

Network Adequacy and Health Care Access Regulations in California

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Californians with state-regulated health insurance may be enrolled in California Department of Insurance (CDI)-regulated policies or Department of Managed Health Care (DMHC)-regulated plans, including Medi-Cal managed care plans. When requested by the Legislature to analyze proposed state legislation that would alter coverage for a test, treatment, or service, the California Health Benefits Review Program (CHBRP) generally considers whether network adequacy and availability of health care providers would impact an enrollee's ability to access services.¹ In addition, on occasion CHBRP analyzes a bill that would directly impact network adequacy requirements. This explainer discusses current network adequacy standards for enrollees in California-regulated plans and policies, related federal and state regulations, and new and evolving issues that impact accessibility and coverage of health care for enrollees in California's state-regulated insurance markets.

What is Network Adequacy?

Health plans and insurers maintain a list of approved providers that it contracts with to deliver medical care to its members; this list is known as a provider network. Providers within a network include those delivering services in primary care, hospitals, specialty care, ancillary care (e.g. laboratory, diagnostic radiology, outpatient retail, etc.), outpatient mental health care, urgent care, and dental care. Network adequacy is the ability of a health plan or insurer to provide enrollees with timely access to a sufficient number of providers within a reasonable geographic distance so that they may utilize medically necessary covered services.

In-Network vs. Out-of-Network

In-network providers are providers that have contracted with the health plan or insurer to render services at an agreed-upon rate. Utilization of these services may involve cost sharing for the enrollee depending on the plan or policy. Out-of-network providers are those without a contract with a health plan or insurer; the health plan or insurer is generally not required to reimburse these providers for services rendered. There are limited exceptions to this rule, such as when an enrollee is experiencing an emergency and requires stabilization. The enrollee may be responsible for the entirety of the provider's fee, or the health plan or insurer may provide less reimbursement than for in-network providers and the provider may require the enrollee to pay the remaining portion of the fee.

¹ At the request of the legislature, CHBRP provides independent, evidence-based analyses of proposed health insurance benefit related legislation that could impact state-regulated health plans and policies.

Network Size

Several factors contribute to the size of a provider network. Insurers generally balance the need to provide adequate access to care to enrollees with other considerations, including minimizing unit costs, offering low premiums for enrollees, and negotiating contracts with providers. There is currently no standard to measure the size or extent of a plan or insurer’s network, making it challenging for consumers and regulators to easily determine differences in network size (Pollitz, 2022).

Standards

States apply their own standards to different types of coverage; there are no national standards for network adequacy. How a state defines its network adequacy standards and how it considers exceptions and crafts safeguards to these standards have significant health insurance market implications. Generally, if network adequacy regulations require too few providers, patients may struggle to get timely care. Conversely, if network adequacy regulations require too many providers, regulators run the risk of inhibiting market competition and increasing costs, as plans that may be required to include certain high-priced providers will likely pass those increased costs on to enrollees through higher premiums (CHCF, 2021). With regard to California, network adequacy requirements differ by regulator. State regulations dictate the minimum network adequacy requirements for plans regulated by DMHC and policies regulated by CDI. For qualified health plans (QHPs), federal standards apply as well.²

Quantitative Metrics

There are three quantitative metrics that are typically used to regulate network adequacy: provider ratios, geographic access, and timely access (details of these metrics in state and federal law are located in Appendix A).

- 1) **Provider ratio** refers to the minimum ratio of the number of providers in the network to the number of enrollees, sometimes referred to as “provider-to-patient” ratios.
- 2) **Geographic access** refers to the proximity of enrollees to in-network providers for medically necessary care. Geographic access is generally measured with a maximum distance in miles or minutes of travel for an enrollee to get to a provider from the enrollee’s home or workplace.
- 3) **Timely access** refers to the maximum number of hours or business days within which an appointment must be available with a provider for medically necessary care.^{3, 4}

DMHC and CDI both categorize network adequacy standards by seven categories of care: primary care, hospital, specialty care, behavioral health care, ancillary care, emergency care, and dental care.

Network Adequacy Regulations Impacting California

The federal Center for Consumer Information and Insurance Oversight (CCIIO), the California Department of Health Care Services (DHCS), DMHC, and CDI all set network adequacy standards for the plans and policies that they regulate or programs they administer. As of 2023, approximately 22.8 million Californians are enrolled in state-regulated health

² QHPs are those certified by the federal Health Insurance Marketplace that may participate in one or more state’s health insurance marketplace. Covered California is California’s marketplace.

³ Timely access standards refer to the availability of an appointment within a given timeframe; these standards do not account for whether the available appointment time will be feasible for the enrollee’s personal schedule, such as work or childcare hours.

⁴ Regulations generally allow exemptions for when the provider determines that a longer wait time will not be detrimental to the enrollee’s health. HSC 1300.67.2.2(c)(5)(G); INS 2240.15(b)(5)(G).

insurance subject to regulation and/or administration by DHCS, DMHC and/or CDI.⁵ Although many of the requirements are similar, there are some differences between requirements for plans and policies based on the regulator. DMHC and CDI implement network adequacy standards that go beyond the minimum requirements set at the federal level.⁶ DHCS administers the state Medi-Cal program and mandates additional requirements for Medi-Cal managed care plans, including County Organized Health Systems (COHS) and plans regulated by DMHC. Additionally, QHPs in the individual and small group markets are subject to additional requirements, as established by CCIIO. Appendix A details the main network adequacy requirements for QHPs and California state-regulated plans and policies.

Federal Regulations for Qualified Health Plans

QHPs are health plans and policies sold through a state marketplace, such as Covered California, or similar plans and policies sold outside of the marketplace (sometimes referred to as "mirror" plans or policies). CCIIO sets regulatory standards for QHPs, including network adequacy requirements. In California, these plans are also subject to state regulation by DMHC or CDI.

Stemming from the Affordable Care Act (ACA) requirement "that all services will be accessible without unreasonable delay," federal regulations set minimum requirements for geographic distribution (based on county size) and timely access for different types of providers and services for all QHPs.⁷ Geographic and timely access standards are broken up by type of provider; however, most have the same standards. Furthermore, federal standards set a threshold level of 35% of essential community providers (ECPs) included in the network for all QHPs (CCIIO, 2022).⁸ QHPs must also provide an accurate provider directory that is accessible to enrollees and administer a process for enrollees to dispute denial of in-network benefits.⁹

Although these requirements are set at the federal level, implementation is left to the states. California's standards extend beyond what is required by federal regulations. With the passage of the ACA, CMS began reviewing all QHPs for network adequacy standard adherence. Federal oversight of network adequacy standards has fluctuated since it was first required by the ACA, with oversight now scheduled to resume in 2023 (Pollitz, 2022).^{10, 11}

State Regulations

All health plans and policies in California regulated by DMHC and CDI are subject to network adequacy standards.¹² Approximately half of all Californians are enrolled in plans and policies regulated by DMHC or CDI.¹³ Each department has standards for accurate provider directories, provider ratios, geographic access to care, and timely access to care.^{14, 15} California is one of seven states to use all three quantitative network adequacy metrics (Gu et al., 2021). The details of the standards, organized by care category, are described in Appendix A.

⁵ See CHBRP's *Sources of Health Insurance in California*, available as a resource at: https://www.chbrp.org/other_publications/index.php

⁶ Cal. Code Regs. Tit. 28, 1300.67.2.2; Cal. Code Regs. Tit. 10, 2240.1

⁷ 45 CFR 156.230.

⁸ 45 CFR 156.235. Essential community providers are providers that serve a large proportion of low-income or medically underserved individuals. The ECP categories are: Federally Qualified Health Centers, Ryan White Program Providers, Family Planning Providers, Indian Health Care Providers, Inpatient Hospitals, and Other ECP Providers. Other ECP providers include Substance Use Disorder Treatment Centers, Community Mental Health Centers, Rural Health Clinics, Black Lung Clinics, Hemophilia Treatment Centers, Sexually Transmitted Disease Clinics, and Tuberculosis Clinics.

⁹ Network Adequacy Standards. 45 CFR 156.230 (2017).

¹⁰ In 2017, Market Stabilization Final Rule suspended federal oversight of network adequacy and reallocated all oversight to the states. However, in 2021 a federal court struck down this rule (Pollitz, 2022).

¹¹ Patient Protection and Affordable Care Act; Market Stabilization. 82 FR 18346 (2017).

¹² HSC 1367.03; INS 10133.54.

¹³ See CHBRP's *Sources of Health Insurance in California*, available as a resource at: https://www.chbrp.org/other_publications/index.php

¹⁴ Standards for timeliness of access to needed health care services. HSC 1367.03; INS 10133.54.

¹⁵ HSC 1367.27; INS 10133.15.

DMHC standards and CDI standards are similar. DMHC-regulated plans and CDI-regulated policies are required to have at least one full-time in-network primary care physician for every 2,000 enrollees. Timely access and geographic access standards are generally identical between the regulators when they exist for both. The major difference is that CDI has geographic and timely access standards for specialty care, outpatient mental health services, and ancillary care while DMHC does not have geographic standards for these care categories.

State regulators regularly publish guidance to assist health plans and policies with maintaining compliance with state law and regulations. For example, in November 2022, DMHC published two All Plan Letters (APLs) pertaining to implementation of recent amendments to laws and regulations related to timely access and network reporting. APL 22-026 directed health plans to documents on the DMHC website to assist with filing requirements. It also alerted health plans of a future APL regarding the department's forthcoming process for confirmation of each plan's network service area of its approved networks (DMHC, 2022b). APL 22-027 was published as a reminder to California health plans of their responsibility to provide timely access to medically necessary basic health care services to enrollees, even to those who are located outside the state when they need services (DMHC, 2022c).

Medi-Cal Managed Care Plans

Approximately 21% of Californians are beneficiaries of Medi-Cal, California's Medicaid program.¹⁶ Medi-Cal managed care plans include COHS and those regulated by DMHC. CMS requires states contracting with managed care organizations, prepaid inpatient health plans, and/or prepaid ambulatory health plans to deliver Medicaid services to have network adequacy standards.^{17, 18} These federal regulations set guidelines for state Medicaid programs, including the types of care that require quantitative network adequacy standards and the geographic scope of standards.¹⁹

Like other state and federal regulations, the standards for Medi-Cal managed care plans include timely access standards and geographic access standards for different categories of care. For specialty care and behavioral health care, geographic access standards are based on county size. Opioid treatment programs have a shorter timely access standard of three business days compared to ten business days for other outpatient mental health care. Additionally, Medi-Cal managed care plans are required to ensure access to culturally competent care for all beneficiaries. This includes considerations for people with limited English proficiency, diverse cultural and ethnic backgrounds, and all genders, sexual orientations, and gender identities (DHCS, 2018). Plans also must provide reasonable accommodations for beneficiaries with physical and mental disabilities.

Interplay of Network Adequacy Regulations

Due to the nature of health insurance regulation, different plans and policies may be subject to multiple, one, or none of the regulators' network adequacy requirements. For example, DMHC-regulated Medi-Cal managed care plans are subject to DMHC as well as Medi-Cal-specific network adequacy standards. Similarly, a QHP on the Covered California marketplace that is regulated by DMHC must meet the requirements for QHPs and DMHC-regulated plans. Non-QHP CDI-regulated policies are only subject to CDI network adequacy regulations. Self-insured plans²⁰ under the Employee

¹⁶ See CHBRP's *Sources of Health Insurance in California*, available as a resource at: https://www.chbrp.org/other_publications/index.php

¹⁷ Network adequacy standards. 42 CFR 438.68 (2020).

¹⁸ Availability of Services. 42 CFR 438.206 (2020).

¹⁹ Network adequacy requirements established by states for Medicaid must include quantitative standards for adult and pediatric primary care, OB/GYN care, adult and pediatric behavioral health care, adult and pediatric specialist care, hospitals, pharmacies, and pediatric dental care. Long-term services and supports, when included in the benefit contract, must also have quantitative network adequacy standards. The standards must consider, at a minimum, anticipated enrollment, expected utilization, characteristics of the population, the numbers and types of providers in-network and whether they are accepting new patients, geographic access, ability of providers to communicate with enrollees with limited English proficiency, accommodations for enrollees with physical or mental disabilities, and systems for triaging/screening and telehealth services.

²⁰ Under self-insured plans, the employer assumes responsibility for collection of premiums from enrollees, and most or all of the cost of benefit claims.

Retirement Income Security Act (ERISA) are not regulated by DMHC nor CDI and therefore are not subject to any of these network adequacy standards.

Many network adequacy requirements are identical across regulators. When there are differences, California's state network adequacy requirements are generally more robust than federal requirements for QHPs. Medi-Cal managed care plans have the most robust network adequacy standards.

Additional Network Adequacy Requirements

Other network adequacy requirements include accuracy of the provider directory, processes for providing coverage by out-of-network providers when in-network providers are not available within existing network adequacy standards, and standards for culturally appropriate care.

Provider Directories

A provider directory is a resource available to enrollees to see a list of in-network providers in their area for a given service or treatment. It includes whether a provider is accepting new patients and, often, the languages spoken by the provider. One of the ways in which regulators ensure transparency between health plans/insurers and enrollees is by requiring the maintenance of accurate provider directories. This allows enrollees to identify an in-network provider for medically necessary services included in their plan contract or policy.

Maintaining an accurate provider directory may be a logistical challenge for many plans and insurers; most information for provider directories must be shared by the providers themselves, and each practice may have an average of 20 plans and/or policies to report to (CAQH, 2019). In 2020, a review of a random sample of health plans by the Centers for Medicare & Medicaid Services (CMS) revealed that all provider directories sampled in the study had inaccuracies (CMS, 2021). In 2015, California passed legislation to improve accuracy of provider directories, requiring health plans and policies to update provider directories at least weekly and maintain a 97% or greater rate of accuracy.^{21, 22} These directories must also include the languages spoken by each provider.

At the federal level, the 2022 No Surprises Act established a federal requirement for health plans and policies to review their provider directories for accuracy at least every 90 days (CMS, 2022a).²³ This rule applies to the individual market, the Health Insurance Marketplaces, and employer-based insurance. Additionally, the law requires health plans and policies to offer in-network coverage for any out-of-network physician inaccurately listed as in-network in the provider directory (CMS, 2022a).

Covered Services from Out-of-Network Providers

Both federal and state regulations govern how health plans and insurers must respond to a patient seeking medically necessary services from an out-of-network provider. California law requires that if a health plan or insurer does not have an available in-network provider for a medically necessary service, the plan or policy must cover out-of-network services at the in-network cost, subject to cost sharing.²⁴ The Affordable Care Act (ACA) requires QHPs have an "effective process for internal claims and appeals and external review" (CCIIIO, 2017). In California, for enrollees in DMHC-regulated plans, the DMHC Help Center exists to partner with enrollees to resolve disputes (DMHC, 2021). If an enrollee is unable to get an appointment that complies with the timely access or geographic access standards set by DMHC, they can file a grievance with their health plan (DMHC, 2022a). If the enrollee is unsatisfied with the plan

²¹ HSC 1367.27 (2015); INS 10133.15.

²² Notice and Information to Covered Persons. 10 CCR 2240.6 (2015).

²³ See CHBRP's *Balance Billing Prohibitions and the No Surprises Act*, available as an issue brief at http://chbrp.org/other_publications/index.php.

²⁴ Cal. Code Regs. Tit. 28, 1300.67.2.2(c)(7); Cal. Code Regs. Tit. 10, 2240.1(e).

decision or if they do not receive a timely response, the enrollee may contact the DMHC Help Center. DMHC's Quick Resolution process provides mediation through a joint phone call between the enrollee and the health plan representative. CDI has a similar process through which enrollees in CDI-regulated plans can contact the Consumer Hotline to report network adequacy concerns or file a complaint (CDI, 2022a).

Standards for Culturally Appropriate Care

The ACA includes civil rights provisions that prohibit discrimination on the grounds of race, color, national origin, sex, age, or disability. All health plans and insurers that receive funding from the federal Department of Health and Human Services are required to abide by its provisions. Requirements include a mandate to post a notice regarding individuals' rights and information about communication assistance for enrollees with limited English proficiency; a prohibition on using low-quality video remote interpreting services and reliance on unqualified staff and translators for such services; and requirements for state health insurance marketplaces to provide translations of specific website content for individuals who are limited English proficient.^{25,26} California law also requires provider directories to include a disclosure informing enrollees that language interpreter services are available at no cost to the enrollee, and information on how to access such services.²⁷

Factors Impacting Network Adequacy

Provider Shortages

Provider availability influences the ability of health plans and insurers to meet network adequacy requirements. The Health Resources & Services Administration (HRSA) identifies Health Professional Shortage Areas (HPSAs) based on population-to-provider ratios, the percentage of the population living below the Federal Poverty Level (FPL), and the travel time to the nearest source of care, along with other metrics for each specific care category measured (HRSA, 2020). For primary care providers, California currently has 71 designated geographic HPSAs in 31 out of 58 counties (HRSA, 2022). For mental health care providers, California currently has 83 designated geographic HPSAs in 41 counties (HRSA, 2022). These provider shortages, present in both rural and urban areas of the state, may impact the ability of a health plan or policy to meet network adequacy standards.

Alternative Standards and Waivers

When health plans and policies are unable to meet a network adequacy requirement, DMHC and CDI allow health plans and policies to seek exceptions to these requirements under certain circumstances. (Gu et al., 2021; CDI, 2022b).^{28,29}

DMHC

DMHC-regulated plans may propose alternative standards to network adequacy requirements under the following conditions:³⁰

- The plan's standards of accessibility are unreasonably restrictive.

²⁵ Public Law 111-148, Tit. 1, 1557; 42 USC 18116.

²⁶ 45 CFR 155.205(c) and 156.250

²⁷ HSC 1367.27 (2015); INS 10133.15.

²⁸ Geographic access Standards. 28 CCR. 1300.67.2.1(a).

²⁹ Discretionary Waiver of Network Access Standards. 10 CCR. 2240.7(a), (b) (2016).

- 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

Proposals must include a description of the reasons justifying the less restrictive standards. If DMHC rejects the proposal, it is required to inform the plan of its reason for doing so.

CDI

CDI-regulated insurers unable to meet network adequacy standards required under state law and regulation may apply for a discretionary waiver of any standard and offer an alternate access delivery system. Waiver applications must be resubmitted annually. Reasons for waivers include:³¹

- Absence of practicing providers located within sufficient geographic proximity based upon the time or distance standards.
- The service area has adequate number of providers, but the insurer is unable to contract with them after negotiating in good faith.
- A provider or facility leaves the network.
- The insurer proposes an innovative network design that is shown to benefit enrollees (e.g. primary care medical homes, “Centers of Excellence,” or accountable care organizations).

In these cases, the plan or insurer may propose alternative standards of accessibility for that portion of its service area.³⁰ For example, if there is not an in-network specialty provider (i.e., psychiatrist, orthopedic surgeon, etc.) present in a rural area, DMHC or CDI would grant the health plan or policy a waiver for the geographic access requirement and establish an alternative standard.

Telehealth

Telehealth options are considered a potential solution to some network adequacy concerns because it can bridge geographic gaps for enrollees living in areas with provider shortages (Ahn et al., 2016). In recent years, there have been changes to regulations at the federal and state levels to account for this. In 2020, in response to COVID-19, CMS permanently relaxed network adequacy requirements for managed care organizations and explicitly called out the use of telehealth to meet standards (Stiver, 2020).³¹ Additionally, CMS developed and disseminated a *State Medicaid & CHIP Telehealth Toolkit* to support states in developing telehealth policies in response to COVID-19 (Medicaid.gov, n.d.). Starting in 2023, CMS will collect data on telehealth services by QHPs and use the data to inform future regulations around telehealth and network adequacy requirements (CMS, 2022b). In California, there have been numerous amendments to state law impacting DMHC-regulated plans and CDI-regulated policies to account for the increased prevalence of telehealth options in regard to network adequacy.³²

Many states are considering legislation to update how telehealth is regulated and revise network adequacy standards to account for the rapid proliferation of telehealth (Augenstein et al., 2022). The COVID-19 pandemic initiated a wave of dozens of federal and state regulation changes, both temporary and permanent, to enable coverage of telehealth services (Augenstein et al., 2022). States will likely continue making changes to policies regarding telehealth, which may include updates to network adequacy requirements.

³⁰ Grievance Systems. 28 CCR. 1368. 28 CCR 1300.67.2.1(a); 10 CCR 2240.7.

³¹ Medicaid Program; Medicaid and Children’s Health Insurance Program (CHIP) Managed Care. 42 CFR Parts 438 and 457 (2020).

³²Including HSC 1367-1374 and INS 10123.855.

Conclusion

Network adequacy standards and regulations are intended to ensure that enrollees have reasonable access to medically necessary services. It is typically measured and standardized based on a variety of metrics, including provider ratios, timely access, geographic access, and provider directories. In California, QHPs and state-regulated health plans and policies are subject to network adequacy standards set by their respective regulator(s). Given the impacts that COVID-19 had in health care delivery and utilization patterns, external factors such as telehealth and provider shortages may influence future proposed legislation and how health plans and policies meet these obligations.

Appendix A.

The following table outlines the main network adequacy standards for QHPs, DMHC-regulated plans, CDI-regulated policies, and Medi-Cal managed care plans. Medi-Cal managed care encompasses both COHS- and DMHC-regulated Medi-Cal managed care plans. The standards are shown for seven categories of care that generally fit how the requirements are framed by the regulators. Within each category of care, standards are broken up by the following types, where applicable:

- **Provider ratio** refers to the minimum ratio of the number of providers in the network to the number of enrollees, sometimes referred to as “provider-to-patient” ratios.
- **Geographic access** refers to the proximity of enrollees to in-network providers for medically necessary care. It is generally measured with a maximum distance in miles or minutes of travel for an enrollee to get to a provider from the enrollee’s home or workplace.
- **Timely access** refers to the maximum number of hours or business days by which an appointment must be available with a provider for medically necessary care.

If the type of plan does not have a specified network adequacy requirement for a certain standard, that is noted with “None specified.” There are additional requirements not listed in this table that do not apply to specific categories of care, including provider directories and cultural competency requirements.

Table 1. Network Adequacy Regulations by Care Category and Federal and California Requirements

| | | QHPs (a) (b) | DMHC-regulated commercial and CalPERS plans | CDI-regulated policies | DMHC-regulated Medi-Cal (c) (d) |
|--------------|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|
| Primary Care | Provider ratio | None specified. | At least one full-time primary care physician per 2,000 covered persons. (e) | At least one full-time primary care physician per 2,000 covered persons. (e) | None specified. |
| | Geographic access | Large Metro County: 10 min / 5miles Metro County: 15 min / 10 miles Micro County: 30 min / 20 miles Rural County: 40 min / 30 miles | Primary care network providers within 30 min / 15 miles of each covered person’s residence or workplace. | Primary care network providers within 30 min / 15 miles of each covered person’s residence or workplace. | Primary care provider within 30 min / 10 miles of enrollee’s residence. |

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|---------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | CEAC: 70 min / 60 miles | | | |
| | Timely access | Appointments must be available within 15 days | Nonurgent appointments for primary care within 10 business days of request. | Nonurgent appointments for primary care within 10 business days of request. | Nonurgent appointments for primary care within 10 business days of request. |
| Hospital | Geographic access | <p>Large Metro County: 20 min / 10 miles</p> <p>Metro County: 45 min / 30 miles</p> <p>Micro County: 80 min / 60 miles</p> <p>Rural County: 75 min / 60 miles</p> <p>CEAC: 110 min / 100 miles</p> | Network hospital with sufficient capacity must be available within 30 min / 15 miles of each covered person's residence or workplace. | Network hospital with sufficient capacity must be available within 30 min / 15 miles of each covered person's residence or workplace. | Network hospital within 30 min / 15 miles of enrollee's residence. |
| Specialty Care | Geographic access | Varies based on the specialty. | <i>None specified.</i> | Network specialists with sufficient capacity to accept covered patients within 60 min / 30 miles of home or workplace. | <p>Rural counties: 90 min / 60 miles from enrollee's residence.</p> <p>Small counties: 75 min / 45 miles from enrollee's residence.</p> <p>Medium counties: 60 min / 30 miles from enrollee's residence.</p> <p>Large counties: 30 min / 15 miles from enrollee's residence.</p> |
| | Timely access | Appointments must be available within 30 business days. | Appointment for nonurgent care within 15 business days of the request.* | Appointment for nonurgent care within 15 business days of the request.* | Appointments must be available within 15 days of a request. |
| Ancillary Services | Geographic access | <p><i>Diagnostic Radiology and Mammography:</i> Large Metro County: 20 min / 10 miles</p> <p>Metro County: 45 min / 30 miles</p> <p>Micro County: 80 min / 60 miles</p> <p>Rural County: 75 min / 60 miles</p> | Within a reasonable distance of the PCP. | <p><i>Outpatient retail pharmacies:</i> adequate number in sufficient proximity to covered persons to permit adequate routine and emergency access.</p> <p><i>Laboratory and other services:</i> available within a reasonable</p> | <p><i>Pharmacy:</i> 30 min / 10 miles from enrollee's residence; request for prior authorization within 24 hours.</p> <p>Requirements for other ancillary services are not specified.</p> |

| | | | | | |
|------------------------------------------|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | CEAC: 110 min / 100 miles | | distance of the prescribing provider. | |
| | Timely access | <i>None specified.</i> | Nonurgent ancillary care appointments within 15 business days of request.* | Nonurgent ancillary care appointments within 15 business days of request.* | <i>None specified.</i> |
| Outpatient Mental Health Services | Geographic access | Large Metro County: 10 min / 5 miles Metro County: 15 min / 10 miles Micro County: 30 min / 20 miles Rural County: 40 min / 30 miles CEAC: 70 min / 60 miles | <i>None specified.</i> | Mental health professionals within 30 min / 15 miles of each covered person's residence or workplace | Rural counties: 90 min / 60 miles from enrollee's residence. Small counties: 75 min / 45 miles from enrollee's residence. Medium counties: 60 min / 30 miles from enrollee's residence. Large counties: 30 min / 15 miles from enrollee's residence. |
| | Timely access | Appointments must be available within 10 business days. | Nonurgent, nonphysician mental health appointment within 10 business days of request. | Nonurgent, nonphysician mental health or substance abuse treatment appointment within 10 business days of request. | Outpatient, non-psychiatrist mental health appointment within 10 business days of request. Outpatient opioid use disorder treatment appointment within 3 business days. |
| Urgent Care | Geographic access | Large Metro County: 20 min / 10 miles Metro County: 45 min / 30 miles Micro County: 80 min / 60 miles Rural County: 75 min / 60 miles CEAC: 110 min / 100 miles | <i>None specified.</i> | <i>None specified.</i> | <i>None specified.</i> |
| Emergency Care | Timely access | <i>None specified.</i> | <i>Services that do not require prior authorization: Within 48 hours of request.*</i> | <i>Services that do not require prior authorization: Within 48 hours of request.</i> | <i>None specified.</i> |

| | | | <i>Services that do require prior authorization: Within 96 hours of request.*</i> | <i>Services that do require prior authorization: Within 96 hours of request.</i> | |
|--------------------|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Dental Care | Geographic access | Large Metro County: 30 min / 15 miles Metro County: 45 min / 30 miles Micro County: 80 min / 60 miles Rural County: 90 min / 75 miles CEAC: 125 min / 110 miles | <i>None specified.</i> | <i>None specified.</i> | 10 miles or 30 min from beneficiary's residence. |
| | Timely access | <i>None specified.</i> | <i>Urgent: Within 72 hours of the request.</i> <i>Nonurgent: within 36 business days of the request.</i> <i>Preventative: within 40 business days of the request.</i> | <i>Urgent: Within 72 hours of the request.</i> <i>Nonurgent: within 36 business days of the request.</i> <i>Preventative: within 40 business days of the request.</i> | <i>Pediatric dental services only:</i> <i>Routine appointment: Within 4 weeks of the request</i> <i>Specialist appointment: Within 30 calendar days of the request.</i> |

Sources: CCIIO, 2017; CCIIO, 2022; CDI, 2022c, Gu et al., 2021; DHCS 2018; CCR. Tit. 10, 2240.1; 28 CCR 1300.67.2.2; HSC 1367.03; 28 CCR 1300.67.2.1.

*unless treating provider finds longer wait will not have a detrimental impact on patient's health.

(a) These standards are based on the new CMS rules that will go into effect in January 2023.

(b) County density designations are based on the Medicare Advantage Network Adequacy Criteria Guidance.

(c) County density designations are determined by the number of people per square mile.

(d) This includes DMHC-regulated Medi-Cal Managed Care plans and COHS.

(e) DMHC-regulated plans and CDI-regulated policies are also required to ensure that there is one physician (of any specialty) per 1200 enrollees.

Key: CCIIO = Center for Consumer Information and Insurance Oversight; CDI = California Department of Insurance; CEAC = Counties with Extreme Access Considerations; CMS = Center for Medicare and Medicaid Services; DMHC = Department of Managed Health Care; COHS = County Organized Health Systems; min = minutes; PCP = primary care provider.

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Drawing on the experience and assistance of multi-disciplinary faculty, researchers, and analysts based at the University of California, CHBRP provides the California Legislature with timely, independent, and rigorous evidence-based analyses of introduced health insurance benefits-related legislation. Most frequently, CHBRP analyzes proposed health insurance benefit mandates (e.g., mandates to cover a test, treatment, or service, such as continuous glucose monitors). For more about CHBRP's 60-day analysis process, see the resource [Academic Rigor on a Legislature's Timeline](#).

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