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CALIFORNIA INSURANCE COMMISSIONER

California Department of Insurance
2026 Filing Instructions for Network Adequacy Reporting

I. OVERVIEW

a. A health insurer is required to file a network adequacy report and accompanying documents with the Department for all current and new health insurance policies, as defined by CIC § 106(b), that include the option of utilizing contracted providers to provide health care services. (10 CCR § 2240.5(a).)

b. Network adequacy regulations are located at 10 CCR § 2240, et seq.

c. Pre-filing conferences with the Department are available. Please reach out to Julia Yee (Julia.Yee@insurance.ca.gov) to schedule.

II. FILE SUBMISSION

a. Network adequacy filings are due annually on June 1st.

b. All network adequacy filing documents must be submitted electronically through the System for Electronic Rate and Form Filing (SERFF). Submit files using the "Network" filing type. Once submitted, do not file any new or revised documents except as part of a response to an objection letter, or with approval from the primary reviewer. (10 CCR §§ 2240.5(b), 2240.4(d).)

i. Attach each document in the appropriate field under the Supporting Documentation tab.
ii. Identify the state tracking numbers of all form filings associated with the network under the General Information tab.
iii. Do not use SERFF or company tracking numbers.
iv. Do not cross-reference form filings for products that will not be used with the network.

c. Submit a separate network adequacy filing for each network. If a network is used with multiple products, only one network adequacy filing is required.

d. Provider and facility data must be submitted directly to Quest at https://sftp.questanalytics.com/public/folder/fhxahcdlbk6njnk4thpr9w/adequacy. (10 CCR § 2240.5(d)(15)(B).)

e. Student health insurance coverage: For policy years beginning on or after January 1, 2026, student health insurance coverage, as defined in CIC § 10965.03, is considered individual health insurance coverage and generally must comply with the provisions of the Insurance Code that are applicable to non-grandfathered individual health insurance, and all rules and regulations issued thereunder. For the 2026-27 school year, insurers selling student health insurance coverage should submit the following items from the following sections of the 2026 Filing Instructions for Network Adequacy Reporting:

i. III.b., "Narrative description."
ii. III.c., "Attestation."
iii. III.d., "Monitoring and Evaluating Accessibility of Care."
iv. III.e., "Recruiting, Selecting, Credentialing, Accrediting, and Tiering Network Providers."
v. III.f., "Transition from Hospital to Community Settings."
vi. III.g., "Timely Access Policies and Procedures."
vii. III.h., "Quality Assurance Processes, Policies, and Procedures."
viii. III.i., "Mental Health/Substance Use Disorder Narrative Report."
ix. III.l., "Hospital Physician Network Report."

x. III.m., "Enrollment Report."
xi. III.n., "Transplant Center Report."
xii. III.o., "Provider Contracts."
xiii. Do not submit provider and facility data to Quest at this time.

III. COMPONENTS OF NETWORK ADEQUACY FILINGS

a. Network Report/Time and Distance Compliance

i. The network report must describe the number and location, by county and zip code, of all network providers and facilities, by categories as described in this section, utilized by the insurer to provide services to covered persons. The report must identify counties and zip codes where the network is not in compliance with the time and distance standards, as well as the average distance to a network provider. The report must identify the location and extent of areas of non-compliance. (10 CCR § 2240.5(c)(1).)
ii. The network report must demonstrate compliance with the time and distance standards set forth in 10 CCR § 2240.1(c) for the insurer's *actual and anticipated enrollment* for the next year (including geographic areas in the service area with no enrollment). The network narrative should include a description of the methodologies used to determine projected enrollment for the following plan year.
iii. The network report must demonstrate compliance with all accessibility and availability requirements of the network adequacy regulations. For tiered networks, adequacy must be demonstrated at the lowest cost tier. (10 CCR §§ 2240.15(b)(1), 2240.1(k).)
iv. The network report must demonstrate compliance with ratio and time-and-distance standards for the following provider and facility categories. Providers and facilities must have sufficient capacity to accept covered persons within a maximum travel time or distance standard as measured from the covered person's residence or workplace.
    1. Primary care providers – 30 minutes or 15 miles. (10 CCR § 2240.1(c)(2).)
    2. Specialists – 60 minutes or 30 miles. (10 CCR § 2240.1(c)(4).)
    3. Mental health providers, substance use disorder providers, and behavioral health – 30 minutes or 15 miles. (10 CCR § 2240.1(c)(6).)
    4. Hospitals – 30 minutes or 15 miles. (10 CCR § 2240.1(c)(7).)
    5. Mental health facilities and substance use disorder facilities – 60 minutes or 30 miles. (10 CCR § 2240.1(c)(6).)
    6. General dentists – 30 minutes or 15 miles. (10 CCR § 2240.1(c)(2) and (a)(2)(A).)
    7. Specialist dentists – 60 minutes or 30 miles. The network must include orthodontists. This standard applies to Exchange dental policies as well. (CCR § 10112.27(a)(5); 10 CCR § 2240.1(c)(4) and (a)(2)(A).)
    8. Optometrists – 30 minutes or 15 miles. (10 CCR § 2240.1(c)(2).)
    9. Ophthalmologists – 60 minutes or 30 miles. (CIC § 10112.27(a)(4); 10 CCR § 2240.1(c)(4).)

b. Network Report/Narrative Descriptions

i. Include narrative descriptions of the following requirements:
    1. The implementation and use by the insurer and its contracting providers of triage, telemedicine, and health information technology to provide timely access to care. (10 CCR § 2240.5(d)(9).)
    2. The service area covered by the network, by county (or by zip code for a partial county), and any change to the service area since the most recently filed network report. (10 CCR

§ 2240.5(c)(2).) Confirm that the service area is defined in the policy forms and certificates. (10 CCR § 2240.2(e).)

3. Telehealth services required by CIC §§ 10123.85 and 10123.855.

ii. Reference the state tracking number for the annual complaint report. (10 CCR § 2240.5(g).)

iii. Reference the state tracking number and submission date of the most recent six-month interim attestation. (10 CCR § 2240.1(l).)

iv. Reference the state tracking number of waivers approved by the Department for the network. Include the date the waiver was approved. (10 CCR § 2240.7.)

v. Include any information specific to the network that the insurer would like the department to consider in its network review.

c. <u>Attestation</u>

i. Include a signed attestation regarding compliance with network adequacy standards. (10 CCR § 2240.5(d)(1).) The attestation must include the following language:

1. The network satisfies all requirements set forth in 10 CCR §§ 2240 through 2240.7. (10 CCR § 2240.5(d)(1).)
2. There are a sufficient number, capacity, and specialties of licensed/accredited providers to provide for the medical needs and characteristics of the covered population. If network providers do not provide a service within the scope of practice, there are sufficient other providers within the network to provide that service. (10 CCR § 2240.1(b).)
3. There are adequate full-time equivalents of primary care physicians in the network accepting new patients covered by the policy to accommodate anticipated enrollment growth. (10 CCR § 2240.1(c)(3).)
4. There are adequate numbers of available primary care providers and specialists with admitting and practice privileges at network hospitals. (10 CCR § 2240.1(c)(8).)
5. There are facilities to provide post-acute care services with sufficient capacity to serve the entire population of covered persons based on normal utilization patterns. (10 CCR § 2240.1(c)(9).)
6. There are an adequate number of network outpatient retail pharmacies located in sufficient proximity to covered persons to permit adequate routine and emergency access. (10 CCR § 2240.1(c)(10).)
7. There are an adequate number of ancillary laboratory and other services dispensed by order or prescription of the prescribing provider are available from contracting providers at locations (where covered persons are served) within a reasonable distance from the prescribing provider. (10 CCR § 2240.1(c)(10).)
8. The network provides access to medically appropriate care from a qualified provider. If medically appropriate care cannot be provided within the network, the insurer must arrange for the required care with available and accessible providers outside the network, with the patient responsible for paying only cost-sharing in an amount equal to the cost-sharing they would have paid for provision of that or a similar service in-network. In addition to in-network copayments and coinsurance, in-network cost sharing includes applicability of the in-network deductible and accrual of cost sharing to the in-network out-of-pocket maximum. (10 CCR § 2240.1(e).)
9. There are a sufficient number of providers to assure access to preventive services required by CIC § 10112.2, including women's preventive care, which includes access to services and contraceptive methods as required by CIC § 10123.196. (10 CCR § 2240.1(g).)

d. **Monitoring and Evaluating Accessibility of Care:** Written policies and procedures for rendering network provider services, which includes a documented system for monitoring and evaluating accessibility of care and waiting time for appointments. (10 CCR §§ 2240.5(d)(2), 2240.1(b)(7).)

e. **Recruiting, Selecting, Credentialing, Accrediting, and Tiering Network Providers:** Written policies and procedures for recruiting network providers, credentialing or accrediting network providers, contracting with network providers, and managing the insurer's network, including the selection and tiering standards (if the network is tiered). (10 CCR §§ 2240.5(d)(4), 2240.1(i), 2240.4(a).)

f. **Transition from Hospital to Community Settings**: Written policies and procedures for coordination of the transition of an insured person from an inpatient hospital to an appropriate community setting consistent with the insured person's post-discharge care needs. (10 CCR § 2240.5(d)(4).)

g. **Timely Access Policies and Procedures**: Written policies and procedures setting forth the insurer's timely access standards. (10 CCR § 2240.5(d)(6).) Standards described in CIC § 10133.54 and 10 CCR § 2240.15(b).

h. **Quality Assurance Processes, Policies, and Procedures:** Compliance monitoring policies and procedures designed to accurately measure the accessibility and availability of contracted providers.

i. Policies and procedures for tracking and documenting network capacity and availability with respect to the standards set forth in 10 CCR §§ 2240.15 and 2240.16. (10 CCR § 2240.15(c)(2)(A).)

ii. Policies and procedures for reviewing and evaluating, no less frequently than quarterly, the information available to the insurer regarding accessibility, availability and continuity of care, including, not limited to, information obtained through covered person and provider surveys, covered person grievances and appeals, and triage or screening services. (10 CCR § 2240.15(c)(2)(D).)

i. **Mental Health/Substance Use Disorder Narrative Report**

i. Evaluate and describe the adequacy of the insurer's mental health and substance use disorder network, as required by 10 CCR §§ 2240.1(c)(6)(C) and 2240.5(d)(5).

1. Substance use disorder facilities:
    a. Confirm whether the network includes an adequate number and geographic distribution of facilities that provide inpatient, residential, and outpatient levels of care: (1) inpatient; (2) residential; (3) outpatient (partial hospitalization and intensive outpatient treatment); and (4) narcotic treatment programs.
    b. Describe how the network was evaluated for the adequacy of each listed facility type, including how facility types (1)-(4) were determined for each facility in the evaluation, and provide the standards used for evaluating access.
    c. Describe the results of the evaluation for each listed facility type by county for each county in the network's service area.
2. Mental health facilities:
    a. Confirm whether the network includes an adequate number and geographic distribution of facilities that provide inpatient, residential, and outpatient levels of care: (1) inpatient; (2) residential; and (3) outpatient (partial hospitalization and intensive outpatient treatment).
    b. Describe how the network was evaluated for the adequacy of each listed facility type, including how facility types (1)-(3) were determined for each facility in the evaluation, and provide the standards used for evaluating access.
    c. Describe the results of the evaluation for each listed facility type by county for each county in the network's service area.

3. Mental health and substance use disorder outpatient professional providers, including specialist physicians who diagnose and treat mental health and substance use disorder conditions (neurologists, psychiatrists, certified addiction medicine specialists, etc.):
    a. Confirm whether the network includes an adequate number and geographic distribution of outpatient professional providers.
    b. Describe how the network was evaluated for the adequacy of professional providers, including: (1) identifying licenses and/or certifications of professional providers included in the evaluation (CIC § 10144.5(a)(4)); and (2) explaining whether provider types were aggregated for purposes of the evaluation and, if so, why aggregation is appropriate for evaluating access.
    c. Confirm the geographic access standard in 10 CCR § 2240.1(c)(6) used to evaluate access. Describe the results for each aggregated outpatient provider grouping by county for each county in the network's service area.

ii. Describe any deficiencies in the network identified by these evaluations and how they are being addressed.

iii. Submit a corrective action plan (CAP); specify all actions that have or will be taken to address the deficiencies, and estimate the time required to do so.

iv. In the mental health narrative, attest to the following:
    1. There are mental health and substance use disorder professionals with skills appropriate to care for the mental health and substance use disorder needs of covered persons and with sufficient capacity to accept covered persons within a maximum travel time of 30 minutes or a maximum travel distance of 15 miles of each covered person's residence or workplace. The network must adequately provide for mental health and substance use disorder treatment, including behavioral health therapy. The network must consider the pattern and frequency with which different therapies, particularly behavioral health therapy, are provided for different patient populations at different ages, such that if it is clinically necessary for a network to have services available in closer proximity to affected covered persons than required by the minimum time and proximity standards stated above then the insurer must make the services available in such closer proximity. (10 CCR § 2240.1(c)(6).)
    2. The network provides adequate access to crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, detoxification, outpatient mental health and substance use evaluation and treatment, psychological testing, outpatient services for monitoring drug therapy, partial hospitalization, intensive outpatient treatment, short-term treatment in a crisis residential program in a licensed psychiatric treatment facility with 24-hour monitoring by clinical staff for stabilization of an acute psychiatric crisis, psychiatric observation for an acute psychiatric crisis, and residential treatment for both mental health and substance use disorders. (10 CCR § 2240.1(c)(6)(A).)
    3. There are mental health and substance use disorder providers of sufficient number and type to provide diagnosis and medically necessary treatment through providers acting within their scope of license and scope of competence established by education, training, and experience to diagnose and treat mental health and substance use disorders. (10 CCR § 2240.1(c)(6)(A).)
    4. There are a sufficient number of the appropriate types of mental health and substance use disorder treatment providers and facilities based on normal utilization patterns. (10 CCR § 2240.1(c)(6)(D).)

5. That covered persons can access information about mental health and substance use disorder services, including benefits, providers, coverage, and other relevant information, by calling a customer service representative, or otherwise contacting the company through an accessible means, during normal business hours. (10 CCR § 2240.1(c)(6)(E).)

j. **Timely Access Compliance Report:** A report describing the rate of compliance during the reporting period with the time elapsed standards in CIC § 10133.54 and 10 CCR §§ 2240.15 and 2240.16. (10 CCR § 2240.5(d)(7).) Insurers must demonstrate compliance based on available providers.

i. CIC § 10133.54(b)(5) provides the wait times for urgent and non-urgent appointments.

ii. Non-urgent followup appointments with a nonphysician mental health or substance use disorder provider must be available 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. The applicable waiting time for an appointment may be extended if the referring or treating health provider determines that a longer waiting time will not have a detrimental impact on the insured's health. This requirement does not limit coverage for non-urgent followup appointments with a nonphysician mental health or substance use disorder provider to once every 10 business days. (CIC § 10133.54(b)(5)(F).)

iii. A referral to a specialist by a primary care provider or another specialist is subject to the relevant time-elapsed standards for urgent and non-urgent care appointments. (CIC § 10133.54(b)(5)(J).)

iv. An insurer must ensure timely access to covered health care services as required by CIC § 10133.54(b), including applicable time-elapsed standards, by assisting an insured to locate available and accessible contracted providers in a timely manner appropriate for the insured's health needs. An insurer must arrange for the provision of services outside the insurer's contracted network if unavailable within the network if medically necessary for the insured's condition. Insured costs for medically necessary referrals to out-of-network providers must not exceed applicable in-network copayments, coinsurance, and deductibles. (CIC § 10133.54(b)(7)(B).)

v. Insurers that file a timely access compliance report with the Department of Managed Health Care using the Provider Appointment Availability Survey ("PAAS") methodology may use the same methodology to develop a timely access compliance report specific to the insurer's network filed with the Department of Insurance.

k. **Noncompliance Report:** Report regarding any noncompliance by the insurer with provisions of 10 CCR § 2240, et seq.

i. The report must state whether or not an incident or pattern described in 10 CCR § 2240.5(d)(8)(A) or (B) occurred during the reporting period.

ii. If an incident or pattern occurred during the reporting period, the report must include a description of the identified non-compliance and the responsive investigation, determination and corrective action. (10 CCR § 2240.5(d)(8).)

l. **Hospital Physician Network Report:** Report describing, for each network hospital, the percentage of physicians in each of the specialties: (1) emergency medicine, (2) anesthesiology, (3) radiology, (4) pathology, and (5) neonatology practicing in the hospitals in the network. (10 CCR § 2240.5(d)(14).)

m. **Enrollment Report:** Report confirming the current status of the insurer's provider network and enrollment. Include the total enrollment in each product line which uses the network on a county-by-county basis, as well as the total enrollment for the entire network. (10 CCR § 2240.5(d)(15).)

n. **Transplant Center Report:** Report demonstrating capacity to provide medically necessary organ, tissue, and stem cell transplant surgery. (10 CCR § 2240.1(f).) Identify and locate each transplant center in its

network by name, address, and type(s) of transplant provided in the facility. (10 CCR §§ 2240.1(f), 2240.5(d)(13).)

o. **Provider Contracts:** Complete copies, including all appendices, attachments and exhibits of the most commonly utilized network provider contracts for each type of provider the insurer includes in the network, including but not limited to hospital, individual or group physician, laboratory, mental health and substance use disorder, rehabilitation, and ancillary service contracts. (10 CCR § 2240.5(d)(3).)

i. Provider contracts must include language pertaining to health care provider reimbursements per CIC § 10120.35.

ii. A health insurer must reimburse contracting health care providers for business expenses to prevent the spread of diseases causing public health emergencies.

p. **Covered Person and Provider Surveys**: Results of the most recent annual covered person and provider surveys required by 10 CCR § 2240.15(c)(2)(B)-(C). Include a comparison with the results of the prior year's surveys and describe the relative change in survey results.

q. **Out-of-Network Utilization**: Data regarding the extent to which members used out-of-network services during the reporting period, including the number of out-of-network claims by type of provider, dollar value of total claims, average value per claim, total amount paid by the health plan, average amount paid per claim, total unpaid claim balances, and average unpaid claim balance per claim. (10 CCR § 2240.5(d)(11).)

r. **Emergency Room Data**: Data regarding the extent to which members used emergency room services during the reporting period. (10 CCR § 2240.5(d)(12).)

s. **Provider and Facility Data**

i. Complete and submit a copy of the CDI Data Collection Template to the Quest web portal for submission of the 10 CCR § 2240.5(d)(15)(B) data:

1. Complete the CDI Data Collection Template for each network. Instructions are located in the template and include validation of completion before submission.
2. Name the template in the following format: "InsurerName_MarketSegment_NetworkName.xlsm".
3. Submit a separate completed copy of the CDI Data Collection Template for each network in .xlsm format to the web portal, https://sftp.questanalytics.com/public/folder/fhxahcdlbk6njnk4thpr9w/adequacy.

ii. Additional facility types in Quest filings:

1. Adult Residential Substance Use Disorder Treatment Facility (RES_SUD)
   a. Facilities must be listed on the AdultResidentialSUDLookup tab of the template and assigned the corresponding Record ID. Unlisted facilities (including licensed hospitals) cannot be submitted with specialty code RES_SUD.
   b. The list is based on the California Department of Health Care Services' master list of Licensed Residential Facilities and/or Certified Alcohol and Drug Programs, https://data.chhs.ca.gov/dataset/community-care-licensing-adult-residential-facility-locations.
2. Licensed Narcotic Treatment Programs (NTP)
   a. Facilities must be listed on the NarcoticTreatmentLookup tab of the template and assigned the corresponding "License__" number. Unlisted facilities cannot be submitted with specialty code NTP.
   b. The list is based on the California Department of Health Care Services' master list of Licensed Narcotic Treatment Programs, available at https://data.chhs.ca.gov/dataset/licensed-narcotic-treatment-programs.

iii. Add a note to reviewer to the SERFF network adequacy filing indicating when the data was submitted. Ensure that the network name on SERFF aligns with the name on the web portal.

t. Waivers (Alternate Access Delivery System) Requests

i. Include state tracking numbers for all waivers previously submitted or approved for the network. Waivers must be resubmitted annually. (10 CCR § 2240.7.)

ii. Filing requirements for discretionary waivers will be issued separately.

u. Provider and Insured Equity Data: Complete and submit the Provider and Insured Equity Data form, available on SERFF. Once logged in to SERFF, select "Filing Rules," "General Instructions," then "CaliforniaLAH." The form is titled, “CDI Provider and Insured Equity Data 2021.pdf.”

IV. OTHER REQUIRED FILINGS

a. Six-Month Interim Attestation

i. An insurer must measure the adequacy of each network every six months and submit a demonstration and attestation. (10 CCR § 2240.1(l).)

ii. A separate six-month interim attestation must be filed for each network. The attestation must be submitted in a new, separate SERFF filing no later than December 1st each year. In each filing, sign and attest to the following:

1. The adequacy of the network has been measured within the requisite six-month period. (10 CCR § 2240.1(l).)
2. The network remains adequate, is adequate considering previously filed waivers, or a CAP has been submitted along with this filing. (10 CCR § 2240.1(l).) If a CAP is necessary, include the following:
    a. Specify all actions that have or will be taken to come into compliance, and estimate the time to do so.
    b. Include waivers to come into compliance with network adequacy requirements.
    c. Demonstrate that network adequacy was measured by submitting documents relied upon to measure adequacy, or describe how adequacy was measured.

b. Notification of Contract Termination

i. Notify the Department: An insurer must notify the Department at least 10 days prior to contract termination with a provider, provider group, or facility, and demonstrate that the network remains in compliance with network adequacy requirements. (10 CCR § 2240.4(d).)

1. Untimely notifications: If notification to the Department occurs less than 10 days before or after the termination, include a detailed explanation as to why the Department was not notified within the required time period.
2. Bundling: When multiple terminations occur within the same period, bundle the terminations in one filing, listing each termination.

ii. Demonstrate Compliance: The notice of termination must demonstrate compliance with the network adequacy requirements by submitting an updated network report as described in 10 CCR § 2240.5(c)(1). (10 CCR § 2240.4(d)).

1. Type of termination
    a. Individual provider terminations: Include a list of alternate providers that enable the network to continue to comply with network adequacy requirements. (10 CCR § 2240.4(d).)
    b. Medical group terminations:
        i. Include a list of alternate providers that enable the network to continue to comply with network adequacy requirements. (10 CCR § 2240.4(d).)

ii. Include an updated network adequacy report as described in 10 CCR § 2240.5(c)(1), or a narrative description of other network providers which enable the network to continue to comply with the network adequacy requirements, notwithstanding termination of the identified provider(s).

c. Facility terminations:

i. Include a list of alternate providers that enable the network to continue to comply with network adequacy requirements. (10 CCR § 2240.4(d).)

ii. Include an updated network adequacy report as described in 10 CCR § 2240.5(c)(1), or a narrative description of other network providers which enable the network to continue to comply with the network adequacy requirements, notwithstanding termination of the identified provider(s).

2. Network adequacy reports should contain the following information:
   a. Name of facility or provider specialty;
   b. Type of facility or provider specialty;
   c. Applicable time and distance standard per 10 CCR § 2240.1(c);
   d. Impacted county (or in partially covered counties, impacted zip code);
   e. Percentage of insureds that do not have access to care in compliance with 10 CCR § 2240.1(c);
   f. Specify areas of noncompliance, if any.
3. Describe how network compliance was determined, citing the applicable standard.
4. Submit waivers pursuant to 10 CCR § 2240.7, as necessary.

iii. Notify Consumers:

1. Confirm that insureds who have seen the provider within the last year have been notified of the termination. Submit a copy of the termination notice in the filing. (10 CCR § 2240.6(m).)
2. Confirm that insureds have been notified of their continuity of care rights. Submit a copy of the notice in the filing. (CIC § 10133.55, 10133.56.)
3. Confirm that the provider network directory has been updated to reflect the termination. (Cal Ins. Code § 10133.15(e)(2); 10 CCR § 2240.6(a).)

c. <u>Notification of Material Change/Non-Compliance</u>

i. An insurer must immediately notify the Department any time a material change to any of its networks results in the insurer being out of compliance with the network adequacy regulations.

ii. The insurer must submit a CAP, specifying all actions that have or will be taken to come into compliance, and estimate the time to do so. (10 CCR § 2240.5(f).)

d. <u>Annual Complaint Reports</u>: Required by 10 CCR § 2240.5(g), must be received by the Department no later than March 31st each year.

V. <u>OUT-OF-NETWORK REPORTING REQUIREMENTS</u>

a. Submit the data required by 10 CCR § 2238.12(a) in Excel format.

b. For each contracting health facility, submit payment information for each service subject to CIC § 10112.8:

i. Service code (10 CCR § 2238.12(a)(1)(A));

ii. Specialty, as applicable (10 CCR § 2238.12(a)(1)(B));

iii. Number of times payment was made for that service code to: (1) a non-contracting individual health professional, and (2) a contracting individual health professional (10 CCR § 2238.12(a)(1)(C), (D)).

c. Submit the number of non-contracting and contracting individual health professionals who submitted claims for reimbursement for services provided at each contracting health facility, separated by specialty. (10 CCR § 2238.12(a)(2), (3).)

VI. **WAIVER (ALTERNATE ACCESS DELIVERY SYSTEM) REQUESTS**: Pursuant to 10 CCR § 2240.7(a) and (e), waiver requests and supporting documentation must be submitted to the Department for approval. Waiver requests must be resubmitted on an annual basis. (10 CCR § 2240.7(a).) The Department will post approved waivers on its website. (10 CCR § 2240.7(f).) The following components must be included:

a. Introductory Information

i. Health insurance company name
ii. Network name
iii. Provider or facility type for which waiver is requested. (10 CCR §§ 2240.7(c)(3), (d)(1).)
iv. County and provider or facility type for which the waiver is requested.
v. Specify whether the waiver request is a renewal of a previously approved waiver. If so, specify any differences in the provider and facility types and geographic areas for which previous waivers were granted.
vi. Specify the time period applicable to the waiver request.

b. Accessibility Details: Describe the affected area, covered persons in that area, and how the insurer determined the absence of providers or facilities. Provide data for members with and without availability within time and distance standards (stated in number and percentage of members). (10 CCR § 2240.7(d)(1).)

c. Basis for Waiver: Specify the reason(s) for a waiver under 10 CCR § 2240.7(b). Cite the specific paragraph(s) under which a waiver is sought. (10 CCR § 2240.7(d)(3).) Include the following for each waiver basis:

i. Absence of practicing providers (10 CCR § 2240.7(b)(1)). A waiver request based on absence of practicing providers located within sufficient geographic proximity based upon the time or distance standards of the regulation must:
   1. Describe the affected area, covered persons in that area, and how the insurer determined the absence of the provider or facility type that is the subject of the waiver request. (10 CCR § 2240.7(d)(1).)
   2. Estimate the percentage of practicing providers or facilities (of the type that is the subject of the waiver) in the affected area that are in the insurer's network.
   3. Specify the time and distance standard proposed in the request.

ii. Inability to contract (10 CCR § 2240.7(b)(2)). A waiver request based on inability to contract means that there are sufficient numbers or types of providers or facilities in the service area to meet the required network access standards, but the insurer demonstrates, through substantial evidence that, after good faith efforts, it is unable to contract with sufficient providers or facilities to meet the network access standards. The request must:
   1. Identify providers and facilities with whom an unsuccessful attempt to contract was made. If a contract was offered, identify offer dates and a record of the communication between the insurer and provider.
   2. Include information such as whether contract negotiations are still in progress or the extent to which the parties are not able to agree on contract terms. Specify the time

period of negotiations. If a contract was not offered, explain why. Documentation must be as specific.
3. Include documentation of good faith efforts taken to contract.
4. Include the specific time and distance standard proposed.

iii. Unavailability of provider or facility (10 CCR § 2240.7(b)(3)). A waiver request based on a provider or facility becoming unavailable within the service area of a previously approved provider network must:
1. Describe why the provider or facility is no longer available, and demonstrate good faith efforts to contract. (10 CCR § 2240.7(b)(2).)
2. If unavailability is due to provider termination, reference the SERFF file number for the notice sent to the Department. (10 CCR § 2240.4(d).)
3. Include a CAP specifying all actions that have or will be taken to come into compliance. Estimate the time to do so.
4. Include location, time, and distance of nearest facility or provider(s).

iv. Innovative network design (10 CCR § 2240.7(b)(4)). A waiver request based upon an innovative network design where the innovative network design is shown to provide a benefit to consumers. The request must:
1. Describe the type of plan design being proposed.
2. Demonstrate that the design will provide a benefit to consumers.
3. Demonstrate that the proposed alternate access delivery system will provide covered persons with access to medically necessary care on a reasonable basis without detriment to their health.
4. Include the specific time and distance standards being proposed.

d. <u>Details of the Alternate Access Delivery System Proposal</u>

i. Demonstrate that the alternate access delivery system will provide covered persons with access to medically necessary care on a reasonable basis without detriment to their health. (10 CCR § 2240.7(c)(1).) Explain how it will provide covered persons in affected areas with access to the provider or facility type for which the waiver is requested.

ii. Demonstrate that procedures are in place to ensure that covered persons obtain all covered services in the alternate access delivery system at no greater cost to the covered persons than if services were obtained from network providers or facilities. (10 CCR § 2240.7(c)(2).) Include an affirmative statement that all covered services will be treated as in-network and that there will be no balance billing for use of an out-of-network provider or facility.

iii. Explain why the alternate access delivery system provides covered persons with a sufficient number of the appropriate types of providers or facilities to which the network adequacy standard in question applies. (10 CCR § 2240.7(c)(3).)

iv. Include information concerning the availability of providers or facilities in the affected area made available to covered persons as part of the alternate access delivery system. Hospitals in affected areas that are part of the alternate access delivery system must be identified by name and address.

v. Include the average travel distance to a provider or facility made available to covered persons as part of the alternate access delivery system (of the type subject to the waiver) that is closest to covered persons in the affected area.

vi. Demonstrate how the insurer will assist covered persons to locate providers or facilities in a manner that assures both availability and accessibility. (10 CCR § 2240.7(c)(4).) Include updated policies and procedures specifying how customer service representatives will assist.

1. Demonstrate that covered persons are able to obtain health care services from a provider or facility within the closest reasonable proximity of the covered person in a timely manner appropriate for the covered person's health needs. (10 CCR § 2240.7(c)(4)(A).) Explain any limitations that will be imposed on covered persons' access in affected areas, including the maximum distance a covered person would be required to travel to access covered services from a network provider or facility.
2. Specify strategies used to ensure that such providers or facilities remain reasonably accessible, and exceptions to network standards based upon rural locations in the service area. (10 CCR § 2240.7(c)(4)(B).)

e. <u>Additional Required Information</u>

i. Alternatives considered, including but not limited to, telemedicine or phone consultation. (10 CCR § 2240.7(d)(2).)
   1. Specify alternatives and if they were rejected, explain why.
   2. If no alternatives were considered, explain why.

ii. Issues or risks that may prevent the alternate access delivery system from providing covered persons with access to medically necessary care on a reasonable basis without detriment to their health. (10 CCR § 2240.7(d)(4).)
   1. Specify steps/protocols put in place to minimize or eliminate these risks.
   2. If no risks have been identified, so state.

iii. Additional documentation necessary to support the request.

f. <u>Comprehensive list of all waiver requests</u>: Submit a comprehensive list of all waivers requested. (Suggested formatting.)

County	Facility/Provider Type	Waiver Provisions

NOTE: The Filing Instructions for Network Adequacy Reporting are provided to assist insurers in submitting a complete filing by setting forth the minimum requirements for compliance with network adequacy standards. Insurers and individuals are advised to review all applicable legal requirements and may not rely upon this information as legal authority or as a defense against disapproval of a filing or regulatory enforcement by the Department. These instructions are subject to change at any time.