

**DEPARTMENT OF MANAGED HEALTH CARE
HELP CENTER
DIVISION OF PLAN SURVEYS**

TECHNICAL ASSISTANCE GUIDE

ACCESS AND AVAILABILITY OF SERVICES

BEHAVIORAL HEALTH SURVEY

OF

PLAN NAME

DATE OF SURVEY:

PLAN COPY

Issuance of this October 21, 2011 Technical Assistance Guide renders all other versions obsolete.

BEHAVIORAL HEALTH TAG

ACCESS AND AVAILABILITY OF SERVICES REQUIREMENTS

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Requirement AA-001: Number and Distribution of Mental Health Providers

STATUTORY/REGULATORY CITATIONS

CA Health and Safety Code section 1345(i)

(i) "Provider" means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

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)(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, 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 1300.51(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.

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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 1300.67.2(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;

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

28 CCR 1300.67.2(b) through (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;

(c) Emergency health care services shall be available and accessible within the service area twenty-four hours a day, seven days a week;

(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;

(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;

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

28 CCR 1300.67.2.1(a)

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.

(a) If, given the facts and circumstances with regard to any portion of its service area, a plan's standards of accessibility adopted pursuant to Item H of Section 1300.51 and/or Section 1300.67.2 are unreasonably restrictive, or 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, the plan may propose alternative standards of accessibility for that portion of its service area. The plan shall do so by including such alternative standards in writing in its plan license application or in a notice of material modification. The plan shall also include a description of the reasons justifying the less restrictive standards based on those facts and circumstances. If the Department rejects the plan's proposal, the Department shall inform the plan of the Department's reason for doing so.

28 CCR 1300.2.2.(a)(1)

(a) Application

1. All health care service plans that provide or arrange for the provision of hospital or physician services, including specialized mental health plans that provide physician or hospital services, or that provide mental health services pursuant to a contract with a full service plan, shall comply with the requirements of this section.

28 CCR 1300.67.2.2.(c)(2)

(c) Standards for Timely Access to Care.

(2) Plans shall ensure that all plan and provider processes necessary to obtain covered health care services, including but not limited to prior authorization processes, are completed in a manner that assures the provision of covered health care services to enrollees in a timely manner appropriate for the enrollee's condition and in compliance with the requirements of this section.

28 CCR 1300.67.2.2.(c)(7)(A)

(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.

28 CCR 1300.74.72(f) and (g)(1)

(f) A plan's referral system shall provide enrollees timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72 and for related health care services as appropriate upon referral from a primary care

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physician, mental health provider or pediatrician meeting the requirements of subsection (b) above.

(g) If a plan contracts with a specialized health care service plan for the purpose of providing Health and Safety Code section 1374.72 services, the following requirements shall apply:

(1) the specialized health care service plan shall maintain a telephone number that an enrollee may call during normal business hours to obtain information about benefits, providers, coverage and any other relevant information concerning an enrollee's mental health services;

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

Staff responsible for the activities described above, for example:

- Medical 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 mental health practitioners
- Policies and procedures to periodically review and update the standards for the number and distribution of mental health practitioners
- Record of periodic review of the standards for the number and distribution of mental health practitioners, including minutes of relevant committee meetings (QM Committee, Public Policy Committee, etc.)
- Documents that demonstrate how the Plan ensures that appropriate mental health services are available without delays detrimental to the health of the enrollees, including out of network referrals, if service is unavailable within network, and medically necessary for the enrollee's medical condition.
- Documents that demonstrate how the Plan defines high-volume specialists
- Documents that define the availability of mental health practitioners (including the number or percentage of open practices)
- Summary referral data indicating number of referrals for each behavioral health specialty within a given timeframe
- Plan mental health practitioner access reports and analysis
- Demographic information indicating needs for vulnerable populations such as children.
- Reports that demonstrate that the Plan has numeric and geographic distribution standards and measures its network against the standards at least annually.
- Reports that demonstrate that, if the Plan found shortcomings in its network of clinicians, it has taken action to remedy those shortcomings and has re-measured.
- Electronic version of the provider directory(s) and links to on-line directory(s)

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AA-001 - Key Element 1:

- 1. The Plan has established a standard for the number of Physicians within the service area. The standard provides for at least one full-time equivalent Physician to each 1,200 enrollees or the Plan may provide an alternative mechanism (i.e., via the filing of a material modification) to demonstrate an adequate ratio of Physicians to enrollees. 28 CCR 1300.67.2(b) and (f); 28 CCR 1300.67.2.1(a); 28 CCR 1300.67.2.2.(c)(2); 28 CCR 1300.67.2.2.(c)(7)(A)**

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have an established standard on the ratio of Physicians to enrollees?			
1.2 Does the Plan's standard provide for at least one Physician for each 1,200 enrollees?			
1.3 Does the Plan's standard provide for at least one Physician for each 1,200 enrollees? If "no," has the Plan established an alternative standard?			
1.4 If the Plan has established an alternative standard, has this standard been submitted to the Department via the filing of a material modification?			

AA-001 - Key Element 2:

- 1. The Plan ensures that its network of mental health providers is adequate to meet the mental health needs of its enrollees. CA Health and Safety Code section 1367(e)(1); 28 CCR 1300.51(d)(H)(iv); 28 CCR 1300.51(d)(I)(5)(d); 28 CCR 1300.67.2(b) through (f); 28 CCR 1300.67.2.1.(a); 28 CCR 1300.67.2.2.(a)(1)**

Assessment Questions	Yes	No	N/A
2.1 Does the Plan have an established standard for the number and geographic distribution of mental health providers who can treat severe mental illness of a person of any age and serious emotional disturbances of a child?			
2.2 Do the standards take into account the various types of mental health practitioners (psychiatrist, psychologist, MFCC, LCSW) acting within the scope of their licensure?			
2.3 Do the standards take into account the various specialties and sub-specialties required to treat the population?			
2.4 Do the standards ensure accessibility for adolescents and children?			
2.5 Does the Plan measure the adequacy of its network against its standards at least annually?			

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Assessment Questions	Yes	No	N/A
2.6 Does the Plan take appropriate action based on adequacy findings?			
2.7 Has the Plan implemented a process to verify periodically that participating mental health providers are accepting new patients?			
2.8 Does the Plan take the periodic verification information into account when monitoring the adequacy of its network?			
2.9 Does the Plan have an established standard for the proximity of specialists to primary care?			

End of Requirement AA-001: Number and Distribution of Specialists

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Requirement AA-002: Number and Distribution of Mental Health Facilities & Programs

STATUTORY/REGULATORY CITATIONS

28 CCR 1300.51(d)(H)(ii) and (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, which does not meet these guidelines, does not meet the requirement of reasonable accessibility.

(ii) Hospitals. In the case of a full service plan, all enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan operated hospital which has a capacity to serve the entire dependent enrollee population based on normal utilization, and, if separate from such hospital, a contracting or plan-operated provider of all emergency health care services.

(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 1300.67.2

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.

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

(c) Emergency health care services shall be available and accessible within the service area twenty-four hours a day, seven days a week;

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(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;

(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;

(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.

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

28 CCR 1300.67.2.1

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.

(a) If, given the facts and circumstances with regard to any portion of its service area, a plan's standards of accessibility adopted pursuant to Item H of Section 1300.51 and/or Section 1300.67.2 are unreasonably restrictive, or 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, the plan may propose alternative standards of accessibility for that portion of its service area. The plan shall do so by including such alternative standards in writing in its plan license application or in a notice of material modification. The plan shall also include a description of the reasons justifying the less restrictive standards based on those facts and circumstances. If the Department rejects the plan's proposal, the Department shall inform the plan of the Department's reason for doing so.

(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:

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- (1) whether the plan contract involved is a group health care service plan contract or an individual health care service plan contract;
 - (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;
 - (5) population density in the portion of the service area, including whether the service area is within a county with a population of 500,000 or fewer;
 - (6) whether, as of January 1, 2002, the county containing the service area had two or fewer full service health care service plans providing coverage to the entire county in the commercial market;
 - (7) the distribution of enrollees in the portion of the service area;
 - (8) the availability and distribution of primary care physicians;
 - (9) the availability and distribution of other types of providers;
 - (10) the existence of exclusive contracts in the provider community or other barriers to entry;
 - (11) patterns of practice in the portion of the service area;
 - (12) driving times;
 - (13) waiting times for appointments;
 - (14) whether the plan or any other health care service plan currently has significant operations in that portion of the service area; and
 - (15) other standards of accessibility that the Director deems necessary or appropriate in the public interest and consistent with the intent and purpose of the Act as applied to specific facts or circumstances.
- (d) At least 30 days before a health care service plan files a notice of material modification of its license with the department in order to withdraw from a county with a population of 500,000 or fewer, the health care service plan shall hold a public meeting at a time and place reasonably calculated to facilitate attendance by affected enrollees in the county from which it intends to withdraw, and shall do all of the following:
- (1) Provide notice announcing the public meeting at least 30 days prior to the public meeting to all affected enrollees, health care providers with which it contracts, the members of the board of supervisors of the affected county, the members of the city councils of cities in the affected county, and the members of the Legislature who represent the affected county.
 - (2) Provide notice announcing the public meeting at least 15 days prior to the public meeting in a newspaper of general circulation within the affected county.
 - (3) At the public meeting, allow testimony, which may be limited to a certain length of time by the health care service plan, of all interested parties.
 - (4) File with the department for review, no less than 30 days prior to the date of mailing or publication, the notices required under subparagraphs (1) and (2).
- (e) The department may require a health care service plan that has filed to withdraw from a portion of a county with a population of fewer than 500,000 to hold a hearing for affected enrollees.
- (f) A representative of the department shall attend the public meeting described in this section.

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28 CCR 1300.67.2.2.(c)(2) and (7)

(c) Standards for Timely Access to Care.

(2) Plans shall ensure that all plan and provider processes necessary to obtain covered health care services, including but not limited to prior authorization processes, are completed in a manner that assures the provision of covered health care services to enrollees in a timely manner appropriate for the enrollee's condition and in compliance with 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 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 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.

28 CCR 1300.74.72(a)

(a) The mental health services required for the diagnosis, and treatment of conditions set forth in Health and Safety Code section 1374.72 shall include, when medically necessary, all health care services required under the Act including, but not limited to, basic health care services within the meaning of Health and Safety Code sections 1345(b) and 1367(i), and section 1300.67 of Title 28. These basic health care services shall, at a minimum, include crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, and services from licensed mental health providers including, but not limited to, psychiatrists and psychologists.

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

Staff responsible for the activities described above, for example:

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

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DOCUMENTS TO BE REVIEWED

- Policies and procedures that define the standards for the number and geographic distribution of mental health facilities and programs within the service area
- Policies and procedures that define the standards for the number and geographic distribution of emergency mental health services within the service area
- Plan mental health hospital, facility, emergency, and program access and/or geographic reports and associated analysis (within each service area and by county, if applicable)
- Record of periodic review of the standards for the number and geographic distribution of mental health facilities and programs within the service area, including minutes of relevant committee meetings (QM Committee, Public Policy Committee, etc.)
- Electronic version of provider / facility directory(s) and link to on-line directory(s)

AA-002 - Key Element 1:

- 1. The Plan ensures that its network of mental health facilities and programs is adequate to meet the mental health needs of its enrollees.**
28 CCR 1300.51(d)(H)(ii) and (iv); 28 CCR 1300.67.2; 28 CCR 1300.67.2.1; 28 CCR 1300.67.2.2.(c)(2) and (7)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have an established standard for the number and geographic distribution of mental health facilities and programs that can treat severe mental illness?			
1.2 Do the standards address the variety of facility types and programs necessary for an adequate network, including: inpatient/hospital, outpatient, specialized treatment facilities, etc.?			
1.3 Do the standards address access to facilities that provide emergency mental health services?			
1.4 Do the standards address the treatment of mental illness of a person of any age, including serious emotional disturbances of adolescents and children?			
1.5 Do the standards provide for access to residential treatment centers (RTC) for children and adolescents?			
1.6 Has the Plan established a mechanism that ensures that the contracting mental health facilities in its service area have the capacity to serve the entire population based upon normal utilization?			
1.7 Does the Plan measure the adequacy of its network against its standards at least annually?			

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Assessment Questions	Yes	No	N/A
1.8 If the Plan has established an alternative standard, has this standard been submitted to the Department via the filing of a material modification?			

End of Requirement AA-002: Number and Distribution of Hospitals and Ancillary Care

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Requirement AA-003: 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.(a)(3)

(a) Application

3. The obligation of a plan to comply with this section shall not be waived when the plan delegates to its medical groups, independent practice associations, or other contracting entities any services or activities that the plan is required to perform. A plan's implementation of this section shall be consistent with the requirements of the Health Care Providers' Bill of Rights, and a material change in the obligations of a plan's contracting providers shall be considered a material change to the provider contract, within the meaning of subsections (b) and (g)(2) of Section 1375.7 of the Act.

28 CCR 1300.67.2.2.(b)(5)

(b) Definitions. For purposes of this section, the following definitions apply.

(5) "Triage" or "screening" means the assessment of an enrollee's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care, for the purpose of determining the urgency of the enrollee's need for care.

(A) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in (G);

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- (B) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in (G);
- (C) Non-urgent appointments for primary care: within ten business days of the request for appointment, except as provided in (G) and (H);
- (D) Non-urgent appointments with specialist physicians: within fifteen business days of the request for appointment, except as provided in (G) and (H);
- (E) Non-urgent appointments with a non-physician mental health care provider: within ten business days of the request for appointment, except as provided in (G) and (H);
- (F) Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within fifteen business days of the request for appointment, except as provided in (G) and (H);
- (G) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee;
- (H) Preventive care services, as defined at subsection (b)(3), and periodic follow up care, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice; and
- (I) A plan may demonstrate compliance with the primary care time-elapsd standards established by this subsection through implementation of standards, processes and systems providing advanced access to primary care appointments, as defined at subsection (b)(1).

28 CCR 1300.67.2.2.(c)(1) and (2)

(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.

(2) Plans shall ensure that all plan and provider processes necessary to obtain covered health care services, including but not limited to prior authorization processes, are completed in a manner that assures the provision of covered health care services to enrollees in a timely manner appropriate for the enrollee's condition and in compliance with the requirements of this section.

28 CCR 1300.67.2.2.(c)(8)

(c) Standards for Timely Access to Care.

Plans shall provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone as defined at subsection (b)(5).

(8) Plans shall provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone as defined at subsection (b)(5).

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(A) Plans shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the enrollee's condition, and that the triage or screening waiting time does not exceed 30 minutes.

(B) A plan may provide or arrange for the provision of telephone triage or screening services through one or more of the following means: plan-operated telephone triage or screening services consistent with subsection (b)(5); telephone medical advice services pursuant to Section 1348.8 of the Act; the plan's contracted primary care and mental health care provider network; or other method that provides triage or screening services consistent with the requirements of this subsection.

1. A plan that arranges for the provision of telephone triage or screening services through contracted primary care and mental health care providers shall require those providers to maintain a procedure for triaging or screening enrollee telephone calls, which, at a minimum, shall include the employment, during and after business hours, of a telephone answering machine and/or an answering service and/or office staff, that will inform the caller:

- a. Regarding the length of wait for a return call from the provider; and
- b. How the caller 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.

2. A plan that arranges for the provision of triage or screening services through contracted primary care and mental health care providers who are unable to meet the time-elapsed standards established in paragraph (8)(A) shall also provide or arrange for the provision of plan-contracted or operated triage or screening services, which shall, at a minimum, be made available to enrollees affected by that portion of the plan's network.

3. Unlicensed staff persons handling enrollee calls may ask questions on behalf of a licensed staff person in order to help ascertain the condition of an enrollee so that the enrollee can be referred to licensed staff. However, under no circumstances shall unlicensed staff persons use the answers to those questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of an enrollee or determine when an enrollee needs to be seen by a licensed medical professional.

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)

(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.

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(2) Compliance monitoring policies and procedures, filed for the Department's review and approval, designed to accurately measure the accessibility and availability of contracted providers, which shall include:

(A) Tracking and documenting network capacity and availability with respect to the standards set forth in subsection (c);

(B) Conducting an annual enrollee experience survey, which shall be conducted in accordance with valid and reliable survey methodology and designed to ascertain compliance with the standards set forth at subsection (c);

(C) Conducting an annual provider survey, which shall be conducted in accordance with valid and reliable survey methodology and designed to solicit, from physicians and non-physician mental health providers, perspective and concerns regarding compliance with the standards set forth at subsection (c);

(D) Reviewing and evaluating, on not less than a quarterly basis, the information available to the plan regarding accessibility, availability and continuity of care, including but not limited to information obtained through enrollee and provider surveys, enrollee grievances and appeals, and triage or screening services; and

(E) Verifying the advanced access programs reported by contracted providers, medical groups and independent practice associations to confirm that appointments are scheduled consistent with the definition of advanced access in subsection (b)(1).

(F) A plan that provides services through a preferred provider organization network may, for that portion of its network, demonstrate compliance with subsections (d)(2)(A) and (D) by monitoring, on not less than an annual basis: the number of PPO primary care and specialty physicians under contract with the plan in each county of the plan's service area; enrollee grievances and appeals regarding timely access; and the rates of compliance with the time-elapsd standards established in subsection (c)(5).

(3) A plan shall implement prompt investigation and corrective action when compliance monitoring discloses that the plan's provider network is not sufficient to ensure timely access as required by this section, including but not limited to taking all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance. Plans shall give advance written notice to all contracted providers affected by a corrective action, and shall include: a description of the identified deficiencies, the rationale for the corrective action, and the name and telephone number of the person authorized to respond to provider concerns regarding the plan's corrective action.

28 CCR 1300.74.72(f)

(f) A plan's referral system shall provide enrollees timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72 and for related health care services as appropriate upon referral from a primary care physician, mental health provider or pediatrician meeting the requirements of [28 CCR 1300.74.72(b)].

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28 CCR 1300.80(b)(5)(D)

(b) The onsite medical survey of a plan shall include, but not be limited to, the following procedures to the extent considered necessary based upon prior experience with the plan and in accordance with the procedures and Standards developed by the Department.

(5) Review of the overall performance of the plan in providing health care benefits, by consideration of the following:

(D) The practice of health professionals and allied personnel in a functionally integrated manner, including the extent of shared responsibility for patient care and coordinated use of equipment, medical records and other facilities and services.

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

Staff responsible for the activities described above, for example:

- Medical Director
- 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's description of triage and screening arrangements, including but not limited to the means of triage, e.g., Plan operated, medical advice service or provider network, provisions during and after business hours, and confirmation that the required messages to each caller.
- Default policy and procedures in the event the triage and screening cannot be performed by certain providers or in a portion of the Plan's network.
- Policies and procedure for screening and triage of enrollee's health concerns and symptoms.
- Policy and procedure describing the responsibilities and scope for use of non-licensed staff handling enrollee calls.
- 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.
- 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.

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AA-003 - 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)(1) and (2); 28 CCR 1300.67.2.2.(c)(10); 28 CCR 1300.74.72(f)

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 wait time for an enrollee to speak by telephone with a Plan customer service representative does not exceed ten minutes?			

AA-003 - 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) and (2)

Assessment Questions	Yes	No	N/A
2.1 Does the Plan have established standards on availability of and access to after-hours crisis intervention and evaluation at both the Plan and provider level?			
2.2 Does the Plan have established standards on availability of and access to after-hours services which address provider message/answering service requirements?			
2.3 Does the Plan have established standards on availability of and access to after-hours services which address availability of providers?			
2.4 Does the Plan have established standards on availability of and access to after-hours services which address provider response to messages left after hours?			
2.5 Does the Plan have established standards on availability of and access to after-hours services which address Plan services (e.g., customer service)?			
2.6 Do the standards ensure that availability of and access to after-hours services is sufficient to prevent delays detrimental to the health of enrollees?			

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Assessment Questions	Yes	No	N/A
2.7 Do the standards address the qualifications of staff/facilities performing crisis intervention and evaluation services?			

AA-003 - Key Element 3:

**3. The Plan provides or arranges for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone as defined by subsection (b)(5).
28 CCR 1300.67.2.2.(b)(5); 28 CCR 1300.67.2.2.(c)(1) and (2); 28 CCR 1300.67.2.2.(c)(8)**

Assessment Questions	Yes	No	N/A
3.1 Does the Plan ensure that telephone triage or screening services are provided in a timely manner, appropriate for the enrollee's condition?			
3.2 Does the Plan ensure that telephone triage or screening service wait time does not exceed 30 minutes?			
3.3 Does the Plan provide or arrange for telephone triage or screening through one or more of the following: 1. Plan operated telephone triage? 2. Screening services? 3. Telephone medical advice services? 4. Plan's contracted primary care and mental health care provider network? 5. Other method consistent with the requirements of the Act?			
3.4 If the Plan arranges telephone triage or screening through contracted primary care and/or mental health provider network, does the Plan require those providers maintain procedures for triage or screening enrollee phone calls?			
3.5 If yes, does the policy include at a minimum; 1. Employment, during and after hours, of a telephone answering machine and/or an answering service and/or office staff? 2. Notice to caller regarding length of wait for a return call from the provider? 3. Notice to caller regarding how they may obtain urgent or emergency care including, if 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?			
3.6 If the Plan arranges for triage/ screening via contracted providers and they are unable to meet the time-elapsed standards, does the Plan provide or arrange for the provisions of plan-contracted or operated triage or screening services?			
3.7 Are those services available to enrollees affected by that portion of the Plan's network?			

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Assessment Questions	Yes	No	N/A
3.8 If the Plan utilizes unlicensed staff to handle enrollee calls, does the Plan have procedures to ensure the unlicensed staff does not use enrollee answers to <u>assess, evaluate, advise, or make a decision</u> regarding the condition of an enrollee?			
3.9 If the Plan utilizes unlicensed staff to handle enrollee calls, does the Plan have procedures to ensure the unlicensed staff does not use enrollee answers to determine when an enrollee <u>needs to be seen by a licensed medical professional?</u>			

AA-003 - Key Element 4:

4. 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.(c)(8); 28 CCR 1300.67.2.2.(d)

Assessment Questions	Yes	No	N/A
4.1 Does the Plan monitor compliance to the screening and triage requirements performed at the provider group level?			
4.2 Does the Plan disseminate its standard to providers (e.g., via facility contracts, provider manual, etc.)?			
4.3 Does the Plan regularly measure providers' performance against its standard?			
4.4 Does the Plan monitor enrollee and provider complaints regarding availability of services?			
4.5 Does the Plan implement corrective action and follow-up review to address any deficiencies?			
4.6 Does the Plan periodically review the appropriateness of its standard and update it when indicated?			

End of Requirement AA-003: Hours of Operation and After Hours Service

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Requirement AA-004: 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. Applicant's Standards of Accessibility. Attach as Exhibit I-5 a detailed description of the applicant's standards with respect to the accessibility and its procedures for monitoring the accessibility of services. Standards should be expressed in terms of the level of accessibility, which the applicant has as its objective, and the 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.

(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(a), (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:

(a) The availability of primary care physicians, who will be responsible for coordinating the provision of health care services to each enrollee;

(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.

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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.(a)(4)

(a) Application

(4) This section confirms requirements for plans to provide or arrange for the provision of access to health care services in a timely manner, and establishes additional metrics for measuring and monitoring the adequacy of plan's contracted provider network to provide enrollees with timely access to needed health care services.

28 CCR 1300.67.2.2.(b)(1), (c)(1) through (5), (7) and (d)

(b) Definitions. For purposes of this section, the following definitions apply.

1. "Advanced access" means the provision, by an individual provider, or by the medical group or independent practice association to which an enrollee is assigned, of appointments with a primary care physician, or other qualified primary care provider such as a nurse practitioner or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the enrollee prefers not to accept the appointment offered within the same or next business day.

(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.

(2) Plans shall ensure that all plan and provider processes necessary to obtain covered health care services, including but not limited to prior authorization processes, are completed in a manner that assures the provision of covered health care services to enrollees in a timely manner appropriate for the enrollee's condition and in compliance with the requirements of this section.

(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.

(4) Interpreter services required by Section 1367.04 of the Act and Section 1300.67.04 of Title 28 shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. This subsection does not modify the requirements established in Section 1300.67.04, or approved by the Department pursuant to Section 1300.67.04 for a plan's language assistance program.

(5) In addition to ensuring compliance with the clinical appropriateness standard set forth at subsection (c)(1), each plan shall ensure that its contracted provider network has adequate

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capacity and availability of licensed health care providers to offer enrollees appointments that meet the following timeframes:

- (A) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in (G);
 - (B) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in (G);
 - (C) Non-urgent appointments for primary care: within ten business days of the request for appointment, except as provided in (G) and (H);
 - (D) Non-urgent appointments with specialist physicians: within fifteen business days of the request for appointment, except as provided in (G) and (H);
 - (E) Non-urgent appointments with a non-physician mental health care provider: within ten business days of the request for appointment, except as provided in (G) and (H);
 - (F) Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within fifteen business days of the request for appointment, except as provided in (G) and (H);
 - (G) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee;
 - (H) Preventive care services, as defined at subsection (b)(3), and periodic follow up care, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice; and
 - (I) A plan may demonstrate compliance with the primary care time-elapsed standards established by this subsection through implementation of standards, processes and systems providing advanced access to primary care appointments, as defined at subsection (b)(1).
- (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-elapsed 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.

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(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.

(2) Compliance monitoring policies and procedures, filed for the Department's review and approval, designed to accurately measure the accessibility and availability of contracted providers, which shall include:

(A) Tracking and documenting network capacity and availability with respect to the standards set forth in subsection (c);

(B) Conducting an annual enrollee experience survey, which shall be conducted in accordance with valid and reliable survey methodology and designed to ascertain compliance with the standards set forth at subsection (c);

(C) Conducting an annual provider survey, which shall be conducted in accordance with valid and reliable survey methodology and designed to solicit, from physicians and non-physician mental health providers, perspective and concerns regarding compliance with the standards set forth at subsection (c);

(D) Reviewing and evaluating, on not less than a quarterly basis, the information available to the plan regarding accessibility, availability and continuity of care, including but not limited to information obtained through enrollee and provider surveys, enrollee grievances and appeals, and triage or screening services; and

(E) Verifying the advanced access programs reported by contracted providers, medical groups and independent practice associations to confirm that appointments are scheduled consistent with the definition of advanced access in subsection (b)(1).

(F) A plan that provides services through a preferred provider organization network may, for that portion of its network, demonstrate compliance with subsections (d)(2)(A) and (D) by monitoring, on not less than an annual basis: the number of PPO primary care and specialty physicians under contract with the plan in each county of the plan's service area; enrollee grievances and appeals regarding timely access; and the rates of compliance with the time-elapsing standards established in subsection (c)(5).

(3) A plan shall implement prompt investigation and corrective action when compliance monitoring discloses that the plan's provider network is not sufficient to ensure timely access as required by this section, including but not limited to taking all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance. Plans shall give advance written notice to all contracted providers affected by a corrective action, and shall include: a description of the identified deficiencies, the rationale for the corrective action, and the name and telephone number of the person authorized to respond to provider concerns regarding the plan's corrective action.

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28 CCR 1300.70(b)(2)(G)(5)

(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.

28 CCR 1300.74.72(b) and (f)

(b) A health plan shall provide coverage for the diagnosis, and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72 through health care providers within the meaning of Health and Safety Code section 1345(i) who are:

- (1) acting within the scope of their licensure, and
- (2) acting within their scope of competence, established by education, training and experience, to diagnose, and treat conditions set forth in Health and Safety Code section 1374.72.

(f) A plan's referral system shall provide enrollees timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72 and for related health care services as appropriate upon referral from a primary care physician, mental health provider or pediatrician meeting the requirements of [28 CCR 1300.74.72(b)].

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 and the Plan's standards for the provision of covered services in a timely manner.
- 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 consistent with the new access regulations.

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- Compliance monitoring policies and procedures, previously filed with the Department, designed to accurately measure the accessibility and availability of contracted providers, which shall include:
 - Tracking and documenting network capacity and availability
 - Annual Enrollee and provider surveys
 - Not less than quarterly review and evaluation of information available regarding access, availability and continuity of care, grievances/ appeals, screening/ triage services, enrollee/ provider survey results.
- Policies and procedures for verifying advanced access programs reported by contracted provider groups, medical groups and IPAs to confirm appointments are scheduled consistent with the definition of advanced access.
- If Plan provides services through PPO, annual monitoring policies for the number of PPO primary and specialty Physicians in each county of the Plan's service area, G&A regarding timely access and rates of compliance with time elapsed standards.
- Appointment availability studies.
- Provider waiting time studies.
- Enrollee and provider surveys designed to solicit from enrollees, providers and non-Physician mental health providers, concerns regarding compliance with the standards set forth in subsection (c) (standards for timely access).
- 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.
- Corrective action plans when compliance monitoring discloses that the Plan's provider network is not sufficient to ensure timely access.
- Policies and procedures to confirm the Plan provides advance notice to all contracted providers affected by a corrective action plan, and includes: a description of the identified deficiencies, the rationale for the corrective action, and the name and telephone number of the person authorized to respond to provider concerns regarding the Plan's corrective action.
- Review licensing filing of the Plan's Access Standards and confirm submission of appropriate policies and procedures.
- Review documents that demonstrate how the Plan ensures that appropriate mental health services are available without delays detrimental to the health of the enrollees.

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AA-004 - 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 problems that develop, which shall include, but is not limited to, waiting time and appointments. 28 CCR 1300.51(d)(H)(iv); 28 CCR 1300.51(d)(I)(5)(d); 28 CCR 1300.67.1(a), (d), and (e); 28 CCR 1300.67.2(e) and (f); 28 CCR 1300.67.2.2.(b)(1), (c)(1) through (5), (7), and (d); 28 CCR 1300.70(b)(2)(G)(5)**

Assessment Questions	Yes	No	N/A
1.1 Does the Plan rely on systems that provide advanced access to primary care appointments?			
1.2 Does the Plan verify the advanced access programs reported by contracted providers, medical groups, and IPAs to confirm that appointments are scheduled consistent with the definition of advanced access? NOTE: If so, and compliance is met, no need to review compliance to standards separately.			
1.3 If Plan provides services through a PPO network, does the Plan monitor at least annually: <ul style="list-style-type: none"> 1. That portion of its network, to ensure adequate numbers of PCP/ SCP; 2. G&A re: timely access; and 3. Rates of compliance with time elapsed standards? 			
1.4 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?			
1.5 Does the Plan have established standards to ensure ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment conditions set forth in 1374.72, including autism conditions?			
1.6 Does the Plan have a documented system of monitoring and evaluating access to care, including waiting time and appointments?			
1.7 Does the Plan monitor Plan and provider processes necessary to obtain covered health care services, including, but not limited to prior authorization, to ensure they are completed in a timely manner?			
1.8 Does the Plan monitor the rescheduling of appointments to assure this is prompt and in a manner appropriate for the enrollee’s health care needs and ensure continuity of care?			
1.9 Does the Plan monitor whether interpreter services are coordinated with scheduled appointments in a manner than ensures provision of interpreter services at the time of the appointment?			
1.10 Does the documented system for monitoring and evaluating access to care include urgent appointments ?			

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Assessment Questions	Yes	No	N/A
1.11 Does the Plan have separate standards for mental health appointment availability for adults, adolescents, and children by type of appointment and type of provider?			
1.12 Does the Plan’s monitoring program track and document network capacity and availability with respect to timely access regulations?			
1.13 Does the Plan have a procedure for providing a list of available mental health providers to enrollees? (Near their home or office.)			
1.14 Does the Plan have a standard for timely evaluation, screening and diagnosis of patients with ASD?			
1.15 Does the Plan monitor compliance with time elapsed appointment standards defined in section 1300.67.2.2.(c) (A-H) including <u>urgent care</u> appointments with <u>no prior authorization</u> within 48 hours?			
1.16 Does the Plan monitor compliance with time elapsed appointment standards defined in section 1300.67.2.2.(c) (A-H) including <u>urgent care</u> appointments with <u>prior authorization</u> within 96 hours?			
1.17 Does the Plan monitor compliance with time elapsed appointment standards defined in section 1300.67.2.2.(c) (A-H) including <u>non-urgent PCP</u> appointments within 10 business days?			
1.18 Does the Plan monitor compliance with time elapsed appointment standards defined in section 1300.67.2.2.(c) (A-H) including <u>non-urgent specialty</u> appointments within 15 business days?			
1.19 Does the Plan monitor compliance with time elapsed appointment standards defined in section 1300.67.2.2.(c) (A-H) including <u>non-urgent appointments</u> with <u>non-Physician mental health provider</u> within <u>10</u> business days?			
1.20 Does the Plan monitor compliance with time elapsed appointment standards defined in section 1300.67.2.2.(c) (A-H) including <u>non-urgent appointments</u> for <u>ancillary services</u> for diagnosis or treatment within <u>15</u> days?			
1.21 Does the Plan monitor call wait times, to ensure callers do not wait longer than ten minutes to speak to a knowledgeable customer service representative?			
1.22 Does the Plan monitor its screening and triage program to ensure these services are provided 24/7?			
1.23 Does the Plan monitor its screening and triage to ensure services are provided timely and wait times do not exceed 30 minutes?			
1.24 Does the Plan monitor its screening and triage to ensure all callers are informed of: <ul style="list-style-type: none"> 1. Length of wait for a return call from a provider; and 2. How caller may obtain urgent or emergency care include, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, delivery urgent or emergency care? 			

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Assessment Questions	Yes	No	N/A
1.25 Does the Plan monitor for instances in which triage services provided through mental health providers do not meet time elapsed standards? (30 minute wait time)			
1.26 Does the Plan monitor unlicensed staff persons who screen enrollee calls to ensure they do not assess, evaluate, advise, or make any decision regarding the condition of the enrollee or determine when an enrollee needs to be seen by a licensed medical professional?			
1.27 Does the Plan evaluate network capacity to ensure that its contracted provider network has the adequate capacity and availability of licensed providers to offer enrollees appointments that meet time elapsed standards?			
1.28 Does the Plan have a procedure for providing a list of available mental health providers to enrollees? (Near their home or office.)			
1.29 If a corrective action has been established, did the Plan give advance written notice to all contracted providers affected by the CAP?			
1.30 Did the notice include the following: 1. Description of identified deficiencies; 2. Rational for the CAP; and 3. Name and telephone number of person authorized to respond to provider concerns regarding the Plan's CAP?			
1.31 When the Plan identifies problems, does it monitor to assure improvements are maintained?			

End of Requirement AA-004: Appointment Availability

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Requirement AA-005: Mental Health Parity Communication of Benefit Information

STATUTORY/REGULATORY CITATIONS

Health and Safety Code section 1367.29

(a) On and after July 1, 2011, in accordance with the requirements of subdivision (b), every health care service plan that provides coverage for professional mental health services, including a specialized health care service plan that provides coverage for professional mental health services, shall issue an identification card to each enrollee in order to assist the enrollee with accessing health benefits coverage information, including, but not limited to, in-network provider access information, and claims processing purposes. The identification card, at a minimum, shall include all of the following information:

(1) The name of the health care service plan issuing the identification card.

(2) The enrollee's identification number.

(3) A telephone number that enrollees or providers may call for assistance with health benefits coverage information, in-network provider access information, and claims processing information, and when assessment services are provided by the health care service plan, access to assessment services for the purpose of referral to an appropriate level of care or an appropriate health care provider.

(4) The health care service plan's Internet Web site address.

(b) The identification card required by this section shall be issued by a health care service plan or a specialized health care service plan to an enrollee upon enrollment or upon any change in the enrollee's coverage that impacts the data content or format of the card.

(c) Nothing in this section requires a health care service plan to issue a separate identification card for professional mental health services coverage if the plan issues a card for health care coverage in general and the card provides the information required by this section.

(d) If a health care service plan or a specialized health care service plan, as described in subdivision (a), delegates responsibility for issuing the identification card to a contractor or an agent, the contractor or agent shall be required to comply with this section.

(e) Nothing in this section shall be construed to prohibit a health care service plan or a specialized health care service plan from meeting the standards of the Workgroup for Electronic Data Interchange (WEDI) or other national uniform standards with respect to identification cards, and a health care service plan shall be deemed compliant with this section if the plan conforms with these standards, as long as the minimum requirements described in subdivision (a) have been met.

(f) For the purposes of this section, "identification card" includes other technology that performs substantially the same function as an identification card.

(g) (1) This section shall not apply to Medicare supplement insurance, Employee Assistance Programs, short-term limited duration health insurance, Champus-supplement insurance, or TRI-CARE supplement insurance, or to hospital indemnity, accident-only, and specified disease insurance. This section shall also not apply to specialized health care service plans, except behavioral health-only plans.

(2) Notwithstanding paragraph (1), this section shall not apply to a behavioral health-only plan that provides coverage for professional mental health services pursuant to a contract with a

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health care service plan or insurer if that plan or insurer issues an identification card to its subscribers or insureds pursuant to this section or Section 10123.198 of the Insurance Code.

Health and Safety Code section 1374.72(a)

(a) Every health plan contract issued, amended, renewed on or after July 1, 2000, that provides hospital, medical or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person any age, and of serious emotional disturbances of a child, as specified in subdivisions (d) and (e) under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

CA Health and Safety Code section 1374.72(a) through (e)

(a) Every health plan contract issued, amended, renewed on or after July 1, 2000, that provides hospital, medical or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person any age, and of serious emotional disturbances of a child, as specified in subdivisions (d) and (e) under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

(b) These benefits shall include the following:

- (1) Outpatient services.
- (2) Inpatient hospital services.
- (3) Partial hospital services.
- (4) Prescription drugs, if the plan contract includes coverage for prescription drugs.

(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include, but not be limited to, the following:

- (1) Maximum lifetime benefits.
- (2) Copayments.
- (3) Individual and family deductibles.

(d) For the purposes of this section, “severe mental illnesses” shall include:

- (1) Schizophrenia.
- (2) Schizoaffective disorder.
- (3) Bipolar disorder (manic-depressive illness).
- (4) Major depressive disorders.
- (5) Panic disorder.
- (6) Obsessive-compulsive disorder.
- (7) Pervasive developmental disorder or autism
- (8) Anorexia nervosa
- (9) Bulimia nervosa

(e) For purposes of this section a child suffering from “serious emotional disturbances of a child” shall be defined as a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child’s age according to expected developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

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28 CCR 1300.63.2(b)(3), (5), and (6)

Notwithstanding Sections 1300.63 and 1300.63.1 of these rules, a plan may combine the evidence of coverage and disclosure form into a single document if such plan complies with each of the following requirements:

(b) Except as may be otherwise permitted by the Director, the combined evidence of coverage and disclosure form shall conform to the following requirements:

(3) It shall be written in clear, concise, easily understood language.

(5) It shall be presented in an easily readable format.

(6) The combined evidence of coverage and disclosure form when taken as a whole, with consideration being given to format, typography and language, must constitute a fair disclosure of the provisions of the health plan.

28 CCR 1300.63.2(c)(3), (4), and (14)

Notwithstanding Sections 1300.63 and 1300.63.1 of these rules, a plan may combine the evidence of coverage and disclosure form into a single document if such plan complies with each of the following requirements:

(c) The combined evidence of coverage and disclosure form shall contain at a minimum the following information:

(3) The definitions for the words contained therein that have meanings other than those attributed to them by the public in general usage.

(4) The manner in which the member can determine who is or may be entitled to benefits, except that a member under group coverage may be referred to the group contract holder for such information.

(14) The exact procedure for obtaining benefits including the procedure for filing claims. The procedure for filing claims must state the time by which the claim must be filed, the form in which it is to be filed, and the address at or to which it shall be delivered or mailed.

28 CCR 1300.67.2(g)

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;

(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.

28 CCR 1300.74.72(a) and (i)

(a) The mental health services required for the diagnosis and treatment of conditions set forth in Health and Safety Code section 1374.72 shall include, when medically necessary, all health care services required under the Act including, but not limited to, basic health care services within the meaning of Health and Safety Code sections 1345(b) and 1367(i), and section 1300.67 of Title 28. These basic health care services shall, at a minimum, include crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, and services from licensed mental health providers including, but not limited to, psychiatrists and psychologists.

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(i) A plan shall include in its Evidence of Coverage or Combined Evidence of Coverage and Disclosure Form a list of mental conditions required to be covered pursuant to Health and Safety Code section 1374.72.

28 CCR 1300.74.72(f) and (g)(1)

(f) A plan's referral system shall provide enrollees timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72 and for related health care services as appropriate upon referral from a primary care physician, mental health provider or pediatrician meeting the requirements of subsection (b) above.

(g) If a plan contracts with a specialized health care service plan for the purpose of providing Health and Safety Code section 1374.72 services, the following requirements shall apply:

(1) the specialized health care service plan shall maintain a telephone number that an enrollee may call during normal business hours to obtain information about benefits, providers, coverage and any other relevant information concerning an enrollee's mental health services;

28 CCR 1300.74.72(f) and (g)(2)

(f) A plan's referral system shall provide enrollees timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72 and for related health care services as appropriate upon referral from a primary care physician, mental health provider or pediatrician meeting the requirements of subsection (b) above.

(g) If a plan contracts with a specialized health care service plan for the purpose of providing Health and Safety Code section 1374.72 services, the following requirements shall apply:

(2) if the plan issues identification cards to enrollees, the identification cards shall include the telephone number required to be maintained above and a brief statement indicating that enrollees may call the telephone number for assistance about mental health services and coverage;

Welfare and Institutions Code 5600.3(a)(2)

(2) For the purposes of this part, "seriously emotionally disturbed children or adolescents" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

(A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

(i) The child is at risk of removal from home or has already been removed from the home.

(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

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(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

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

Staff responsible for the activities described above, for example:

- Director of Customer Service
- QA Director
- Compliance Officer

DOCUMENTS TO BE REVIEWED

- Evidence of Coverage or Combined Evidence of Coverage and Disclosure Form (for each applicable product line).
- Schedule of Benefits (for each applicable product line.)
- Marketing materials, such as summaries of benefits, and presentation materials, such as PowerPoint presentations.
- Enrollee education materials from the Plan and, if applicable, the delegate. These may include brochures on mental health services and enrollee newsletters that contain articles on mental health benefits and services.
- Sample enrollee identification card for each applicable product line.
- Customer Service staff reference materials (desktop procedures, scripts, training materials, etc.).
- Plan’s Web site section that communicates mental health benefits and access information.

AA-005 - Key Element 1:

1. The Plan’s Evidence of Coverage or Combined Evidence of Coverage and Disclosure Form and the Schedule of Benefits accurately and clearly describe benefit coverage for mental health parity diagnoses/conditions, distinguish between parity and non-parity mental health benefits, if applicable, and describe how enrollees can obtain both parity and non-parity mental health benefits.

Health and Safety Code section 1374.72(a); 28 CCR 1300.63.2(b)(3), (5), and (6); 28 CCR 1300.63.2(c)(3), (4), and (14); 28 CCR 1300.74.72(a) and (i)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan’s EOC accurately and clearly describe benefit and coverage information for mental health parity conditions?			
1.2 Does the Plan’s EOC distinguish between parity and non-parity mental health benefits?			
1.3 Does the EOC describe how enrollees can obtain both parity and non-parity mental health benefits?			

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AA-005 - Key Element 2:

- 2. The Plan’s marketing materials and enrollee educational materials accurately present benefit and coverage information for parity diagnoses/conditions and clearly distinguishes between parity and non-parity mental health benefits, if applicable. CA Health and Safety Code sections 1374.72(a) through (e); 28 CCR 1300.67.2(g); 28 CCR 1300.74.72(a) and (i)**

Assessment Questions	Yes	No	N/A
2.1 Do the Plan’s marketing and enrollee education materials accurately present benefit and coverage information for parity diagnoses/conditions?			
2.2 Do the Plan’s marketing and enrollee education materials clearly distinguish between parity and non-parity mental health benefits, if applicable?			

AA-005 - Key Element 3:

- 3. The Plan regularly informs each enrollee how to obtain mental health services. Health and Safety Code section 1374.72(a); 28 CCR 1300.67.2(g); 28 CCR 1300.74.72(a) and (i)**

Assessment Questions	Yes	No	N/A
3.1 Has the Plan developed materials that explain how to obtain routine mental health services?			
3.2 Has the Plan developed materials that explain how to obtain after-hours mental health services?			
3.3 Has the Plan developed materials that explain how to obtain urgent mental health services?			
3.4 Has the Plan developed materials that explain how to obtain emergency mental health services?			
3.5 Do the Plan’s marketing and enrollee education materials inform enrollees how to obtain covered services in accordance with the specific needs of the enrollee (i.e. based on diagnosis of autism, depression, eating disorders, etc.)?			
3.6 Does the Plan regularly inform enrollees how to obtain mental health services?			

AA-005 - Key Element 4:

- 4. If a Plan contracts with a specialized health care plan to provide mental health services, the specialized plan maintains a telephone number during normal business hours to respond to enrollee requests for information about mental health benefits, providers, coverage, and any other relevant information. 28 CCR 1300.74.72(f) and (g)(1)**

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Assessment Question	Yes	No	N/A
4.1 Does the specialized plan maintain a telephone number during normal business hours to respond to enrollee requests for information about mental health benefits, providers, and coverage?			

AA-005 - Key Element 5:

- 5. If the Plan contracts with a specialized health care service plan to provide mental health services, the Plan includes on the enrollee’s ID card the telephone number that enrollees can call during business hours to obtain information regarding benefits, providers, coverage, and any other relevant information.**
CA Health and Safety Code Section 1369.29; 28 CCR 1300.74.72(f) and (g)(2)

Assessment Question	Yes	No	N/A
5.1 Does the Plan include – on the enrollee’s ID card – the specialized plan’s telephone number that enrollees can call during business hours to obtain information regarding benefits, providers, and coverage?			
5.2 Do enrollee ID cards include: The enrollee’s identification number, the name of the Health Plan, and the Plan’s Web site address? Note: Not applicable to EAP plans.			

AA-005 - Key Element 6:

- 6. The Plan’s Member/Customer Service staff accurately present mental health benefit and coverage information and how to obtain mental health services for parity and non-parity conditions.**
28 CCR 1300.74.72(f) and (g)(1)

Assessment Questions	Yes	No	N/A
6.1 Do Member/Customer Service staff have the information necessary to accurately assist enrollees in obtaining information about benefits, providers, coverage, and any other relevant information concerning an enrollee’s mental health services?			
6.2 Are the scripts, system documentation, training materials, and other materials used by Member Services about mental health coverage accurate?			
6.3 Do audit and monitoring reports validate that accurate information regarding mental health parity benefits is monitored and communicated?			

End of Requirement AA-005: Mental Health Parity Communication of Benefit Information

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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 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.

(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 [list of its contracting providers] 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 website. Plans shall ensure that the information provided is updated at least quarterly. A plan may satisfy this update requirement by

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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:

- Medical 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, including primary care providers, medical groups, independent practice associations, hospitals, and all other health professionals, including psychologists, licensed clinical social workers, marriage and family therapists, and nurse midwives?			
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?			

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Assessment Questions	Yes	No	N/A
1.3 Does the Plan's list of contracted providers indicate which providers have notified the Plan that they have closed practices?			
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, board certifications, and any recognized sub-specialty qualifications that a sub-specialist may have?			

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