

**DEPARTMENT OF MANAGED HEALTH CARE
OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS**

TECHNICAL ASSISTANCE GUIDE

ACCESS AND AVAILABILITY OF SERVICES

ROUTINE VISION SURVEY

OF

PLAN NAME

DATE OF SURVEY:

PLAN COPY

Issuance of this November 22, 2011 Technical Assistance Guide renders all other versions obsolete.

VISION TAG

ACCESS AND AVAILABILITY OF SERVICES REQUIREMENTS

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Requirement AA-001: Number and Distribution of Providers

STATUTORY/REGULATORY CITATIONS

CA Health and Safety Code section 1367(e)(1)

All services shall be readily available at reasonable times to each enrollee consistent with good professional practice. To the extent feasible, the plan shall make all services readily accessible to all enrollees consistent with section 1367.03.

28 CCR 1300.51(d)(H)

(d) Exhibits to Plan Application.

H. Geographical Area Served.

Note: The applicant is required to demonstrate that, throughout the geographic regions designated as the plan's Service Area, a comprehensive range of primary, specialty, institutional and ancillary services are readily available at reasonable times to all enrollees and, to the extent feasible, that all services are readily accessible to all enrollees.

For the purpose of evaluating the geographic aspects of availability and accessibility, consideration will be given to the actual and projected enrollment of the plan based on the residence and place of work of enrollees within and, if applicable, outside the service area, including the individual and group enrollment projections furnished in Items CC, DD and EE of this application.

An applicant for plan license must demonstrate compliance with the accessibility requirement in each of the areas specified in paragraphs (i) through (iv) below, either by demonstrating compliance with the guideline specified in such paragraphs or, in the alternative, by presenting other information demonstrating compliance with reasonable accessibility. These guidelines apply only with respect to initial license applications and provide presumptively reasonable standards in the absence of actual operating experience. Such guidelines are not intended to express minimum standards of accessibility either for applicants or for licensees nor to create any inference that a plan, which does not meet these guidelines, does not meet the requirement of reasonable accessibility.

28 CCR 1300.67.2(a) and (d)

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

(a) The location of facilities providing the primary health care services of the plan shall be within reasonable proximity of the business or personal residences of enrollees, and so located as to not result in unreasonable barriers to accessibility.

(d) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably ensure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be approximately one full-time equivalent primary care physicians for each two

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thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees.

28 CCR 1300.67.2.1(b) and (c)(2), (3), (4), and (9)

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

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

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

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

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

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

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

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

28 CCR 1300.67.2.2.(c)(7)

(c) Standards for Timely Access to Care

(7) Plans shall ensure they have sufficient numbers of contracted providers to maintain compliance with the standards established by this section.

(A) This section does not modify the requirements regarding provider-to-enrollee ratio or geographic accessibility established by Sections 1300.51, 1300.67.2 or 1300.67.2.1 of Title 28.

(B) A plan operating in a service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsd standards, by referring enrollees to, or, in the case of a preferred provider network, by assisting enrollees to locate, available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. Plans shall arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network, when

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medically necessary for the enrollee's condition. Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance, and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Optometric Director
- Director of Contracting/Provider Relations
- QM Director

DOCUMENTS TO BE REVIEWED

- Policies and procedures that define the standards for the number and distribution of optometric providers within the service area
- Policies and procedures to periodically update/review the standards for the number and distribution of optometric providers within the service area
- Distribution service area maps indicating location and numbers of enrollees in comparison with optometric providers
- Plan access reports that provide information on provider distributions, closed practices and the like.
- Record of periodic review of the standards for the number and distribution of providers within the service area, including minutes of relevant Committee meetings (QM Committee, Public Policy Committee, etc.)
- Documents describing how the Plan monitors and ensures compliance with network standards.
- Corrective action plans for areas where access does not meet the standards
- Electronic version of the Plan's provider directory(s) and the link to the Plan's online directory(s).
- Review licensing filing of the Plan's Access standards and confirm submission of appropriate policies and procedures.
- Review procedures for referring enrollee's outside the contracted network, including but not limited to, policies and procedures, criteria for determining out of network referral, policy and procedures regarding applicable co-pays and co-insurance for enrollees accessing care out of network.

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AA-001 - Key Element 1:

- 1. The Plan has established a standard for geographic distribution of providers. 28 CCR 1300.51(d)(H); 28 CCR 1300.67.2(a) and (d); 28 CCR 1300.67.2.1(b) and (c)(2), (3), (4), and (9)**

Assessment Question	Yes	No	N/A
1.1 Does the Plan have an established standard on geographic distribution of specialty/vision care providers?			

AA-001 - Key Element 2:

- 2. The Plan can demonstrate that, throughout the geographic regions designated as the Plan's Service Area, a comprehensive range of specialty/optometry services are readily available at reasonable times to all enrollees and, to the extent feasible, that all services are readily accessible to all enrollees. 28 CCR 1300.51(d)(H); 28 CCR 1300.67.2(a) and (d); 28 CCR 1300.67.2.1(b) and (c)(2), (3), (4), and (9)**

Assessment Questions	Yes	No	N/A
2.1 Does the Plan have an established standard for the numbers of optometric providers which is consistent with the enrollee population?			
2.2 Can the Plan demonstrate reasonable accessibility of optometry services within all regions of the Plan's service area?			
2.3 Can the Plan demonstrate sufficient numbers of staff, professionals, administrative and support staff that reasonably ensures that all services offered by the Plan will be accessible to enrollees on an appropriate basis without delays?			
2.4 Is the Plan's provider network and demonstrated accessibility consistent with documents filed with the Division of Licensing?			

AA-001 - Key Element 3:

- 3. The Plan has established a mechanism that ensures that its health care services are readily available at reasonable times to each enrollee consistent with good professional practice. CA Health and Safety Code section 1367(e)(1); 28 CCR 1300.67.2.2.(c)(7)**

Assessment Questions	Yes	No	N/A
3.1 Does the Plan have mechanisms to ensure that its health care services are readily available at reasonable times to each enrollee consistent with good professional practice?			

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3.2	Does the Plan have mechanisms to ensure timely access to services in the event there is a shortage of providers in a particular area?			
3.3	In the event of a shortage of providers in a particular area, does the Plan assist enrollees in locating contracted providers in neighboring service areas?			
3.4	If services are not available in Plan, does the Plan have mechanisms to arrange for referrals outside the Plan's network when medically necessary for the enrollee?			
3.5	Does the Plan ensure that services referred outside the Plan's contracted network do not exceed applicable co-pays, and co-insurance?			

End of Requirement AA-001: Number and Distribution of Primary Care Providers

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Requirement AA-002: Hours of Operation and After-Hours Service

STATUTORY/REGULATORY CITATIONS

28 CCR 1300.67.2(b) and (d)

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

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

(d) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and there shall be approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees;

28 CCR 1300.67.2(b) and (f)

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

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

(f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments;

28 CCR 1300.67.2.2.(c)(1), (3), (7), (9), and (10)

(c) Standards for Timely Access to Care.

(1) Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. Plans shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.

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

(7) Plans shall ensure they have sufficient numbers of contracted providers to maintain compliance with the standards established by this section.

(A) This section does not modify the requirements regarding provider-to-enrollee ratio or geographic accessibility established by Sections 1300.51, 1300.67.2 or 1300.67.2.1 of Title 28.

(B) A plan operating in a service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this

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section, including applicable time-elapsing standards, by referring enrollees to, or, in the case of a preferred provider network, by assisting enrollees to locate, available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. Plans shall arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network, when medically necessary for the enrollee's condition. Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

(9) Dental, vision, chiropractic, and acupuncture plans shall ensure that contracted providers employ an answering service or a telephone answering machine during non-business hours, which provide instructions regarding how enrollees may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

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

28 CCR 1300.67.2.2.(c)(10)

(c) Standards for Timely Access to Care

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

28 CCR 1300.67.2.2.(d)(1)

(d) Quality Assurance Processes. Each plan shall have written quality assurance systems, policies and procedures designed to ensure that the plan's provider network is sufficient to provide accessibility, availability, and continuity of covered health care services as required by the Act and this section. In addition to the requirements established by Section 1300.70 of Title 28, a plan's quality assurance program shall address:

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

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Optometric Director

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- QM Director
- Provider Relations Manager

DOCUMENTS TO BE REVIEWED

- Policies and procedures defining standards for hours of operation
- Policies and procedures for monitoring of the standards for hours of operation
- Policies and procedures defining standards for after-hours coverage requirements
- Policies and procedures for monitoring of the standards for after-hours care
- Plan after-hours coverage and access monitoring reports, after-hours or other types of telephone access studies from the Plan's telephone system or other methodologies (such as random calling at various times and dates)
- Committee meeting minutes (of any/all appropriate committees)
- Provider Manual or other methods to communicate standards to providers
- Corrective action plans
- Review licensing filing of the Plan's access standards and confirm submission of appropriate policies and procedures.

AA-002 - Key Element 1:

- 1. The Plan has established a standard defining reasonable hours of operation for provider health care facilities that are sufficient to prevent delays detrimental to the health of enrollees.**
28 CCR 1300.67.2(b) and (d); 28 CCR 1300.67.2.2.(c)(10)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have an established standard that defines reasonable hours of operation for provider facilities?			
1.2 Does the standard ensure that availability is sufficient to prevent delays detrimental to the health of enrollees?			
1.3 Does the Plan ensure that, during normal business hours, the waiting time for an enrollee to speak by telephone with a Plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns, does not exceed ten minutes?			

AA-002 - Key Element 2:

- 2. The Plan has established standards that ensure that the availability of, and access to, after-hours services both at the Plan and provider level are sufficient to prevent delays detrimental to the health of enrollees.**
28 CCR 1300.67.2(b) and (d); 28 CCR 1300.67.2.2.(c)(1), (3), (7), (9), and (10)

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Assessment Questions	Yes	No	N/A
2.1 Does the Plan have established standards on availability of, and access to, after-hours services which address provider message/answering service requirements?			
2.2 Does the Plan have established standards on availability of, and access to, after-hours services which address availability of providers?			
2.3 Does the Plan have established standards on availability of, and access to, after-hours services which address provider response to messages left after-hours?			
2.4 Does the Plan have established standards on availability of, and access to, after-hours services which address Plan services? (e.g., customer service)			
2.5 Do the standards ensure that availability of, and access to, after-hours services are sufficient to prevent delays detrimental to the health of enrollees?			
2.6 Does the Plan ensure that contracted providers employ an answering service or telephone answering machine during non-business hours?			
2.7 Does the answering service, or answering machine used during non-business hours provide instructions regarding: (a) How enrollees may obtain urgent or emergency care? (b) How to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care?			

AA-002 - Key Element 3:

- 3. The Plan has established and implemented a documented system for monitoring and evaluating providers' adherence to the standards regarding hours of operation and after-hours services.
28 CCR 1300.67.2(b) and (f); 28 CCR 1300.67.2.2.(d)(1)**

Assessment Questions	Yes	No	N/A
3.1 Has the Plan established standards for the provision of covered services in a timely manner?			
3.2 Does the Plan disseminate its standard to providers (e.g., via provider contracts, provider manual, etc.)?			

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3.3	Does the Plan regularly measure providers' performance against its standard?			
3.4	Does the Plan implement corrective action and follow-up review to address any deficiencies?			
3.5	Does the Plan periodically review the appropriateness of its standard and update it when indicated?			

End of Requirement AA-002: Hours of Operation and After-Hours Service

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Requirement AA-003: Appointment Availability

STATUTORY/REGULATORY CITATIONS

28 CCR 1300.51(d)(I)(5)(d)

(d) Exhibits to Plan Application.

I. Description of Health Care Arrangements.

Note: Providers of Health Care Services. The information in this item is for the purpose of assessing the adequacy of the applicant's health care provider arrangements.

If the service area of the plan and the distribution of its enrollees is so geographically limited that all plan health care providers are readily available and accessible to all enrollees, no geographic division of the provider information required in this part need be made.

However, if applicant's service area is divided into separate provider networks for regions within the service area, the information required in this Item-1 must be furnished separately for each such region and provider network.

5. Applicants Standards of Accessibility. Attach as Exhibit I-5 a detailed description of the applicant's standards with respect to the accessibility and its procedures from monitoring the accessibility of services. Standards should be expressed in terms of the level of accessibility, which the applicant has as its objective, and minimum level of accessibility below which corrective action will be taken. Cover each of the following:

d. the proximity of specialists, hospitals, etc. to sources of primary care, and

28 CCR 1300.51(d)(H)(iv)

(d) Exhibits to Plan Application.

H. Geographical Area Served.

Note: The applicant is required to demonstrate that, throughout the geographic regions designated as the plan's Service Area, a comprehensive range of primary, specialty, institutional and ancillary services are readily available at reasonable times to all enrollees and, to the extent feasible, that all services are readily accessible to all enrollees.

For the purpose of evaluating the geographic aspects of availability and accessibility, consideration will be given to the actual and projected enrollment of the plan based on the residence and place of work of enrollees within and, if applicable, outside the service area, including the individual and group enrollment projections furnished in Items CC, DD and EE of this application.

An applicant for plan license must demonstrate compliance with the accessibility requirement in each of the areas specified in paragraphs (i) through (iv) below, either by demonstrating compliance with the guideline specified in such paragraphs or, in the alternative, by presenting other information demonstrating compliance with reasonable accessibility. These guidelines apply only with respect to initial license applications and provide presumptively reasonable standards in the absence of actual operating experience. Such guidelines are not intended to express minimum standards of accessibility either for applicants or for licensees nor to create any inference that a plan,

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which does not meet these guidelines, does not meet the requirement of reasonable accessibility.

(iv) Ancillary Services. Ancillary laboratory, pharmacy and similar services and goods dispensed by order or prescription on the primary care provider are available from contracting or plan-operated providers at locations (where enrollees are personally served) within a reasonable distance from the primary care provider.

28 CCR 1300.67.1(d) and (e)

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

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

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

28 CCR 1300.67.2(e) and (f)

(e) A plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral;

(f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments;

28 CCR 1300.67.2.2.(c)(1), (3), (9), and (10)

(c) Standards for Timely Access to Care.

(1) Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. Plans shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.

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

(9) Dental, vision, chiropractic, and acupuncture plans shall ensure that contracted providers employ an answering service or a telephone answering machine during non-business hours, which provide instructions regarding how enrollees may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

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

28 CCR 1300.67.2.2.(d)(1)

(d) Quality Assurance Processes. Each plan shall have written quality assurance systems, policies and procedures designed to ensure that the plan's provider network is sufficient to provide accessibility, availability and continuity of covered health care services as required by the Act and this section. In addition to the requirements established by Section 1300.70 of Title 28, a plan's quality assurance program shall address:

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

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- QM Director
- Director of Provider Relations
- Director of Network Management or its equivalent

DOCUMENTS TO BE REVIEWED

- Policies and procedures that define appointment availability
- Policies and procedures that address re-scheduling of appointments
- Appointment availability studies
- Enrollee and provider satisfaction surveys
- Reports on complaint and grievances
- Telephone access studies from the Plan's telephone system or other methodologies (such as anonymous "mystery shopper" or random calling at various times and dates)
- Committee or applicable subcommittee minutes, prior two years
- Corrective action plans and re-measurement of appointment availability to assure improvements are sustained
- Review licensing filing of the Plan's access standards and confirm submission of appropriate policies and procedures.

AA-003 - Key Element 1:

1. Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing

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problems that develop, which shall include, but is not limited to, waiting time and appointments.

28 CCR 1300.51(d)(I)(5)(d); 28 CCR 1300.51(d)(H)(iv); 28 CCR 1300.67.1(d), and (e); 28 CCR 1300.67.2(e) and (f); 28 CCR 1300.67.2.2.(c)(1), (3), (9), and (10); 28 CCR 1300.67.2.2.(d)(1)

Assessment Questions	Yes	No	N/A
1.1 Does the health Plan have a documented system of monitoring and evaluating access to care, including waiting time and appointments?			
1.2 Does the Plan have established standards to ensure ready referral, and provision of covered services in a timely manner appropriate for the nature of the enrollee's condition and in a manner consistent with good professional practice?			
1.3 Does the documented system for monitoring and evaluating access to care include urgent appointments?			
1.4 Does the documented system for monitoring and evaluating include rescheduling of appointments to ensure rescheduling is prompt and consistent with health care needs, continuity of care?			
1.5 Does the monitoring system include assessment of provider networks throughout the service regions?			
1.6 In the event of provider shortages, does the monitoring system identify shortages and take corrective steps to remedy shortages?			
1.7 In the event of provider shortages, does the Plan monitor customer service efforts to assist enrollees in locating a contracted provider in neighboring service areas?			
1.8 As a way to identify provider shortages or services which may not be available from the Plan's contracted network, does the monitoring system track out of network referrals?			
1.9 Does the Plan monitor that contracted providers employ an answering service or telephone answering machine during non-business hours?			
1.10 Does the Plan monitor the answering service, or the answering machine used during non-business hours to ensure it provides instructions regarding: (a) How enrollees may obtain urgent or emergency care? (b) How to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care?			
1.11 Does the Plan monitor that telephone service accessibility including that contact with a knowledgeable customer service representative does not exceed ten minutes?			

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Assessment Questions	Yes	No	N/A
1.12 Does the Plan evaluate network capacity? (This is the percentage of the network accepting referrals / new patients.)			
1.13 Does the Plan ensure that there are open practices that are accepting new patients?			
1.14 When the Plan identifies problems, does it take action to ensure appointment availability?			
1.15 When the Plan identifies problems, does it monitor to assure improvements are maintained?			

End of Requirement AA-003: Appointment Availability

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Requirement AA-004: Enrollee Health Education

STATUTORY/REGULATORY CITATIONS

28 CCR 1300.67.2(g)

A section of the health education program shall be designated to inform enrollees regarding accessibility of service in accordance with the needs of such enrollees for such information regarding that plan or area.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Supervisor or Manager of Health Education or equivalent
- QM Director
- Director or Manager of Customer Relations or Member Services

DOCUMENTS TO BE REVIEWED

- Policies and procedures of the Health Education Program
- Health Education Program description
- Plan and delegate Web sites
- Patient education materials regarding the accessibility of service (e.g., certificate of coverage member handbook);
- Plan reviews of delegated entities' Health Education Programs and notification to enrollees of how to access services

AA-004 - Key Element 1:

1. The Plan regularly distributes materials to each enrollee that explain how to obtain services.

28 CCR 1300.67.2(g)

Assessment Questions	Yes	No	N/A
1.1 Has the Plan developed materials that explain how to obtain optometric services?			
1.2 Has the Plan developed materials that explain how to obtain after-hours care?			
1.3 Has the Plan developed materials that explain how to obtain urgent care?			
1.4 Does the Plan regularly distribute the materials to enrollees?			

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End of Requirement AA-004: Enrollee Health Education

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Requirement AA-005: Preventive Health Care (formerly QM-005)

STATUTORY/REGULATORY CITATIONS

28 CCR 1300.67(f)(1), (4), and (8)

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

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

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

(8) Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan.

28 CCR 1300.67(f)(8)

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

(8) Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan.

28 CCR 1300.67.2(f)

(f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments.

28 CCR 1300.70(b)(2)(G)(5) and (6) *(Applicable to delegated groups only)*

(b) Quality Assurance Program Structure and Requirements.

(2) Program Requirements.

In order to meet these obligations each plan's QA program shall meet all of the following requirements:

(G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees. If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:

(5) Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the plan and/or delegated providers.

(6) Ensure that health services include appropriate preventive health care measures consistent with professionally recognized standards of practice. There should be

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screening for conditions when professionally recognized standards of practice indicate that screening should be done.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Optometric Director
- QA Director
- QA Coordinator

DOCUMENTS TO BE REVIEWED

- Policies and procedures ensuring provision of preventive care services
- Preventive care guidelines
- Minutes of QA Committee or subcommittee meetings
- Provider Manual
- Health education literature
- Provider education and informational materials
- Results of measurement of other preventive health guidelines
- List of preventive care objectives with associated tracking reports

AA-005 - Key Element 1:

**1. The Plan has established preventive care guidelines. The Plan has disseminated its guidelines to its providers, regularly monitors performance against the standards and addresses any deficiencies.
28 CCR 1300.67(f)(1), (4), and (8); 28 CCR 1300.67.2(f)**

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have established preventive guidelines?			
1.2 Does the Plan use appropriate methods in developing or adopting preventive guidelines?			
1.3 Are the guidelines comprehensive?			
1.4 Does the Plan have an effective mechanism for distributing its guidelines to participating providers?			
1.5 Does the Plan monitor the provision of preventive services on an individual and Plan-wide basis?			
1.6 Does the Plan regularly measure the level of preventive care provided to enrollees against its established guidelines?			
1.7 Does the Plan critically evaluate the results of preventive care monitoring?			

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Assessment Questions	Yes	No	N/A
1.8 Does the Plan <u>develop and implement</u> corrective actions or QM Programs with measurable goals to increase levels of preventive care for enrollees?			
1.9 Does the Plan <u>re-measure and critically evaluate</u> the results of corrective actions or QM Programs to increase levels of preventive care for enrollees?			
1.10 Does the Plan develop and implement additional corrective actions or QM Programs based on the critical evaluation of its past corrective actions or QM Programs?			

AA-005 - Key Element 2:

**2. The Plan has an effective Health Education Program designed to educate enrollees regarding personal health behavior and health care, including recommendations regarding the optimal use of health care services provided by the Plan or health care organizations affiliated with the Plan.
28 CCR 1300.67(f)(8)**

Assessment Question	Yes	No	N/A
2.1 Does the Plan have effective preventive health education services that include information regarding personal health behavior and optimal use of preventive services provided under the Plan?			

End of Requirement AA-005: Preventive Health Care

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Requirement AA-006: List of Contracting Providers Available Upon Request

STATUTORY/REGULATORY CITATIONS

CA Health and Safety Code section 1367.26

(a) A health care service plan shall provide, upon request, a list of the following contracting providers, within the enrollee's or prospective enrollee's general geographic area:

(1) Primary care providers.

(2) Medical groups.

(3) Independent practice associations.

(4) Hospitals.

(5) All other available contracting physicians, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, and nurse midwives to the extent their services may be accessed and are covered through the contract with the plan.

(b) This list shall indicate which providers have notified the plan that they have closed practices or are otherwise not accepting new patients at that time.

(c) The list shall indicate that it is subject to change without notice and shall provide a telephone number that enrollees can contact to obtain information regarding a particular provider. This information shall include whether or not that provider has indicated that he or she is accepting new patients.

(d) A health care service plan shall provide this information in written form to its enrollees or prospective enrollees upon request. A plan may, with the permission of the enrollee, satisfy the requirements of this section by directing the enrollee or prospective enrollee to the plan's provider listings on its Web site. Plans shall ensure that the information provided is updated at least quarterly. A plan may satisfy this update requirement by providing an insert or addendum to any existing provider listing. This requirement shall not mandate a complete republishing of a plan's provider directory.

(e) Each plan shall make information available, upon request, concerning a contracting provider's professional degree, board certifications and any recognized subspecialty qualifications a specialist may have.

(f) Nothing in this section shall prohibit a plan from requiring its contracting providers, contracting provider groups, or contracting specialized health care plans to satisfy these requirements. If a plan delegates the responsibility of complying with this section to its contracting providers, contracting provider groups, or contracting specialized health care plans, the plan shall ensure that the requirements of this section are met.

(g) Every health care service plan shall allow enrollees to request the information required by this section through their toll-free telephone number or in writing.

CA Health and Safety Code section 1367.26(d)

(d) A health care service plan shall provide this information in written form to its enrollees or prospective enrollees upon request. A plan may, with the permission of the enrollee, satisfy the requirements of this section by directing the enrollee or prospective

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enrollee to the plan's provider listings on its website. Plans shall ensure that the information provided is updated at least quarterly. A plan may satisfy this update requirement by providing an insert or addendum to any existing provider listing. This requirement shall not mandate a complete republishing of a plan's provider directory.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Optometric Director
- Director of Contracting / Provider Relations
- Director of QM

DOCUMENTS TO BE REVIEWED

- Plan Provider Directory
- Electronic version of the Plan's Provider Directory and the Plan's online Provider Directory
- Any available updates to the Plan Provider Directory.
- Policies and procedures relevant to the update of contact information for contracted providers.
- Previous versions of the Plan Provider Directory that show that modifications have been made, where needed.
- Documents and correspondence between the Plan and contracted providers that indicate any changes to the provider's contact information.

AA-006 - Key Element 1:

1. The Plan has a complete list of contracted providers that includes all required information.

CA Health and Safety Code section 1367.26

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have a list of all of its contracted providers?			
1.2 Does the Plan maintain records of each provider's professional degree, board certifications, and any recognized subspecialty qualifications that a specialist may have?			
1.3 Does the Plan's list of contracted providers indicate which providers have notified the Plan that they have <u>closed practices</u> ?			

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Assessment Questions	Yes	No	N/A
1.4 Does the Plan's list of contracted providers indicate which providers are not accepting new patients at this time?			
1.5 Does the Plan's list of contracted providers indicate that the list is subject to change without notice?			
1.6 Does the Plan's list of contracted providers include a telephone number that enrollees can contact to obtain information regarding a particular provider, including whether or not that provider is accepting new patients?			

AA-006 - Key Element 2:

- 2. The Plan properly updates its list of contracted providers.
CA Health and Safety Code section 1367.26(d)**

Assessment Questions	Yes	No	N/A
2.1 Does the Plan either: a) Provide the provider list in written form to its enrollees and prospective enrollees upon request or, b) With the permission of the enrollee or prospective enrollee, refer the inquiry to the Plan's Web site?			
2.2 Does the Plan have policies and procedures that ensure that all of the information contained in its provider directory is updated quarterly?			

AA-006 - Key Element 3:

- 3. The Plan provides provider information to its enrollees upon telephone or written request.
CA Health and Safety Code section 1367.26**

Assessment Questions	Yes	No	N/A
3.1 Does the Plan provide enrollees and prospective enrollees with provider information through their toll-free telephone number or in writing?			
3.2 Does the Plan provide information to enrollees and prospective enrollees about each provider's professional degree and board certifications?			

End of Requirement AA-006: List of Contracting Providers Available Upon Request