August 7, 2026

Mary Watanabe, Director
California Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814

SUBJECT: Proposed Amendments to 28 CCR § 1300.67.2 and Associated Network Adequacy Methodologies

Dear Director Watanabe:

California's hospitals share the Department of Managed Health Care's continued commitment to ensuring that commercial health plan enrollees have timely, geographically accessible care and that health plan networks reflect true on-the-ground capacity needed to meet enrollees' medical needs. On behalf of nearly 400 hospital and health system members, the California Hospital Association (CHA) appreciates the opportunity to provide feedback on the Department of Managed Health Care's (DMHC) proposed amendments to network adequacy standards and evaluation methodologies (28 CCR § 1300.67.2). These proposed network adequacy standards and regulatory updates are an important step toward improving access to care in California and holding insurers accountable to patients and their providers.

Support for Enhanced Health Plan Accountability and Capacity Standards

CHA strongly supports DMHC's efforts to establish stricter oversight and accountability for health plan networks. For too long, patients and their health care providers have borne the operational and financial weight of "ghost" networks and insufficient health plan capacity, which restrict patient access and exacerbate the non-clinical workload on the health care system. DMHC's incorporation of concrete tracking metrics, such as county and network-level hospital bed-to-enrollee ratios (a maximum of 250 enrollees per licensed acute bed), provides a meaningful, data-driven standard for evaluating real network capacity. In addition, tracking out-of-network referral rates for hospital care will help regulators identify underlying network deficiencies and hold plans accountable when they fail to maintain true, on-the-ground capacity. By establishing these objective benchmarks, DMHC creates a direct regulatory lever to force plans to build functional networks rather than relying on paper compliance or shifting care out-of-network unnecessarily.

Support for Post-Acute Care Discharge Mandates

CHA supports the proposed post-acute discharge standards set forth in Section 1300.67.2(i)(2)–(3). Delayed discharges remain one of the primary drivers of hospital overcrowding and emergency department boarding. When health plans fail to maintain adequate post-acute care (PAC) networks or

drag out authorization processes, patients who are medically cleared for transfer remain stranded in acute care beds for days or weeks — to the detriment of their health and recovery.

The draft regulations establish critical protections by mandating clear time frames for PAC authorization: **48 hours** when no prior authorization is required, and **96 hours** when prior authorization is required.

Crucially, requiring health plans to arrange and cover out-of-network PAC facility stays or durable medical equipment when in-network capacity is unavailable directly addresses a long-standing systemic failure. It is further strengthened by prohibiting plans from discontinuing hospital coverage until the care plan is agreed upon and the patient is safely transferred. Importantly, this includes a requirement for the plan to authorize and pay for out-of-network care at in-network cost-sharing rates in such circumstances. Furthermore, mandating that the plans staff licensed case managers and offer a clear, time-stamped method for authorization submission will streamline workflows and significantly alleviate acute bed gridlock.

Caution Regarding Operational Burdens and Rigid Capacity Triggers

While CHA supports DMHC's regulatory goals and proposed updates, hospitals urge the department to carefully consider the operational challenges that could result from rigid utilization formulas and capacity metrics.

Rigid triggers could introduce unintended administrative complexities for facilities already facing severe operational constraints. For example, DMHC must ensure that hospitals are not inappropriately penalized or burdened by capacity classification, such as the "Maximum Capacity Hospital" designation, when those occupancy levels are driven by health plan authorization delays or bottlenecks downstream in PAC.

Preventing Unintended Consequences and Health Plan Gaming

DMHC should maintain strong oversight to ensure health plans comply with these regulatory requirements:

- **Restricting Access to High-Capacity Facilities:** Because a plan cannot meet its county bed-sufficiency ratio if it relies too heavily on a facility designated as a "Maximum Capacity Hospital," health plans may be incentivized to inappropriately steer, divert, or restrict admissions away from tertiary and quaternary regional centers, or other hospitals with high capacity. DMHC must ensure plans do not penalize high-volume facilities or limit patient choice to avoid regulatory triggers.
- **Disincentivizing Out-of-Network Approvals:** The introduction of strict out-of-network referral thresholds (e.g., 5 to 8 hospital referrals per 1,000 enrollees) could inadvertently incentivize health plans to aggressively delay or deny necessary out-of-network authorizations or refuse to negotiate Single Case Agreements, even when appropriate or medically necessary. DMHC must actively monitor plan authorization data to ensure plans do not inappropriately deny out-of-network access for rare, complex, or highly specialized care. This oversight is necessary to prevent certain plans from denying needed referrals simply to keep their non-network referral counts below enforcement thresholds.

Importance of Active, Continuous Enforcement

These new standards will only be effective if paired with rigorous and ongoing enforcement. Relying solely on retroactive annual reporting reviews allows health plans to engage in non-compliant practices without immediate consequence. Hospitals urge DMHC to implement real-time monitoring, conduct

targeted audits, and enforce swift administrative penalties against plans that breach mandatory discharge timelines or network availability rules.

Consideration of Integrated Health Plan Characteristics

Finally, as California moves forward to implement these stronger network adequacy standards, CHA urges DMHC to give special consideration to integrated health plans' unique characteristics. This would ensure that strict ratios and thresholds do not disrupt their streamlined approach to patient-centered care or impede their ability to continue delivering highly coordinated health care services.

CHA appreciates DMHC's leadership on these critical issues and looks forward to working collaboratively with the department to ensure these regulations improve patient flow and network transparency across California.

Sincerely,

Michelle Millerick, MPH
Vice President, Policy
California Hospital Association

cc: Amanda Levy, Deputy Director, Health Policy and Stakeholder Relations, Office of the Director, Department of Managed Health Care