and in subsection (c)(5)(I) of this Rule;

(F) Nonurgent follow up appointments with a nonphysician mental health care or substance use disorder provider: within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition, except as provided in subsection (c)(5)(H) of this Rule. This subsection does not limit coverage for nonurgent follow up appointments with a nonphysician mental health care or substance use disorder provider to once every 10 business days.

(G) Non–urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within fifteen business days of the request for appointment, except as provided in subsection (c)(5)(H) and in subsection (c)(5)(I) of this Rule;

(H) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee;

(I) Preventive care services and periodic follow up care, including standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac, mental health, or substance use disorder conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of their practice;

(J) A referral to a specialist by a primary care provider or another specialist shall be subject to the relevant time–elapsed standard in subsection (c)(5)(A), (B), or (D) of this Rule, unless the requirements in subsection (c)(5)(H) or (I) of this Rule are met, and shall be subject to the other provisions of this section; and

(K) A plan may demonstrate compliance with the primary care time–elapsed standards established by this subsection through implementation of standards, processes and systems providing advanced access to primary care appointments, as defined at subsection (b)(1) of this Rule.

(6) In addition to ensuring compliance with the clinical appropriateness standard set forth in subsection (c)(1) of this Rule, each dental plan, and each full–service plan offering coverage for dental services, shall ensure that dental networks have adequate capacity and availability of licensed health care providers to offer enrollees appointments for covered dental services in accordance with the following requirements:

(A) Urgent appointments within the dental plan network shall be offered within 72 hours of the time of request for appointment, if consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice;

(B) Non–urgent appointments shall be offered within 36 business days of the request for appointment, except as provided in subsection (c)(6)(C) of this Rule; and

(C) Preventive dental care appointments shall be offered within 40 business days of the request for appointment.

(7) A plan shall ensure it has sufficient numbers of network providers to maintain compliance with the standards established by this section.

(A) This section does not modify the requirements regarding provider–to–enrollee ratios or geographic accessibility established by Rules 1300.51, 1300.67.2 or 1300.67.2.1.

(B) A plan operating in a network service area, or a portion of a network service area, that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time–elapsed standards, by referring enrollees to, or, in the case of a preferred provider organization or point–of–service network, by assisting an enrollee to locate, available and accessible network providers in neighboring network service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs.

(C) A plan shall arrange for the provision of covered services from providers outside the plan's network if unavailable within the network, if medically

necessary for the enrollee's condition. A plan shall ensure that enrollee costs for medically necessary referrals to non–network providers under this Rule shall not exceed applicable in–network co–payments, co–insurance, and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific network provider. If medically necessary treatment of a mental health or substance use disorder is not available in network within the geographic and timely access standards set by law or regulation, a plan shall arrange coverage outside the plan's network in accordance with subsection (d) of section 1374.72 of the Knox Keene Act.

(8) A plan shall provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone as defined at subsection (b)(19) of this Rule.

(A) A plan shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the enrollee's condition, and the triage or screening waiting time does not exceed 30 minutes.

(B) A plan may provide or arrange for the provision of telephone triage or screening services through one or more of the following means: plan–operated telephone triage or screening services consistent with subsection (b)(19) of this Rule; telephone medical advice services pursuant to section 1348.8 of the Knox–KeeneAct; the plan's contracted primary care and mental health care or substance use disorder network; or another method that provides triage or screening services consistent with the requirements of this subsection.

(i) A plan that arranges for the provision of telephone triage or screening services through primary care, mental health care, and substance use disorder network providers shall require those providers to maintain a procedure for triaging or screening enrollee telephone calls, which, at a minimum, shall include the employment, during and after business hours, of a telephone answering machine, an answering service, or office staff, that shall inform the caller of both of the following:

a. Regarding the length of wait for a return call from the provider; and

b. How the caller may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on–call to triage or screen by telephone, or if needed, deliver urgent or emergency care.

(ii) A plan that arranges for the provision of triage or screening services through network primary care, mental health care and substance use disorder providers who are unable to meet the time–elapsed standards established in subsection (c)(8)(A) shall also provide or arrange for the provision of plan–contracted or plan–operated triage or screening services, which shall, at a minimum, be made available to enrollees affected by that portion of the plan's network.

(iii) An unlicensed staff person handling enrollee calls may ask questions on behalf of a licensed staff person in order to help ascertain the condition of an enrollee so that the enrollee may be referred to a licensed staff person. However, an unlicensed staff person shall not, under any circumstances, use the answers to those questions to assess, evaluate, advise, or make any decision regarding the condition of an enrollee or determine when an enrollee needs to be seen by a licensed medical professional.

(9) A plan that provides dental, vision, chiropractic, or acupuncture services shall ensure that network providers delivering these health care services employ an answering service or a telephone answering machine during non–business hours that provides instructions regarding how an enrollee may obtain urgent

or emergency care, including, if applicable, how to contact another provider who has agreed to be on–call to triage or screen by telephone, or if needed, deliver urgent or emergency care.

(10) A plan shall ensure that, during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed ten minutes.

(d) Quality Assurance Processes.

Effective January 1, 2023, each plan shall have written quality assurance systems, policies, and procedures designed to ensure that the plan's network is sufficient to provide accessibility, availability, and continuity of covered health care services as required by the Knox–Keene Act and this Rule. In addition to the requirements established by Rule 1300.70, a plan's quality assurance program shall address:

(1) Standards for the provision of covered services in a timely manner consistent with the requirements of this section.

(2) Compliance monitoring policies and procedures, filed for the Department's review and approval, designed to accurately measure the accessibility and availability of network providers including:

(A) Tracking and documenting network capacity and availability with respect to the standards set forth in:

(i) Subsections (c)(1)–(4), (c)(5)(H)–(K), (c)(6), and (c)(8)–(9) of this Rule, except as provided by subsection (d)(2)(F) of this Rule;

(ii) Subsection (c)(7) of this Rule; and

(iii) Subsection (c)(5)(A)–(G) of this Rule by administering the Provider Appointment Availability Survey, pursuant to subsection (f) of this Rule.

(B) Conducting an annual Enrollee Experience Survey. The Enrollee Experience Survey shall:

(i) Be conducted in accordance with a statistically valid and reliable survey methodology.

(ii) Obtain enrollees' perspectives and concerns regarding their experience obtaining timely appointments for health care services within the standards set forth in subsection (c) of this Rule.

(iii) Inform enrollees of their right to obtain an appointment within each of the time–elapsed standards set forth in subsections (c)(1) and (5) of this Rule, and their right to receive interpreter services at that appointment, as required by subsection (c)(4) of this Rule. The requirement to notify enrollees who are surveyed about their right to obtain a timely appointment shall be in addition to the notice requirements set forth in section 1367.031 of the Knox–KeeneAct. The notice may be included in the survey or in a document attached to the survey.

(iv) Evaluate the experience of limited English proficient enrollees in obtaining interpreter services by obtaining the enrollee's perspectives and concerns regarding:

a. Coordination of appointments with an interpreter;

b. Availability of interpreters who speak the enrollee's preferred language; and

c. Quality of interpreter services received.

(v) Be translated into the enrollee's preferred language, in those situations where:

a. The plan is aware of the enrollee's preferred language; and

b. The enrollee's preferred language is one of the top 15 languages spoken by limited English proficient individuals in California as determined by the Department of Health Care Services.

(C) Conducting an annual Provider Satisfaction Survey, which shall be conducted in accordance with a statistically valid and reliable survey methodology and designed to obtain, from physicians and non–physician mental health providers, perspectives and concerns regarding compliance with the standards set forth in subsection (c). In addition, the Provider Satisfaction Survey shall evaluate provider perspectives and concerns with the plan's language assistance program regarding: (i) Coordination of appointments with an interpreter;

(ii) Availability of an interpreter, based on the needs of the enrollee; and

(iii) The ability of the interpreter to effectively communicate with the provider on behalf of the enrollee.

(D) The plan's process for reviewing and evaluating, on not less than a quarterly basis, all the information available to the plan regarding the plan's ability to meet timely access compliance and network adequacy requirements set forth under the Knox–Keene Act, including accessibility, availability, continuity of care, and network capacity requirements. The plan's review and evaluation shall include, at a minimum, the information from its quality assurance processes required under sections 1367, 1367.03, 1370 of the Knox–Keene Act, and Rules 1300.67.2, 1300.67.2.2, 1300.68, and 1300.70. The plan's process for reviewing and evaluating available information shall ensure that enrollees have access to the full range of covered services through an adequate network, as required under this Rule, and sections 1367, 1367.03, 1367.035, and 1375.9 of the Knox–Keene Act, and Rules 1300.51(d), items H., I., and J., and 1300.67.2.

(E) Verifying, at least once every three years, the advanced access programs reported by network providers and provider groups by confirming that appointments are scheduled consistent with the definition of advanced access in subsection (b)(1). The plan shall require network providers to give written notice to the plan no later than 30 calendar days immediately following the date upon which a network provider no longer provides advanced access appointments to enrollees. The plan shall also review the available information related to access and availability for providers offering advanced access appointments, including enrollee grievances and appeals, pursuant to subsection (d)(2)(D) of this Rule.

(F) A plan that provides services through a preferred provider organization line of business may, for that product line, demonstrate compliance with the timely access and continuity of care requirements of subsection (d)(2)(A)(i) of this Rule by monitoring, on not less than an annual basis: enrollee grievances and appeals regarding timely access; the results of the Provider Appointment Availability Survey; the results of the Enrollee Experience Survey; and the results of the Provider Satisfaction Survey. This subsection does not exempt a plan that provides services through a preferred provider organization line of business from all other requirements set forth in subsection (d)(2).

(3) A plan's process for documenting and implementing prompt investigation and corrective action when compliance monitoring discloses that the plan's network is not sufficient to ensure timely access and network adequacy as required by this Rule. A plan's quality assurance process shall ensure the plan takes all necessary and appropriate action to identify the cause(s) underlying identified timely access and network adequacy deficiencies and to bring its network into compliance. A plan shall give advance written notice to all network providers affected by a corrective action, and shall include a description of the identified deficiencies, the rationale for the corrective action, and the name and telephone number of the person authorized to respond to provider concerns regarding the plan's corrective action.

(e) Enrollee Disclosure and Education.

(1) A plan shall disclose in all Evidences of Coverage the availability of triage or screening services and how to obtain those services. A plan shall disclose standards for timely access in the manner required under section 1367.031 of the Knox–Keene Act.

(2) The telephone number at which enrollees can access triage and screening services shall be included on enrollee membership cards. A plan or its delegated provider group may comply with this requirement through an additional selection in its automated customer service telephone answering system, where applicable, so long as the customer service number is included on the enrollee's membership card.

(f) Provider Appointment Availability Survey.

(1) Beginning January 1, 2023, and annually thereafter, a plan shall demonstrate that each of its networks has adequate capacity and availability of network providers sufficient to offer enrollees appointments within the standards set forth in subsection (c)(5)(A)–(G) by administering the Provider Appointment Availability Survey, and reporting rates of compliance for each network. When conducting the Provider Appointment Availability Survey, the plan shall follow all requirements in the Provider Appointment Availability Survey Manual, which is hereby incorporated by reference, and the Timely Access Submission Instruction Manual, which is hereby incorporated by reference. A plan shall use the versions of the Provider Appointment Availability Survey Manual and the Timely Access Submission Instruction Manual noticed on the Department's website at www.dmhc.ca.gov, on or before May 1 of the measurement year. In conducting the Provider Appointment Availability Survey, a plan must do all of the following:

(A) Determine the networks required to be surveyed;

(B) Complete a Contact List Report Form for each of the applicable Provider Survey Types;

(C) Determine the number of network providers from which the plan is required to obtain survey responses to meet the required sample size; (D) Select the network providers to be surveyed for each network;

(E) Prepare the survey questions;

(F) Administer the Provider Appointment Availability Survey using one or more of the three modalities set forth in Provider Appointment Availability Survey Manual: Extraction, the Three Step Protocol, or a Qualified Advanced Access Provider. If a plan uses the Three Step Protocol, the plan shall adhere to the following timeframes in conducting the survey:

(i) All surveys shall be completed, including any required follow–up calls, within 17 business days of sending the initial survey invitation via email, electronic communication, or fax. If an email, electronic communication, or fax survey invitation cannot be sent to a provider, because the appropriate contact was not available or the provider prefers to be contacted by telephone, the survey shall be completed by telephone within 5 business days from the date of the initial telephone call. (ii) If the provider has not responded within 2 business days of sending the initial survey invitation, a reminder notice may be sent to the provider.

(iii) If the provider does not respond to the survey within 5 business days of the plan sending the survey invitation, the plan shall initiate the survey via telephone within 6–15 business days of sending the initial survey invitation.

(iv) If a provider's office does not answer the initial call, the plan shall call the provider back on or before the next business day to initiate the telephone survey. The plan may leave a telephone message requesting that the provider complete the survey via a call back number and/or email, electronic communication, or fax, within 2 business days of the telephone message.

(v) If a provider declines to respond to the survey, the plan shall offer the provider's office the option to respond at a later time. If the provider is willing to participate at a later time, the plan shall offer the provider the option to receive a follow–up call within the next 2 business days.

(vi) If the provider does not complete the telephone survey within 2 business days of the initial telephone call or the telephone message left requesting the provider complete the survey or during the follow–up telephone call, the non–responding provider shall be replaced with a provider from the oversample.

(vii) If the plan was unable to initiate a telephone survey of the provider within 6–15 business days of sending the initial survey attempt conducted via email, electronic communication or fax, the provider shall be recorded on the Raw Data Report Form as a non–responder and replaced with a provider from the oversample.

(G) Record the survey outcome, the provider's survey responses, and compliance determinations on the Raw Data Report Form;

(H) Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form;

(I) Identify whether each network met or exceeded the threshold rates of compliance set forth in subsection (b)(12)(A). If a network failed to meet or exceed the threshold rates of compliance, the plan shall implement prompt investigation and corrective action, as required by subsection (d)(3), to bring the network into compliance with this section;

(J) Conduct the quality assurance review and create the quality assurance report; and

(K) Submit the plan's Timely Access Compliance Report, in accordance with the requirements set forth in subsection (h) and the Timely Access and Annual Network Submission Instruction Manual.

(2) A plan shall complete the report forms identified in subsection (h)(6)(B) in accordance with the requirements set forth in the Provider Appointment Availability Survey Manual and Timely Access Submission Instruction Manual. A plan's final rates of compliance shall be determined and calculated in accordance with all requirements and instructions set forth in the Provider Appointment Availability Survey Manual and the Timely Access Submission Instruction Manual. A plan shall report rates of compliance that include survey results from network providers made available to the plan through a plan–to–plan contract with a subcontracted plan.

(3) After the annual Provider Appointment Availability Survey has been completed, a plan shall have an external vendor, who is not affiliated with the plan, conduct a quality assurance review. The quality assurance review shall be documented in a quality assurance report prepared by the plan's external vendor. The quality assurance review and report shall meet all requirements set forth in the Provider Appointment Availability Survey Manual. The quality assurance review shall ensure that:

(A) The plan followed all statutory and regulatory requirements related to the Provider Appointment Availability Survey, the Provider Appointment Availability Survey Manual, and Provider Appointment Availability Survey Report Form Instructions, as set forth in the Timely Access Submission Instruction Manual.

(B) All information in the plan's Provider Appointment Availability Survey Report Forms submitted to the Department is true, complete, and accurate.

(4) A plan shall ensure the following actions are conducted in accordance with the Provider Appointment Availability Manual and the Timely Access Submission Instruction Manual:

(A) Gathering information and data to complete the Provider Appointment Availability Survey Report Forms.

(B) Validating the information and data included in the Provider Appointment Availability Survey Report Forms, set forth in (h)(6)(B)(i), and correcting any errors.

(C) Verifying all providers in the plan's Provider Appointment Availability Survey Report Forms meet all eligibility criteria.

(D) Reporting any errors the plan did not correct and identifying the steps the plan will take to ensure compliance with the Provider Appointment Availability Survey Manual and Provider Appointment Availability Survey Report Form Instructions, as set forth in the Timely Access Submission Instruction Manual in future reporting years. Nothing in this section shall relieve the plan of its obligation to report accurate information and data in the Timely Access Compliance Report submitted to the Department pursuant to subsection (h)(6).

(5) A plan shall not require or instruct network providers to hold appointments open that are not available to patients for the purpose of satisfying appointment waiting time standards set forth under subsection (c)(5)(A)–(G).

(6) This subsection (f) does not modify the requirements of a plan to maintain a network sufficient to provide timely access and network adequacy as set forth in subsection (c) and the Knox–Keene Act.

(g) Requests for Alternative Access Standards. In addition to a plan's ability to request alternative time and distance standards and alternative provider to enrollee ratios pursuant to Rule 1300.67.2.1, a plan may also file a notice of material modification to request the Department's approval of alternative time–elapsed standards, alternatives to time–elapsed standards, or an alternative standard for the threshold rates of compliance set forth in the definition of patterns of non–compliance in subsection (b)(12)(A).

(1) A request for an alternative time–elapsed standard or an alternative to time–elapsed standards shall include:

(A) An explanation of the plan's clinical and operational reasons for requesting the alternative standard, together with information and documentation, including scientifically valid evidence (based on reliable and verifiable data), demonstrating that the proposed alternative standard is consistent with professionally recognized standards of practice and a description of the expected impact of the alternative standard on clinical outcomes, on access for enrollees, and on network providers;

(B) Information demonstrating and substantiating why a proposed alternative standard is more appropriate than the standards set forth in subsection (b)(12)(A) and subsection (c);

(C) A description of all the steps the plan has taken, and any additional steps the plan will take to demonstrate its reasonable efforts, to bring its network into compliance with the existing standards set forth under Rule 1300.67.2.2, including contracting with additional providers. The description shall include how the request for the alternative standard will address any changes or deficiencies noted by the health plan between the results of the current and prior year's Provider Appointment Availability Surveys;

(D) For a plan that received approval for an alternative standard, filing, on an annual basis, an amendment requesting approval for continued use of the alternative standard, and providing updated information and documentation to substantiate the continued need for the alternative standard;

(2) In approving or disapproving a plan's proposed alternative standards, the Department may consider all relevant factors, including the factors set forth in subsections (d) and (e) of section 1367.03 of the Knox–Keene Act and subsection (c) of Rule 1300.67.2.1.

(3) The Department may consider the information submitted by the plan pursuant to subsection (h), and information related to monitoring of networks as set forth in subsection (d) of this Rule and subsections (d)–(f) of Rule 1300.67.2.

(4) A request for an alternative standard to the threshold rates of compliance set forth in subsection (b)(12)(A) of this Rule, shall include the information set forth under subsection (g)(1)(B)–(C) and shall be subject to subsections (g)(2) and (g)(3) of this Rule.

(h) Filing, Implementation and Reporting Requirements.

(1) The requirements set forth in subsection (h)(6)–(8) of this Rule shall apply only to reporting plans, except as specified in (h)(1)(B) of this Rule. Except as specified in subsection (h)(5) of this Rule, this subsection (h) shall be effective on and after January 1, 2023.

(A) By May 1 of each year, a reporting plan shall file with the Department a Timely Access Compliance Report, as described in subsection (h)(6) of this Rule, and an Annual Network Report, as described in subsection (h)(7) of this Rule, except as otherwise described in subsection (h)(4) of this Rule. Both reports shall include the network access profile, as set forth in subsection (h)(8) of this Rule.

(B) By May 1 of each year, a subcontracted plan for one or more of the networks identified in subsection (h)(1)(A) of this Rule, and a plan set forth in subsection (a)(2) of this Rule, shall complete only the network access profile, as set forth in subsections (h)(8)(A)–(C) of this Rule. This subsection and subsections (h)(2)–(h)(3), (h)(5), (h)(9) and the requirements to complete theAnnual Network Report section of the network access profile in subsections (h)(4)(A)(iv)b. and (h)(4)(B) of this Rule shall apply to plans that do not meet the definition of a reporting plan, as set forth in subsection (b)(17) of this Rule. This subsection shall not apply to any plan that meets the description set forth in subsection (h)(1)(A) of this Rule.

(2) A reporting plan shall submit the Timely Access Compliance Report and Annual Network Report using report form templates issued by the Department pursuant to this section. All health plans shall designate an individual as a compliance officer who shall be responsible for reviewing and submitting the required reports and information, and verifying, pursuant to Rule 1004, that the information and data submitted within the reports and the network access profile is true and correct and does not contain misstatements or omissions of material fact. All plans shall submit the required report forms and information through the Department's web portal, accessible at www.dmhc.ca.gov.

(3) Beginning with measurement year 2023, when reporting networks that include network providers made available through plan–to–plan contracts, the primary plan is the reporting plan for the network, and is responsible for submitting all information and data, including the Timely Access Compliance Report and theAnnual Network Report, as described in subsections (h)(1)(A), (h)(6)(B)–(G) and (h)(7) of this Rule, on an annual basis. The subcontracted plan for a network is subject to the reporting requirements set forth in subsection (h)(1)(B) of this Rule. The primary plan's submission shall include all network providers, enrollment, grievance and other required data set forth in these subsections, whether maintained by the plan, a subcontracted plan, or a delegated provider group.

(4) Implementation Reporting.

(A) For reporting year 2023, a plan shall submit:

(i) The Timely Access Compliance Report, as set forth in (h)(6) of this Rule, unless otherwise specified, reported according to the measurement year set forth in subsection (b)(4)(A) of this Rule. A plan shall submit the measurement year

2022 Provider Appointment Availability Survey data required in subsection (h)(6)(B) of this Rule using the methodology and report forms described in the plan's policies and procedures filed with the Department for measurement year 2022.

(ii) The Annual Network Report, as set forth in subsection (h)(7) of this Rule, reported according to the measurement year set forth in subsection (b)(4)(B) of this Rule, and the network capture date set forth in subsection (b)(7)(A) of this Rule.

(iii) Grievance data as described in subsection (h)(7)(A)(iv) of this Rule, and the Out–of–Network Payment Report Form as described in (h)(7)(C) of this Rule, reported according to the measurement year set forth in subsection (b)(4)(A) of this Rule.

(iv) The network access profile information, as set forth in subsection (h)(8) of this Rule, with the following:

a. December 31, 2021 as the Timely Access Compliance Report network capture date, and

b. The network capture date set forth in subsection (b)(7)(A) of this Rule for the Annual Network Report.

(B) Beginning in reporting year 2024, a plan shall submit the Timely Access Compliance Report, the Annual Network Report, and accompanying network access profile information as set forth in subsections (h)(6)(B), (h)(7)(A)(i)–(iii), and (h)(8) of this Rule, using the network capture date, defined in subsection (b)(7) of this Rule for the applicable measurement year.

(5) Implementation Policies and Procedures. Within three months following the effective date of this section, a plan shall file an amendment pursuant to section 1352 of the Knox–Keene Act disclosing how the plan will achieve compliance with the requirements of this Rule. The submission shall include policies and procedures necessary for compliance with the requirements of this Rule.

(6) Timely Access Compliance Report. A plan shall submit the items set forth in subsections (h)(6) and (h)(8) of this Rule, as part of its Timely Access Compliance Report for each applicable measurement year, as defined in (b)(4)(A) of this Rule. Each item shall be submitted in accordance with the requirements set forth in the Timely Access Submission Instruction Manual. The following items shall be included in the plan's Timely Access Compliance Report:

(A) The Department issued filing number for the plan's policies and procedures setting forth:

(i) The plan's timely access standards, consistent with the standards set forth in subsection (c), including, as may be applicable, any alternative time–elapsed standards and alternatives to time–elapsed standards for which the plan obtained the Department's prior approval by order.

(ii) The plan's QualityAssurance Processes for monitoring each timely access standard and implementing corrective action, as set forth in subsection (d) of this Rule and the Provider Appointment Availability Survey Manual, including any alternative standards to the threshold rates of compliance for urgent or non–urgent appointments approved by the Department.

(iii) The plan's oversight procedures for ensuring compliance with the timely access standards set forth in subsection (c) of this Rule, including any periodic reporting requirements related to adherence of timely access standards by subcontracted plans in plan–to–plan contracts.

(B) Provider Appointment Availability Survey Report Forms.

(i) A plan shall submit the information and data obtained by the plan from conducting the Provider Appointment Availability Survey for each of the applicable Provider Survey Types set forth in the Provider Appointment

Availability Survey Manual. A plan shall submit the information and data obtained by the plan from conducting the Provider Appointment Availability Survey on the report forms issued by the Department, form numbers 40–254 through 40–264, which are incorporated by reference and referred to collectively as "Provider Appointment Availability Survey Report Forms." A plan shall use the version of each report form listed below noticed on the Department's website at www.dmhc.ca.gov, on or before May 1 of the measurement year.

a. Primary Care Providers Contact List Report Form (Form No. 40– 254).

b. Non–Physician Mental Health Care Providers Contact List Report Form (Form No. 40–255).

c. Specialist Physicians Contact List Report Form (Form No. 40–256).

d. Psychiatrists Contact List Report Form (Form No. 40–257).

e. Ancillary Service Providers Contact List Report Form (Form No. 40–258).

f. Primary Care Providers Raw Data Report Form (Form No. 40–259).

g. Non–Physician Mental Health Care Providers Raw Data Report Form (Form No. 40–260).

h. Specialist Physicians Raw Data Report Form (Form No. 40–261).

i. Psychiatrists Raw Data Report Form (Form No. 40–262).

j. Ancillary Service Providers Raw Data Report Form (Form No. 40– 263).

k. Results Report Form (Form No. 40–264), which includes the following:

1. Primary Care Providers Results Tab;

2. Non–Physician Mental Health Care Providers Results Tab;

3. Specialist Physicians Results Tab;

4. Psychiatrists Results Tab;

5. Ancillary Service Providers Results Tab;

6. Summary of Rates of Compliance Tab; and

7. Network by Provider Survey Type Tab.

(ii) A plan shall complete all Provider Appointment Availability Survey Report Forms as specified in the Provider Appointment Availability Survey Manual and Timely Access Submission Instruction Manual. For each Provider Survey Type applicable to a plan's network, a plan shall submit:

a. At least one Contact List Report Form containing all network providers specified in the Provider Appointment Availability Survey Manual. A plan shall populate the Contact List Report Form with the required network provider information as of the network capture date for the applicable measurement year.

b. At least one Raw Data Report Form, which shall contain each of the network providers the plan surveyed or attempted to survey, and the outcome or response to the Provider Appointment Availability Survey.

c. The results of the survey in Results Tabs, set forth in subsection (h)(6)(B)(i)k.1.–5. of this Rule, in a single Results Report Form. The Results Report Form is programmed by the Department to automatically calculate the rates of compliance using the formulas set forth on the Summary of Rates of Compliance Report Form and the Network by Provider Survey Type Report Form based on the information entered by the plan on each Results Tab set forth in subsection (h)(6)(B)(i)k.1.–5. of this Rule.

(C)(i) The Department issued filing number for the plan's efiling containing a description of the plan's procedure for identifying any incidents of non–compliance resulting in substantial harm to an enrollee, as defined in Civil Code section 3428, and patterns of non–compliance, as defined in subsection (b)(12) of this Rule. The policy and procedure shall include:

a. The plan's definition of an incident of non–compliance resulting in substantial harm to an enrollee, which at a minimum shall include the definition set forth in Civil Code section 3428;

b. The plan's definition of patterns of non–compliance, which at a minimum shall include the definitions set forth in subsection (b)(12) of this Rule; and

c. The plan's monitoring mechanism and the sources of information or data the plan uses to identify any patterns of non–compliance and incidents of non–compliance resulting in substantial harm to an enrollee.

(ii) Information describing whether the plan identified:

a. Any incidents of non–compliance resulting in substantial harm to an enrollee that occurred during the measurement year; and

b. Any patterns of non–compliance that occurred during the measurement year.

(iii)Adescription of the identified non–compliance, set forth in subsection (h)(6)(C)(ii) of this Rule, and the plan's responsive investigation and determination.

(iv) A corrective action plan, which shall include the following information with respect to each identified incident of non–compliance resulting in substantial harm to an enrollee and pattern of non–compliance:

a. The steps the plan has taken or intends to take with respect to each issue of non–compliance in order to address the non–compliance and to bring its network into compliance with the Knox–Keene Act; and

b. Any follow–up actions the plan has taken or intends to take to ensure compliance with the Knox–Keene Act.

(v) If the plan did not submit the information set forth in subsection (h)(6)(C)(ii)–(iv) of this Rule in a prior reporting year, the plan shall include the omitted information in the current reporting year.

(D) The Department issued filing number containing the plan's policies and procedures used for verifying network providers' advanced access programs, and a list of all provider groups and network providers utilizing advanced access appointment scheduling.

(E) The Department issued filing number containing a description of the implementation and use of triage, telemedicine, including the applicable telehealth modalities, and health information technology used by the plan and its network providers to provide timely access to care, as applicable.

(F) The Department issued filing number containing the plan's survey questions, survey methodology, and policies and procedures for administering and evaluating the results of the Enrollee Experience Survey and the Provider Satisfaction Survey. The plan shall include the results of the most recent annual Enrollee Experience Survey and Provider Satisfaction Survey, and a comparison with the results of the prior year's Enrollee Experience Survey and Provider Satisfaction Survey, including a discussion of the relative change in survey results.

(G) The quality assurance report including all information set forth in the Provider Appointment Availability Survey Manual.

(7) Annual Network Report. The Annual Network Report shall confirm the status of each of the plan's networks and enrollment, including the data categories set forth in subsections (a) and (g) of section 1367.035 of the Knox–Keene Act. The Annual Network Report shall consist of the items set forth in subsection (h)(7) and subsection (h)(8) of this Rule, for the applicable measurement year. The plan shall submit the items described in subsection (h)(7) within the Department's report forms in the manner described in subsection (h)(7)(B) of this Rule and in the Annual Network Submission Instruction Manual, which is hereby incorporated by reference. A plan shall use the version of the Annual Network Submission Instruction Manual noticed on the Department's website at www.dmhc.ca.gov, on or before November 1 of the calendar year prior to the reporting year.

(A) The Annual Network Report shall include the following information and data, in the format approved by the Department set forth in subsection (h)(7)(B) of this Rule and incorporated documents:

(i) The plan's enrollment in each network and product line, on a ZIP Code and county basis.

(ii) The network service area of each network, on a ZIP Code and county basis.

(iii) A complete list of all network providers within each network.

(iv) All grievances regarding network adequacy and timely access compliance received for each network during the measurement year described in subsection (b)(4)(A) of this Rule.

(B) Annual Network Report Forms. A plan shall submit the network information and data set forth in subsection (h)(7) of this Rule in accordance with the Annual Network Submission Instruction Manual. A plan shall use and submit only the following report forms issued by the Department, form numbers 40–265 through 40–272, which are incorporated by reference and referred to collectively as "Annual Network Report Forms". A plan shall use the version of each report form listed below noticed on the Department's website at www.dmhc.ca.gov, on or before November 1 of the calendar year prior to the reporting year.

(i) Network Service Area and Enrollment Report Form (Form No. 40–265).

(ii) PCP and PCP Non–Physician Medical Practitioner Report Form (Form No. 40–266).

(iii) Specialist and Specialist Non–Physician Medical Practitioner Report Form (Form No. 40–267).

(iv) Mental Health Professional and Mental Health Facility Report Form (Form No. 40–268).

(v) Other Outpatient Provider Report Form (Form No. 40–269).

(vi) Hospital and Clinic Report Form (Form No. 40–270).

(vii) Telehealth Report Form (Form No. 40–271).

(viii) Timely Access and Network Adequacy Grievance Report Form (Form No. 40–272).

(C) A plan required to submit data in accordance with subsection (a)(4) of section 1371.31 of the Knox–Keene Act, shall use and submit only the report form issued by the Department for the submission of the required data, which is incorporated by reference and referred to as "Out–of–Network Payment Report Form" (Form No. 40–273) (October 27, 2022). A plan shall submit this data in accordance with the Annual Network Submission Instruction Manual. The plan shall report data required for the Out–of–Network Payment Report Form in accordance with the measurement year described in subsection (b)(4)(A) of this Rule.

(D) A plan required to submit data in accordance with subsection (d) of section 1374.141 of the Knox–Keene Act, shall use and submit only the report form issued by the Department for the submission of the required data, which is incorporated by reference and referred to as "Third–Party Corporate Telehealth Provider Report Form" (Form No. 40–274). A plan shall use the version of this report form noticed on the Department's website at www.dmhc.ca.gov, on or before November 1 of the calendar year prior to the reporting year. The plan shall report data required for the Third–Party Corporate Telehealth Provider Report Form in accordance with the data capture timeframes described in the report form instructions for this form.

(8) Network Access Profile. Before submission of the report forms set forth in section (h)(6) and (h)(7) of this Rule, the plan shall identify a health plan contact, complete or update the network access profile in the Department's

web portal, so that it contains current information and data as of the network capture date for each applicable measurement year, as defined in subsection (b)(4)(A)–(B) of this Rule. The plan shall identify each network by its network name and network identifier, and describe each network identified pursuant to the requirements in this subsection and in the Annual Network Submission Instruction Manual. Prior to submission, the plan shall affirm the accuracy of the information and data, as described in subsection (h)(2) of this Rule. The plan shall submit the network access profile data as follows:

(A) The plan shall update the network access profile each year before submitting the reports to reflect changes to the reported networks as of the network capture date.

(B) Within the network access profile, the plan shall identify the network name and Department–assigned network identifier for each reported network. To the extent a plan has removed, added, or changed a reported network since the prior measurement year, the plan shall identify the appropriate amendment or notice of material modification of the plan's license, consistent with section 1352 of the Knox–Keene Act and related regulations.

(C) Within the network access profile, for each network the plan shall identify:

(i) The product lines that use the network;

(ii) The network service area; and

(iii) The source of network providers, including: a.Whether the plan directly employs or contracts with network providers, in accordance with subsections (b)(10)(B)(i)–(iii) of this Rule;

b.Whether the plan serves as a primary plan or subcontracted plan for the network;

c. If the plan is a primary plan, the subcontracted plan networks that contribute network providers through plan–to–plan contracts, and any delegation of plan functions to those subcontracted plans, as applicable; and

d. If the plan serves as a subcontracted plan, the networks to which the plan contributes network providers through a plan–to–plan contract.

(D) Within the Annual Network Submission Instruction Manual and the Department's web portal, the Department shall set forth standardized terminology the plan shall use to submit data in the report forms. The plan shall report the required data within the report forms either by using the standardized terminology when reporting the information listed in subsections (h)(8)(D)(i)–(x) of this Rule, or by connecting the plan's own terminology to the standardized terminology, as available, via the crosswalk tables provided by the Department within the Department's web portal. Such areas of standardized terminology shall include the following:

(i) Hospital and other inpatient facility names. The plan shall report hospital and other inpatient facility names using the name on record with the California Department of Health Care Access and Information (HCAI), available at hcai.ca.gov, as of the network capture date. The Department shall make available annually a standardized list of hospital names within its web portal, based on the most recent data obtained from HCAI.

(ii) Product line categories.

(iii) Provider types. The plan shall report physician specialty type, non–physician medical practitioner specialty type, mental health professional specialty type, other outpatient provider type, hospital and other inpatient facility type, clinic type, and mental health facility type, according to the standardized terminology. Plans shall report physician specialties according to the network provider's primary specialty practice areas and plan credentialing. The plan shall identify the physician using the Department's standardized terminology, consistent with the physician specialty and subspecialty

designations recognized by the American Board of Medical Specialties and the Knox–Keene Act. Non–physician medical practitioner specialty designations shall be based on the areas of specialization available through the appropriate licensing boards, as applicable.

(iv) Provider languages spoken.

(v) Provider group names. The plan shall report provider group names using the business name registered with the Secretary of State, the name on file with the Department for capitated provider groups, or the name on file with the Department for risk–bearing organizations that file information with the Department pursuant to Rule 1300.75.4.2, as applicable. The Department shall make available annually a standardized list of provider group names within the Department's web portal, based on filings with the Department and the Secretary of State. Each provider group reported by the plan shall match the most recent list on the Department's web portal. If the provider group is not listed on the Department's standardized list, the plan shall report the provider group using a name that is reported consistent within this subsection.

(vi) Type of license or certificate. The standardized terminology shall be consistent with one or more of the following sources: the Department of Consumer Affairs, the California Board of Registered Nursing, the Medical Board of California, the Osteopathic Medical Board of California, the National Plan and Provider Enumeration System taxonomy, or departments within California Health and Human Services Agency, including the Department of Health Care Services.

(vii) ZIP Code and county. The Department shall make available annually in its web portal a list of ZIP Codes and counties for the State of California, issued by the USPS. Each ZIP Code and county combination reported by the plan within California shall match the USPS list of ZIP Codes posted on the Department's web portal.

(viii) California license number and National Provider Identifier (NPI). The plan shall report NPI using the active identifier for that provider published on the National Plan and Provider Enumeration System (NPPES), NPI Registry, available at npiregistry.cms.hhs.gov, as of the network capture date. The plan shall report the California license using the active license number published by the Department of Consumer Affairs, available at www.dca.ca.gov, as of the network capture date. The Department shall make available annually, within its web portal, a list of active California license numbers for physicians updated based on the network capture date, derived from the Department of Consumer Affairs (www.dca.ca.gov). The Department shall make available annually in its web portal a list of de–activated NPIs, updated based on the network capture date, derived from the NPPES, NPI registry.

(ix) Grievance field values. The plan shall report information related to timely access and network adequacy grievances, as set forth in section 1367.035(a)(6) of the Knox–Keene Act.

(x) Telehealth location and modality. The plan shall report the modality by which telehealth is delivered and the location where the patient may receive telehealth services.

(9) Nothing in this section shall prohibit the Department from reviewing the information and data submitted pursuant to subsection (h) of this Rule for completeness or accurate reporting, and preventing submission of information and data that is incomplete or does not conform to the requirements set forth in this subsection or within any incorporated documents within this subsection. Information and data that is erroneous or contrary to the plan's representations to the Department within the plan's submission, or in other approved or pending filings, assessments, or actions with the Department, may be omitted from the

Department's review of the Timely Access Compliance Report or the Annual Network Report. The plan shall retain full responsibility for ensuring the accuracy of the information and data, as set forth and required by subsections (a)(3), (a)(5), (h)(2), (i), and (j) of this Rule.

(i) Determining Compliance and Non–Compliance.

(1) A network is non–compliant with the requirements of this Rule and the Knox–Keene Act, related to timely access and network adequacy, under any of the following circumstances:

(A) The plan's annual submission pursuant to subsection (h) of this Rule does not demonstrate the plan has met network adequacy for a network service area;

(B) The results of the plan's Provider Appointment Availability Survey indicate a pattern of non–compliance, as described in subsection

(b)(12)(A) of this Rule, was identified during a measurement year;

(C) The Department identified a pattern of non–compliance, as described in subsection (b)(12)(B) of this Rule;

(D) The plan failed to report timely, accurate, or complete information and data demonstrating network adequacy or timely access for a network service area.

(2) If the plan contends that the Department's finding of a violation of the Knox–Keene Act made during the review of the information submitted pursuant to this section was made as a result of the plan's failure to submit timely, accurate, or complete information in the reports set forth in subsections (h)(6)(B), (h)(7), and (h)(8) of this Rule, and not due to an actual failure of the plan to meet network adequacy requirements or time–elapsed standards set forth in subsection (c) of this Rule, the plan shall demonstrate that the Department's finding was due only to the plan's failure to submit timely, complete, or accurate information.

(3) The Department may find the plan is non–compliant with the requirements of subsection (c) of this Rule where the plan failed to provide timely access to health care services. When evaluating compliance with the standards set forth in subsection (c) of this Rule, the Department may focus more upon patterns of non–compliance rather than isolated episodes of non–compliance.

(4) The Department may consider all relevant factors when evaluating the severity and extent of non–compliance, including:

(A) The efforts by a plan to evade the standards, such as referring enrollees to providers who are not appropriate for an enrollee's condition, failing to maintain an adequate number or type of network providers necessary to deliver timely and appropriate care, or misreporting network providers who are available to deliver covered services;

(B) The nature and extent of a plan's efforts to avoid or correct non–compliance, including whether a plan has taken all necessary and appropriate action to identify the cause(s) underlying identified timely access, network adequacy or data reporting deficiencies and to bring its network into compliance;

(C) The failure of a plan to follow the requirements of this section when submitting the annual reports set forth in subsection (h);

(D) The nature of physician practices, including group and individual practices, the nature of a plan's network, and the nature of the health care services offered, including the population served;

(E) The nature and extent to which a single instance of non–compliance results in, or contributes to, substantial harm including serious injury or damages to an enrollee;

(F) The plan's failure to monitor its network to ensure network adequacy, or to ensure network capacity and availability to meet the standards set forth under subsection (c);

(G) The nature and extent to which a single instance of non–compliance or a pattern of non–compliance results from the plan's failure to identify and address areas of network adequacy noncompliance in a manner prescribed under the Knox–Keene Act;

(H) The number of relevant network providers in the region, whether providers of the relevant health care services are otherwise available in the region, and a health plan's demonstration of its actions to bring the relevant providers into the network as network providers; and

(I) Whether the plan's non–compliance involves the same or similar enrollee cultural, demographic, or health circumstances.

(5) The Department may take enforcement action against a plan for any finding of non–compliance pursuant to this section.

(A) If a finding was made as a result of the plan's failure to submit complete or accurate information in the reports set forth in subsections (h)(6)(B), (h)(7), and (h)(8) of this Rule, the Department may take enforcement action for the plan's failure to submit complete or accurate network information.

(B) Prior to taking enforcement action, the Department may provide the plan with an opportunity to respond to the Department's findings of non–compliance, and present a corrective action plan, as applicable.

(i) A plan shall demonstrate it has implemented corrective action through appropriate staffing or other resources needed to bring itself into compliance with the reporting requirements within this section.

(ii) The Department may take enforcement action if the plan's failure to submit timely, complete or accurate information prevented the Department from reviewing the Plan's annual submission for compliance.

(iii) The Department may take enforcement action if the plan's responsive information or corrective action plan does not timely or sufficiently address the findings of non–compliance.

(iv) This subsection does not prevent the Department from taking immediate enforcement action related to the information submitted in subsections (h)(6), (h)(7), and (h)(8) of this Rule.

(j) Review and Enforcement.

Failure to comply with requirements of this section, including the failure to submit timely, complete, and accurate information and data within the Department's web portal or required annual reports, or failure to correct an identified deficiency, may constitute a basis for disciplinary or enforcement action against the plan. The Department may request additional information from the plan as deemed necessary to complete the review of required reports or information or to carry out and complete any enforcement action. The reporting plan shall be responsible for demonstrating compliance with this Rule and the Knox–Keene Act. The Director shall have the civil, criminal, and administrative remedies available under the Knox–Keene Act, including section 1394. Nothing in this section shall be construed as limiting the director's authority pursuant to Article 7 (commencing with section 1386) orArticle 8 (commencing with section 1390) of the Knox–Keene Act.

(k) A plan shall not prevent, discourage, or discipline a network provider or employee for informing an enrollee or subscriber about the timely access standards.

(*l*) This rule applies to a licensed health care service plan that provides services to Medi–Cal beneficiaries. Nothing in this regulation is intended to

alter the legal and contractual obligations for Medi–Cal managed care plans' reporting requirements to the Department of Health Care Services.

NOTE: Authority cited: Sections 1344, 1346, 1367.03, 1386 and 1394, Health and Safety Code. Reference: Sections 1342, 1367, 1367.01, 1367.03, 1367.035, 1367.04, 1370, 1371.31, 1375.7 and 1380, Health and Safety Code.

HISTORY:

1. New section filed 12–18–2009; operative 1–17–2010 (Register 2009, No. 51).
2. Amendment of section heading, section and NOTE filed 1–12–2022; operative 4–1–2022 (Register 2022, No. 2). (Transmission deadline specified in Government Code section 11346.4(b) extended 60 calendar days pursuant to Executive Order N–40–20. Filing deadline specified in Government Code section 11349.3(a) extended 60 calendar days pursuant to Executive Order N–40–20 and an additional 60 calendar days pursuant to Executive Order N–71–20.)
3. Amendment of subsections (d), (f)(1), (h)(1), (h)(3), (h)(4)(A)–(h)(4)(A)(i), (h)(4)(A)(iv)a. and (h)(4)(B) filed 3–16–2022; operative 4–1–2022 pursuant to Government Code section 11343.4(b)(3). Submitted to OAL for filing and printing only pursuant to Government Code section 11343.8. Exempt from the APA pursuant to Health and Safety Code section 1367.03(f)(3) (Register 2022, No. 11).
4. Amendment filed 4–25–2023; operative 4–25–2023. Submitted to OAL for fil-ing and printing pursuant to Government Code section 11343.8. Exempt from the APA pursuant to Health and Safety Code section 1367.03, subsections (f)(3) and (f)(5) (Register 2023, No. 17).