Regardless of whether the product is a PPO or an HMO, DMHC reviews products to ensure compliance with network adequacy standards under the KKA and associated regs. In general, DMHC reviews provider network for the following:

- Disclosure of the market segment the product will serve (e.g., individual and/or small or large group; HMO or PPO, etc.).

- A description of the service area where the product will be offered, by county. If partial counties are included, describe the zip codes of parts of the county to be served.

- A disclosure of providers (hospitals, provider groups, individual physicians) who will participate in the product by virtue of existing provider contracts or if they will be signing new provider contracts.

- Plan should point out, by county, if there are any cities and areas of the county that do not meet the existing access and availability standards. The Plan should do the same for the hospital and ancillary network. Examples include, but are not limited to: portions of the service area not meeting the geographic access standards, providers of a particular specialty unwilling to contract, specialties for which there are no contracts, only letters of agreement have been secured with the providers, or that certain providers are currently at capacity. The Plan should state how it will resolve any such identified access or availability issues with specificity.

A discussion of the policies and procedures to be implemented by the Plan to monitor access to and the adequacy of the network.

Exhibit H - Specific Service Area and Maps

H-1: Description of Service Area

- List the counties where network will be offered. If the Plan is not requesting approval to serve an entire county, provide a list of zip codes and associated city for each zip code and state whether the Plan is classifying the zip code as urban or rural. Define "urban" and "rural."

H-2: Map(s) of Service Area

- Provide maps by county. If approval for service to a portion of a county is requested, use a map showing the entire county but shade in the area where the Plan is seeking approval for the product. In all cases the maps must include the names of major cities and show major roadways.
- To speed the Department's review, submit separate maps for hospitals and professional providers. One map should show all the hospital locations and subscriber locations, another map should show all of the PCP locations and subscriber locations, and another map should show all specialist locations and subscriber locations. If the Plan has a software program that has a radius field function (ability to show by use of color a

certain mile radius around a provider), it is useful to demonstrate that the Department's access standard is being met.

Exhibit I - Provider Lists, Capacity, and Access Standards

Exhibit I-1: Physicians

❑ Submit a provider list with the following: provider name, address including county, provider group affiliation, whether a PCP or specialist, specialty (within primary care please denote whether pediatrician, etc.), hospitals to which the physician has active admitting privileges, whether the physician is accepting new patients (Y/N), and business hours. To speed the Department's review, submit the list in Excel format. The Plan should specifically disclose if the proposed provider network or any of the provider groups within the network are missing any particular specialties.

❑ If provider groups proposed to be in the network have not yet signed contracts to participate, the Plan should list such provider groups, provide the anticipated date of executing the contract with such provider group, and the contingency Plan if no contract is executed.

❑ If the Plan relies on hospitalists or other admitting arrangements to ensure access to inpatient care at Plan-contracted hospitals, explain these arrangements and analyze the adequacy of the arrangements to address the needs of the projected enrollee population.

❑ It speeds the Department's review if the Plan provides, by county, a count of each type of physician provider in the provider list for the service area for the network (e.g., Cardiologists: 3). Plan should list only those physicians that are accepting new patients. The list should be submitted in Excel format.

Exhibit I-2: Hospitals

❑ Submit a list of hospitals where the Plan's contracted physicians have admitting privileges. The hospital list should include the name, address including county, the number of OSHPD-designated Available Beds, Available Bed occupancy rate and time period measured, JCAHO accreditation status, term date, and whether the Plan has received notice of contract termination from the hospital. It speeds the Department's review if the Plan also indicates each provider group listed in I-2 that primarily admits to such hospital.

❑ Disclosure if the Plan will be relying on tertiary-level specialists and/or hospitals located outside the county of the proposed service area and a separate list of such under the appropriate Exhibit I-1 or I-2. If applicable, the Plan should list those tertiary-level specialists or hospitals that are in the Network.

Exhibit I-3: Ancillary Providers

❑ Submit a list of ancillary service providers. Include the name of the provider; address; type of service provided; if the network is for multiple counties, the county the provider will serve; and provider group affiliation if exclusive to a particular provider group. Please indicate if the service is provided by a contracting hospital. Plan should identify any missing ancillary services, or services that are only available to enrollees assigned to a particular provider group. To speed the Department's review, submit the list in Excel format.

❑ It speeds the Department's review if the Plan provides a count of each type of ancillary provider, by county, in the provider list for the service area (e.g., Dialysis Centers: 3). The list should be submitted in Excel format.

❑ If the Plan is going to offer any other benefits (e.g., vision benefit) the provider list must also be furnished with the name of the provider, address, type of services it provides enrollees, if the network is for multiple counties, the county they will serve, and if exclusive to a particular provider group, as opposed to being accessible to all enrollees in the service area, the provider group affiliation of the service provider. To speed the Department's review, submit the list in Excel format.

Exhibit I-4: Calculation of Ratios

❑ Provide the ratio of PCPs to projected enrollment and the ratio of total physicians to the projected enrollment. If there are enrollees in other products already utilizing the proposed providers, be sure to account for these enrollees in the ratio calculations.

Exhibit I-5: Access Standards

❑ Explain whether the Plan is changing its access standards. If so, describe the changes, state the new standards, and provide an analysis of the Plan's continued compliance with Cal. Health and Saf. Code §§ 1367, and Cal. Code of Regs., tit. 28, §§ 1300.51(d), Items H and I, 1300.67.2, 1300.67.2.1.

If the Plan is seeking an alternate access standard, please provide a discussion of the basis for the request. The discussion should include the topics listed in Cal. Code of Regs., tit. 28, § 1300.67.2.1(c)(1)-(15)).

Timely Access Standards

Health and Safety Code section 1367.03 required the DMHC to adopt a regulation to ensure that consumers have timely access to health care services, including indicators of timeliness (waiting times); and also requires that the OPA Report Card include timely access compliance data.

- The DMHC promulgated Rule 1300.67.2.2, which became operative on January 17, 2010. Health Plans were required to submit Filings to the DMHC by October

18, 2010, to demonstrate how the Plans were going to comply with the Timely Access Regulation that included:

- Provider network data
- PCP-to-Enrollee ratios
- Quality assurance policies and procedures
- Survey forms (Annual Enrollee and Provider Satisfaction Surveys; and Industry Collaborative Effort (ICE) Appointment Availability Survey)
- Subscriber/Enrollee disclosures (EOC)
- Provider contract amendments
- Amendment filings, unless request alternate standards, then material modification required.

Beginning in January 2011, Plans were required to fully implement/operationalize the timely access regulation. On March 31, 2012, all full service and mental health plans were required to file their first annual compliance report, and this compliance report is required to be submitted annually thereafter.

A very important part of this report includes the Plan's contracted Provider Network and Enrollment data on a county-by-county basis, including Enrollment in each product line (e.g. commercial, Medi-Cal, HFP, etc) and a list of each Plan's contracted physicians (PCPs, specialists, non-MD mental health, etc), hospitals and other contracted providers (e.g. medical groups, FQHCs, non-MD mid-level providers). The timely access regulatory requirement is critical to consumer protection to ensure that enrollees are able to access care and obtain appointments within time-elapsed standards.