

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

TECHNICAL ASSISTANCE GUIDE

ACCESS AND AVAILABILITY OF SERVICES

**ROUTINE SPECIALIZED¹ SURVEY
OF
PLAN NAME**

DATE OF SURVEY:

PLAN COPY

Issuance of this April 15, 2026 Technical Assistance Guide renders all other versions obsolete

¹ Dental, vision, and chiropractic health care service plans.

SPECIALIZED TAG

ACCESS AND AVAILABILITY OF SERVICES REQUIREMENTS

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This Technical Assistance Guide (TAG) serves as a guide for medical surveys which are conducted under the Health and Safety Code medical survey statutes and regulations. This TAG may be revised as appropriate, to incorporate new or updated relevant legal requirements as they impact the surveys, or for any other reason as determined by the Department. Health plans are responsible for complying with applicable statutes and regulations upon their effective dates and, therefore, are deemed to have prior notice of all statutes and regulations effective during the medical survey period. Health plans may be assessed for compliance with those requirements even when they have not yet been added to the TAG. The Department's medical survey authority is broad, and includes, but is not limited to, reviewing books and records, conducting interviews, making site visits, and making telephone calls to verify information as part of the survey assessment of any Key Element question in this TAG. The recipients of these telephone calls may include, but not be limited to, health plan and delegate physicians/medical directors, plan customer service representatives, triage nurses, and/or network/contracted providers.

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Requirement AA-001: Access Monitoring and Out of Network Provider Coverage

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

Staff responsible for the activities described above, for example:

- Dental, Optometric, or Chiropractic Director
- Director of Contracting/Provider Relations
- QA Director
- Grievance Director
- UM Director
- Public Policy Committee Representative

DOCUMENTS TO BE REVIEWED

- Documents describing how the Plan monitors and ensures compliance with network standards.
- Documents describing how the Plan arranges for out-of-network services when medically necessary services are unavailable within the Plan's network or service area. This could include formal policies and procedures and desk-level guidance.
- Records demonstrating the Plan is monitoring requests for out-of-network services and regularly assessing its network adequacy, including minutes of relevant Committee meetings (AA Committee, GA Committee, QA Committee, Public Policy Committee, BOD, etc.)
- Evidence of routine review and tracking and trending of enrollee grievances and appeals related to access, coverage of out-of-network services (e.g., claims payments/reimbursement), and availability of in-network providers.
- Investigation and corrective action plans when the Plan identifies a network adequacy deficiency in particular specialty, service area, etc. through its routine review of its networks, grievances and appeals, etc.
- Investigation and corrective action plans when Plan review of enrollee grievances, claims payments, etc. identifies a problem with enrollee access to medically necessary out-of-network services.
- Corrective action plans for areas where access does not meet the standards.
- Evidence of follow-up on corrective action plans (CAPs).

AA-001 - Key Element 1:

1. The Plan has processes to ensure that if covered health care services are unavailable in the service area or network, the Plan arranges for medically necessary services in a neighboring network or outside of the Plan's service area or network.

28 CCR [1300.67.2.2\(c\)\(7\)\(B\), \(C\), \(d\)\(1\)](#); 28 CCR [1300.70\(a\)\(1\), \(3\)](#)

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Assessment Questions	
1.1	If the Plan has a shortage of one or more types of providers, does it ensure timely access to covered services by referring enrollees to or by assisting an enrollee to locate, available and accessible network providers in neighboring network service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs? Rule 1300.67.2.2(c)(7)(B), (d)(1)
1.1 Comments	
1.2	Does the Plan have a process to arrange for the provision of covered services from providers outside the Plan's network if unavailable within network, if medically necessary for the enrollee's condition? Rule 1300.67.2.2(c)(7)(C), (d)(1)
1.2 Comments	
1.3	Does the Plan have a process to ensure that enrollee costs for medically necessary referrals to a non-network provider do not exceed applicable co-payments, co-insurance, and deductibles? Rule 1300.67.2.2(c)(7)(C)
1.3 Comments	
1.4	Does the Plan document that issues regarding access to covered health care services are reviewed, that problems are identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated? Rule 1300.70(a)(1), (3)
1.4 Comments	

AA-001 - Key Element 2:

2. The Plan has a documented system for monitoring and evaluating access to care.

28 CCR [1300.67.2\(j\)](#); 28 CCR [1300.67.2.2\(c\)\(1\)](#)

Assessment Questions	
2.1	Does the Plan have a documented system of monitoring and evaluating access to care? Rule 1300.67.2.2(c)(1) ; Rule 1300.67.2(j)
2.1 Comments	
2.2	Do the Plan's monitoring systems and processes ensure covered health care services are provided in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice? Rule 1300.67.2.2(c)(1)

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AA-001 - Key Element 3

3. The Plan has processes to ensure that it tracks and monitors complaints about access to care and has a monitoring system pertaining to timely access to care and adequacy of its networks.
28 CCR [1300.67.2.2\(a\)\(4\), \(c\)\(1\), \(d\)\(1\)](#); 28 CCR [1300.68\(b\)\(1\), \(c\), \(e\)\(1\), \(2\)](#)

Assessment Questions	
3.1	Does the Plan track and monitor complaints about access to care to ensure compliance with timely access and network adequacy standards? Rule 1300.67.2.2(a)(4), (c)(1), (d)(1) ; Rule 1300.68(e)(1), (2)
3.1 Comments	
3.2	Does the Plan's grievance officer continuously review the operation of the grievance systems to identify any emergent patterns of access to care grievances? Rule 1300.68(b)(1)
3.2 Comments	
3.3	Does the Plan demonstrate it improves plan policies and procedures upon identification of emergent patterns of access to care grievances? Rule 1300.67.2.2(d)(1) ; Rule 1300.68(b)(1)
3.3 Comments	
3.4	Does the Plan demonstrate that its grievance system, policies, and actions taken in response to access to care grievances are effective? Rule 1300.67.2.2(d)(1) ; Rule 1300.68(c)
3.4 Comments	

End of Requirement AA-001: Access Monitoring and Out of Network Provider Coverage

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Requirement AA-002: Timely Access to Plan Services

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

Staff responsible for the activities described above, for example:

- Dental, Optometric, or Chiropractic Director
- QA Director
- Provider Relations Manager, responsible for compliance oversight of provider groups
- Director of Member Services Department or Call Center

DOCUMENTS TO BE REVIEWED

- Policies and procedures defining standards for hours of operation and after-hours care.
- Policies and procedures for monitoring the standards for hours of operation and after-hours care.
- Delegation agreements.
- 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 and referenced monitoring reports, studies, audits (of any/all appropriate committees).
- Evidence of CAPs (for the Plan itself or any entity to which the tasks in the assessment questions are delegated).
- Provider Manual or other methods to communicate standards to providers.

AA-002 - Key Element 1:

1. The Plan ensures timely access to customer service representatives.

28 CCR [1300.67.2.2\(c\)\(10\)](#)

Assessment Questions	
1.1	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 during normal business hours? Rule 1300.67.2.2(c)(10)
1.1 Comments	
1.2	Does the Plan ensure that its customer service representatives are knowledgeable and competent regarding the enrollees' questions? Rule 1300.67.2.2(c)(10)
1.2 Comments	

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AA-002 - Key Element 2:

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

Assessment Questions	
2.1	Does the Plan monitor its network providers to ensure they employ an answering service or a telephone answering machine during non-business hours that provides instructions regarding how an enrollee may obtain urgent or emergency care? Rule 1300.67.2.2(c)(9)
2.1 Comments	
2.2	If applicable, does the Plan monitor its network providers when they direct their patients to contact another provider who has agreed to be on-call to triage or screen by telephone, or if needed, deliver urgent or emergency care? Rule 1300.67.2.2(c)(9)
2.2 Comments	

End of Requirement AA-002: Timely Access to Plan Services

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Requirement AA-003: Appointment Availability

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

Staff responsible for the activities described above, for example:

- QA 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.
- Monitoring and oversight tools such as appointment availability studies, enrollee and provider satisfaction surveys, reports on grievances, and telephone access studies (such as anonymous "mystery shopper").
- Committee or applicable subcommittee minutes.
- Corrective action plans.
- Licensing filing(s) of the Plan's access standards.

AA-003 - Key Element 1:

1. FOR DENTAL PLANS ONLY:

The Plan ensures that contracted dental provider networks have adequate capacity and availability of licensed health care providers to offer enrollees appointments for covered dental service in accordance with requirements.
28 CCR [1300.67.2.2\(c\)\(6\)](#)

Assessment Questions	
1.1	Does the Plan monitor to ensure its dental networks have urgent appointments offered within 72 hours of the time of request for appointment? Rule 1300.67.2.2(c)(6)(A)
1.1 Comments	
1.2	Does the Plan monitor to ensure its dental networks have non-urgent appointments offered within 36 business days of the request for appointment? Rule 1300.67.2.2(c)(6)(B)
1.2 Comments	
1.3	Does the Plan monitor to ensure its dental network have preventive dental care appointments offered within 40 business days of the request for appointment? Rule 1300.67.2.2(c)(6)(C)
1.3 Comments	

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End of Requirement AA-003: Appointment Availability

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Requirement AA-004: Enrollee Health Education

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

Staff responsible for the activities described above, for example:

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

DOCUMENTS TO BE REVIEWED

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

AA-004 - Key Element 1:

1. The Plan regularly informs each enrollee how to obtain services.
CA Health and Safety Code section 1367.031(a), (b), (c), (d); 28 CCR [1300.67.2\(k\)](#); 28 CCR [1300.67\(f\)\(8\)](#)

Assessment Questions	
1.1	Does the Plan's health education program inform enrollees regarding accessibility of services to meet the enrollees' needs in the enrollees' area? Rule 1300.67.2(k)
1.1 Comments	
1.2	Does the Plan have health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of preventive health care services provided by the Plan? Rule 1300.67(f)(8)
1.2 Comments	
1.3	Does the Plan communicate timely access standards to enrollees, including information related to interpreter services, no less than annually? Section 1367.031(a), (b)
1.3 Comments	
1.4	FOR DENTAL PLANS ONLY: Does the Plan provide enrollees with information regarding urgent and non-urgent appointment times? Section 1367.031(c)
1.4 Comments	

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| 1.5 | <p>Is the information provided to the enrollee pursuant to Section 1367.031 provided in the following manner:</p> <ul style="list-style-type: none">(1) In a separate section of the evidence of coverage titled “Timely Access to Care.”(2) At least annually, in or with newsletters, outreach, or other materials that are routinely disseminated to the plan’s enrollees.(3) Commencing January 1, 2018, in a separate section of the provider directory published and maintained by the health care service plan pursuant to Section 1367.27. The separate section shall be titled “Timely Access to Care.”(4) On the internet website published and maintained by the health care service plan, in a manner that allows enrollees and prospective enrollees to easily locate the information. |
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[Section 1367.031\(d\)](#)

1.5 Comments

End of Requirement AA-004: Enrollee Health Education

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Requirement AA-005: Provider Directories

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

Staff responsible for the activities described below, for example:

- Director of Contracting/Provider Relations
- Director of QA and/or other persons responsible for QA
- Individuals responsible for AA survey/data analysis
- Individuals responsible for provider directories
- Individuals who can give a provider directory systems demonstration to the Department (upon request)

DOCUMENTS TO BE REVIEWED

- Online and printed version(s) of the Plan's provider directory/directories.
- Plan's Provider Directory Policies and Procedures (Exhibit J-14) and any other policies and procedures relevant to updating information for contracted providers and the Plan's process for updating the Plan's provider directory/directories.
- Provider Directory Worksheets (Exhibit J-15).
- Plan's provider notice templates (semi-annual verification notice, notice of pending provider directory removal).
- Plan's provider notification log or communication timing/tracking history (should include dates notices were sent to providers and if/when responses were received).
- Plan's documentation of attempts to verify information of providers who failed to respond to the required notice in a timely manner.
- Evidence the Plan suppressed providers who failed to respond to the required notice in a timely manner.
- Plan's log or list of all reports of inaccuracies received by the Plan, through online interface, email, and telephone.
- Internal audit(s) that verifies accuracy of the provider directory and any other evidence that demonstrates the Plan reviews for accuracy.
- Evidence that the Plan updates provider directory content when changes are submitted by providers and when investigations determine contents are inaccurate.
- Provider Directory Vendor contract (if applicable).
- Quality Assurance/Access and Availability program policies/internal guidance.
- List of grievances handled by the Plan related to provider directories.
- Annual report of grievances related to access and availability submitted by the Plan to the Department.
- Consumer complaints filed with the Department related to provider directories.

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AA-005 - Key Element 1:

1. The Plan has adequate processes to ensure the accuracy of the information in the provider directory.

CA Health and Safety Code section [1367.27\(a\), \(e\)\(1\)\(A\), \(C\), \(E\), \(f\)\(1\), \(n\)\(1\), \(2\)](#)

Assessment Questions	
1.1	Does the plan take appropriate steps to ensure the accuracy of the information concerning each provider listed in the Plan's provider directory or directories per Section 1367.27? Section 1367.27(f)(1)
1.1 Comments	
1.2	Does the Plan review and update the entire provider directory or directories for each product offered, at least annually? Section 1367.27(f)(1)
1.2 Comments	
1.3	Does the Plan ensure that the provider directory or directories do not include information on a provider that is not currently under contract with the plan? Section 1367.27(a)
1.3 Comments	
1.4	Is the Plan's online provider directory or directories updated at least weekly when informed of changes/upon confirmation that a provider's practice location or other information required under subdivision (i) has changed? Section 1367.27(e)(1)(C)
1.4 Comments	
1.5	Is the Plan's online provider directory or directories updated at least weekly when informed of changes/upon confirmation that a provider is no longer accepting new patients for a particular plan product or an individual provider within a provider group is no longer accepting new patients? Section 1367.27(e)(1)(A)
1.5 Comments	
1.6	Is the Plan's online provider directory or directories updated at least weekly when informed of changes/upon confirmation of changes affecting content or accuracy? Section 1367.27(e)(1)(E)
1.6 Comments	
1.7	If a Plan requires its contracting provider groups or contracted specialized health care service plan to provide the Plan with information to satisfy the requirements of Section 1367.27, does the Plan retain responsibility for ensuring Section 1367.27 is satisfied? Section 1367.27(n)(1)-(2)
1.7 Comments	

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AA-005 - Key Element 2:

2. The Plan has adequate processes to: (1) notify providers of their obligation to update their information in the provider directory, and (2) allow providers to promptly verify contents of the provider directory and submit changes.
CA Health and Safety Code section [1367.27\(l\)\(1\)\(A\)-\(B\)](#), [\(l\)\(2\)\(A\)-\(C\)](#), [\(l\)\(3\)-\(4\)](#), [\(m\)\(2\)](#)

Assessment Questions	
2.1	Does the Plan have a process, including an online interface, to allow providers to promptly verify or submit changes to its provider directory information? Section 1367.27(m)(2)
2.1 Comments	
2.2	Does the Plan's online interface allow providers to submit verification or changes electronically and generate an acknowledgment of receipt? Section 1367.27(m)(2)
2.2 Comments	
2.3	Does the Plan's provider notice template satisfy the content requirements of Section 1367.27(l)(2)(A)-(C)? • The information the Plan has in its directory or directories regarding the provider or provider group, including a list of networks and Plan products that include the contracted provider or provider group. • A statement that the failure to respond to the notification may result in a delay of payment or reimbursement of a claim pursuant to subdivision (p). • Instructions on how the provider or provider group can update the information in the provider directory or directories using the online interface developed pursuant to subdivision (m). Section 1367.27(l)(2)(A)-(C)
2.3 Comments	
2.4	Does the Plan notify its contracted providers every 6 months? Section 1367.27(l)(1)(A)-(B)
2.4 Comments	
2.5	Does the Plan require an affirmative response from providers acknowledging the notification was received? Section 1367.27(l)(3)
2.5 Comments	
2.6	Does the Plan require all notified providers to confirm their directory information is current and accurate or otherwise update their directory information? Section 1367.27(l)(3)
2.6 Comments	

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2.7	If the Plan does not receive an affirmative response and confirmation (or updated information) from the provider within 30 business days, does the Plan have a process to verify the provider's information within 15 business days? Section 1367.27(l)(4)
2.7 Comments	
2.8	If the Plan is unable to verify whether the provider's information is correct or requires updates, does the Plan notify the provider 10 business days in advance of removal that the provider will be removed from the provider directory or directories? Section 1367.27(l)(4)
2.8 Comments	
2.9	Does the Plan ensure providers who do not respond (within the 10-business-day notice period) are not included in the next required update of the provider directory or directories? Section 1367.27(l)(4)
2.9 Comments	

AA-005 - Key Element 3:

- 3. The Plan properly maintains its online provider directory.**
CA Health and Safety Code section [1367.27\(b\) and \(c\)](#)

Assessment Questions	
3.1	Is an online provider directory or directories available on the Plan's website? Section 1367.27(c)
3.1 Comments	
3.2	Is the Plan's online directory or directories available to the public, potential enrollees, enrollees, and providers without any restrictions or limitations? Section 1367.27(c)(1)
3.2 Comments	
3.3	Is the Plan's online directory or directories accessible through an identifiable link or tab and in a manner that is accessible and searchable by enrollees, potential enrollees, the public, and providers? Section 1367.27(c)(2)
3.3 Comments	

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3.4	Does the Plan's public website allow provider searches by, at a minimum: • name, • practice address, • city, • ZIP Code, • California license number, • National Provider Identified number, • admitting privileges to an identified hospital, • product, • tier, • provider language or languages, • provider group, hospital name, facility name, or clinic name, as appropriate? Section 1367.27(b) and (c)(2)
3.4 Comments	

AA-005 - Key Element 4:

4. The Plan's provider directory contains all required information. CA Health and Safety Code section [1367.27\(i\)\(1\)-\(10\)](#)

Assessment Questions	
4.1	Does the Plan's directory contain the provider's name, practitioner type, practice location or locations, and contact information? Section 1367.27(i)(1)-(2)
4.1 Comments	
4.2	Does the Plan's directory include the National Provider Identifier number, California license number, and type of license, for each listed provider? Section 1367.27(i)(3)-(4)
4.2 Comments	
4.3	Does the Plan's directory include the area of specialty, including board certification or other accreditation(if any) as applicable to each listed provider? Section 1367.27(i)(5)
4.3 Comments	
4.4	Does the Plan's directory include the provider's office email address, if available? Section 1367.27(i)(6)
4.4 Comments	
4.5	Does the Plan's directory include the name of each affiliated provider group or specialty plan practice group that is currently under contract with the Plan and through which the provider sees enrollees? Section 1367.27(i)(7)
4.5 Comments	

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4.6	Does the Plan's directory include the names of each allied health care professional to the extent there is a direct contract for those services covered through a contract with the Plan? Section 1367.27(i)(8)
4.6 Comments	
4.7	Does the Plan's directory identify the non-English language(s), if any, spoken by a health care provider or other medical professional as well as non-English language(s) spoken by a qualified medical interpreter, in accordance with Section 1367.04, if any, on the provider's staff? Section 1367.27(i)(9)
4.7 Comments	
4.8	Does the Plan's directory include identification of providers who no longer accept new patients for some or all of the Plan's products? Section 1367.27(i)(10)
4.8 Comments	

AA-005 - Key Element 5:

5. The Plan has adequate procedures for receiving and investigating reports of provider directory inaccuracy.

CA Health and Safety Code section [1367.27\(f\), \(i\)\(3\), \(m\)\(3\), \(o\)\(1\)-\(2\)](#)

Assessment Questions	
5.1	Does the Plan have a telephone number and dedicated email address to receive reports of a potential directory inaccuracy? Section 1367.27(m)(3)
5.1 Comments	
5.2	Does the Plan's provider directory and website prominently display the Plan's dedicated email address and telephone number to report a potential directory inaccuracy? Section 1367.27(f)
5.2 Comments	
5.3	Does the Plan's provider directory website include a hyperlink, linking to a form where inaccurate information can be directly reported to the Plan? Section 1367.27(m)(3)
5.3 Comments	
5.4	Can the Plan provide evidence that it promptly investigates each time it receives a report of a potential directory inaccuracy, taking no more than thirty (30) business days to verify the accuracy of the information or update the provider directory or directories? Section 1367.27(i)(3) and (o)(1)
5.4 Comments	

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5.5	Can the Plan provide evidence that its investigation includes contacting the affected provider within five business days? Section 1367.27(o)(2)(A)
5.5 Comments	
5.6	Does the Plan document the receipt and outcome of each reported potential directory inaccuracy, including: • Provider's name • Provider's location • Description of the Plan's investigation • Outcome of the investigation, and • Any changes/updates made to its provider directory or directories? Section 1367.27(o)(2)(B)
5.6 Comments	
5.7	Can the Plan provide evidence that it makes changes to provider directory information—required as a result of any investigation—no later than the next scheduled weekly update, or the update immediately following that update? Section 1367.27(o)(2)(C)
5.7 Comments	
5.8	For printed provider directories, is the change made no later than the next required update? Section 1367.27(o)(2)(C)
5.8 Comments	

AA-005 - Key Element 6:

6. The Plan's provider directory contains the required enrollee disclosures.
CA Health and Safety Code section [1367.27\(g\)\(1\)-\(2\)](#)

Assessment Questions	
6.1	Does the Plan's provider directory or directories include a statement informing enrollees that they are entitled to language interpreter services at no cost, including information on how to obtain interpretation services? Section 1367.27(g)(1)
6.1 Comments	
6.2	Does the Plan's provider directory or directories include a statement informing enrollees that they are entitled to full and equal access to covered services, including enrollees with disabilities as required under the Americans with Disabilities Act of 1990 and Section 404 of the Rehabilitation Act of 1973? Section 1367.27(g)(2)
6.2 Comments	

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AA-005 - Key Element 7:

7. The Plan properly updates and distributes its printed provider directory to enrollees.

CA Health and Safety Code section [1367.27\(d\)\(1\)-\(2\)](#)

Assessment Questions	
7.1	Can a printed copy of the Plan's directory or directories be requested by enrollees, potential enrollees, providers, and members of the public via the Plan's toll-free telephone number, electronically, or in writing? <u>Section 1367.27(d)(1)</u>
7.1 Comments	
7.2	Does the Plan's printed directory or directories contain the provider information required by Section 1367.27(i)? <u>Section 1367.27(d)(1)</u>
7.2 Comments	
7.3	Does the Plan provide a printed copy of the provider directory to the requester by mail postmarked no later than five business days following the date of the request? <u>Section 1367.27(d)(1)</u>
7.3 Comments	
7.4	Does the Plan update its printed directory or directories at least quarterly? <u>Section 1367.27(d)(2)</u>
7.4 Comments	

End of Requirement AA-005 Provider Directories

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Statutory/Regulatory Citations

CA Health and Safety Code section 1367.031

AA-004 [KE1](#)

(a) A health care service plan contract that is issued, renewed, or amended on or after July 1, 2017, shall provide information to an enrollee regarding the standards for timely access to care adopted pursuant to Section 1367.03 and the information required by this section, including information related to receipt of interpreter services in a timely manner, no less than annually.

(b) A health care service plan contract that is issued, renewed, or amended on or after July 1, 2022, shall provide information to an enrollee regarding the standards for timely access to care required by Section 1367.03 and the information required by this section, including information related to receipt of interpreter services in a timely manner, no less than annually.

(c) A health care service plan at a minimum shall provide information regarding appointment wait times for urgent care, nonurgent primary care, nonurgent specialty care, and telephone screening established in Section 1367.032 or pursuant to Section 1367.03 to enrollees and contracting providers. The information shall also include notice of the availability of interpreter services at the time of the appointment pursuant to Section 1367.04. A health care service plan may indicate that exceptions to appointment wait times may apply if the department has found exceptions to be permissible.

(d) The information required to be provided pursuant to this section shall be provided to an enrollee with individual coverage upon initial enrollment and annually thereafter upon renewal, and to enrollees and subscribers with group coverage upon initial enrollment and annually thereafter upon renewal. A health care service plan may include this information with other materials sent to the enrollee. The information shall also be provided in the following manner:

(1) In a separate section of the evidence of coverage titled "Timely Access to Care."

(2) At least annually, in or with newsletters, outreach, or other materials that are routinely disseminated to the plan's enrollees.

(3) Commencing January 1, 2018, in a separate section of the provider directory published and maintained by the health care service plan pursuant to Section 1367.27. The separate section shall be titled "Timely Access to Care."

(4) On the internet website published and maintained by the health care service plan, in a manner that allows enrollees and prospective enrollees to easily locate the information.

CA Health and Safety Code section 1367.27

AA-004 [KE1](#)

AA-005 [KE1](#) [KE2](#) [KE3](#) [KE4](#) [KE5](#) [KE6](#) [KE7](#)

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(a) Commencing July 1, 2016, a health care service plan shall publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to the plan's enrollees, including those that accept new patients. A provider directory shall not list or include information on a provider that is not currently under contract with the plan.

(b) A health care service plan shall provide the directory or directories for the specific network offered for each product using a consistent method of network and product naming, numbering, or other classification method that ensures the public, enrollees, potential enrollees, the department, and other state or federal agencies can easily identify the networks and plan products in which a provider participates. By July 31, 2017, or 12 months after the date provider directory standards are developed under subdivision (k), whichever occurs later, a health care service plan shall use the naming, numbering, or classification method developed by the department pursuant to subdivision (k).

(c)(1) An online provider directory or directories shall be available on the plan's Internet Web site to the public, potential enrollees, enrollees, and providers without any restrictions or limitations. The directory or directories shall be accessible without any requirement that an individual seeking the directory information demonstrate coverage with the plan, indicate interest in obtaining coverage with the plan, provide a member identification or policy number, provide any other identifying information, or create or access an account.

(2) The online provider directory or directories shall be accessible on the plan's public Internet Web site through an identifiable link or tab and in a manner that is accessible and searchable by enrollees, potential enrollees, the public, and providers. By July 31, 2017, or 12 months after the date provider directory standards are developed under subdivision (k), whichever occurs later, the plan's public Internet Web site shall allow provider searches by, at a minimum, name, practice address, city, ZIP Code, California license number, National Provider Identifier number, admitting privileges to an identified hospital, product, tier, provider language or languages, provider group, hospital name, facility name, or clinic name, as appropriate.

(d)(1) A health care service plan shall allow enrollees, potential enrollees, providers, and members of the public to request a printed copy of the provider directory or directories by contacting the plan through the plan's toll-free telephone number, electronically, or in writing. A printed copy of the provider directory or directories shall include the information required in subdivisions (h) and (i). The printed copy of the provider directory or directories shall be provided to the requester by mail postmarked no later than five business days following the date of the request and may be limited to the geographic region in which the requester resides or works or intends to reside or work.

(2) A health care service plan shall update its printed provider directory or directories at least quarterly, or more frequently, if required by federal law.

(e)(1) The plan shall update the online provider directory or directories, at least weekly, or more frequently, if required by federal law, when informed of and upon confirmation by the plan of any of the following:

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- (A) A contracting provider is no longer accepting new patients for that product, or an individual provider within a provider group is no longer accepting new patients.
 - (B) A provider is no longer under contract for a particular plan product.
 - (C) A provider's practice location or other information required under subdivision (h) or (i) has changed.
 - (D) Upon completion of the investigation described in subdivision (o), a change is necessary based on an enrollee complaint that a provider was not accepting new patients, was otherwise not available, or whose contact information was listed incorrectly.
 - (E) Any other information that affects the content or accuracy of the provider directory or directories.
- (2) Upon confirmation of any of the following, the plan shall delete a provider from the directory or directories when:
- (A) A provider has retired or otherwise has ceased to practice.
 - (B) A provider or provider group is no longer under contract with the plan for any reason.
 - (C) The contracting provider group has informed the plan that the provider is no longer associated with the provider group and is no longer under contract with the plan.
- (f) The provider directory or directories shall include both an email address and a telephone number for members of the public and providers to notify the plan if the provider directory information appears to be inaccurate. This information shall be disclosed prominently in the directory or directories and on the plan's Internet Web site.
- (g) The provider directory or directories shall include the following disclosures informing enrollees that they are entitled to both of the following:
- (1) Language interpreter services, at no cost to the enrollee, including how to obtain interpretation services in accordance with Section 1367.04.
 - (2) Full and equal access to covered services, including enrollees with disabilities as required under the federal Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.
- (i) A vision, dental, or other specialized health care service plan, except for a specialized mental health plan, shall include all of the following information for each provider directory or directories used by the plan for its networks:
- (1) The provider's name, practice location or locations, and contact information.
 - (2) Type of practitioner.
 - (3) National Provider Identifier number.
 - (4) California license number and type of license, if applicable.
 - (5) The area of specialty, including board certification, or other accreditation, if any.
 - (6) The provider's office email address, if available.
 - (7) The name of each affiliated provider group or specialty plan practice group currently under contract with the plan through which the provider sees enrollees.
 - (8) The names of each allied health care professional to the extent there is a direct contract for those services covered through a contract with the plan.
 - (9) The non-English language, if any, spoken by a health care provider or other medical

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professional as well as non-English language spoken by a qualified medical interpreter, in accordance with Section 1367.04, if any, on the provider's staff.

(10) Identification of providers who no longer accept new patients for some or all of the plan's products.

(11) All other applicable information necessary to conduct a provider search pursuant to paragraph (2) of subdivision (c).

(j)(1) The contract between the plan and a provider shall include a requirement that the provider inform the plan within five business days when either of the following occurs:

(3) If an enrollee or potential enrollee informs a plan of a possible inaccuracy in the provider directory or directories, the plan shall promptly investigate, and, if necessary, undertake corrective action within 30 business days to ensure the accuracy of the directory or directories.

(l)(1) A plan shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the plan's provider directory or directories in accordance with this section, and shall, at least annually, review and update the entire provider directory or directories for each product offered. Each calendar year the plan shall notify all contracted providers described in subdivisions (h) and (i) as follows:

(A) For individual providers who are not affiliated with a provider group described in subparagraph (A) or (B) of paragraph (8) of subdivision (h) and providers described in subdivision (i), the plan shall notify each provider at least once every six months.

(B) For all other providers described in subdivision (h) who are not subject to the requirements of subparagraph (A), the plan shall notify its contracted providers to ensure that all of the providers are contacted by the plan at least once annually.

(2) The notification shall include all of the following:

(A) The information the plan has in its directory or directories regarding the provider or provider group, including a list of networks and plan products that include the contracted provider or provider group.

(B) A statement that the failure to respond to the notification may result in a delay of payment or reimbursement of a claim pursuant to subdivision (p).

(C) Instructions on how the provider or provider group can update the information in the provider directory or directories using the online interface developed pursuant to subdivision (m).

(3) The plan shall require an affirmative response from the provider or provider group acknowledging that the notification was received. The provider or provider group shall confirm that the information in the provider directory or directories is current and accurate or update the information required to be in the directory or directories pursuant to this section, including whether or not the provider or provider group is accepting new patients for each plan product.

(4) If the plan does not receive an affirmative response and confirmation from the provider that the information is current and accurate or, as an alternative, updates any information required to be in the directory or directories pursuant to this section, within 30 business days, the plan shall take no more than 15 business days to verify whether the provider's information is correct or requires updates. The plan shall document the

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receipt and outcome of each attempt to verify the information. If the plan is unable to verify whether the provider's information is correct or requires updates, the plan shall notify the provider 10 business days in advance of removal that the provider will be removed from the provider directory or directories. The provider shall be removed from the provider directory or directories at the next required update of the provider directory or directories after the 10-business-day notice period. A provider shall not be removed from the provider directory or directories if he or she responds before the end of the 10-business-day notice period.

(m) A plan shall establish policies and procedures with regard to the regular updating of its provider directory or directories, including the weekly, quarterly, and annual updates required pursuant to this section, or more frequently, if required by federal law or guidance.

(2) Every health care service plan shall ensure processes are in place to allow providers to promptly verify or submit changes to the information required to be in the directory or directories pursuant to this section. Those processes shall, at a minimum, include an online interface for providers to submit verification or changes electronically and shall generate an acknowledgment of receipt from the health care service plan. Providers shall verify or submit changes to information required to be in the directory or directories pursuant to this section using the process required by the health care service plan.

(3) The plan shall establish and maintain a process for enrollees, potential enrollees, other providers, and the public to identify and report possible inaccurate, incomplete, or misleading information currently listed in the plan's provider directory or directories. This process shall, at a minimum, include a telephone number and a dedicated email address at which the plan will accept these reports, as well as a hyperlink on the plan's provider directory Internet Web site linking to a form where the information can be reported directly to the plan through its Internet Web site.

(n)(1) This section does not prohibit a plan from requiring its provider groups or contracting specialized health care service plans to provide information to the plan that is required by the plan to satisfy the requirements of this section for each of the providers that contract with the provider group or contracting specialized health care service plan. This responsibility shall be specifically documented in a written contract between the plan and the provider group or contracting specialized health care service plan.

(2) If a plan requires its contracting provider groups or contracting specialized health care service plans to provide the plan with information described in paragraph (1), the plan shall continue to retain responsibility for ensuring that the requirements of this section are satisfied.

(o)(1) Whenever a health care service plan receives a report indicating that information listed in its provider directory or directories is inaccurate, the plan shall promptly investigate the reported inaccuracy and, no later than 30 business days following receipt of the report, either verify the accuracy of the information or update the

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information in its provider directory or directories, as applicable.

(2) When investigating a report regarding its provider directory or directories, the plan shall, at a minimum, do the following:

(A) Contact the affected provider no later than five business days following receipt of the report.

(B) Document the receipt and outcome of each report. The documentation shall include the provider's name, location, and a description of the plan's investigation, the outcome of the investigation, and any changes or updates made to its provider directory or directories.

(C) If changes to a plan's provider directory or directories are required as a result of the plan's investigation, the changes to the online provider directory or directories shall be made no later than the next scheduled weekly update, or the update immediately following that update, or sooner if required by federal law or regulations. For printed provider directories, the change shall be made no later than the next required update, or sooner if required by federal law or regulations.

28 CCR 1300.67

AA-004 [KE1](#)

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

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

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

28 CCR 1300.67.2 (j)

AA-001 [KE2](#)

(j) Each plan shall have a documented system for monitoring and evaluating access to care, including a system for addressing problems that develop. The monitoring system shall consider the plan's ability to deliver care to enrollees in accordance with the access requirements and network adequacy standards set forth in the Knox-Keene Act and Title 28, including accessibility, availability, continuity of care, network capacity, and timely access requirements.

(1) When identifying network accessibility problems, the plan shall consider enrollee grievances, the unavailability of network providers, shortages of one or more provider types within the network, requests for referrals to non-network providers, delays in access to care, and other indicators of lack of access to covered services for enrollees. The plan shall document any conclusions regarding health plan compliance with these requirements resulting from this review.

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(2) For plans that delegate patient care to other health care service plans, provider groups, or other entities, the plan shall have a process for monitoring and evaluating each delegate's ability to deliver care to enrollees in accordance with the access requirements and network adequacy standards set forth in the Knox-Keene Act and Title 28, including accessibility, availability, continuity of care, network capacity, and timely access requirements.

28 CCR 1300.67.2(k)

AA-004 [KE1](#)

...

(k) 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 1300.67.2.2.

AA-001 [KE1](#); [KE2](#); [KE3](#)

AA-002 [KE1](#); [KE2](#)

AA-003 [KE1](#)

(a) Application.

- (1) A health care service plan that provides or arranges for the provision of hospital or physician services, including a specialized mental health plan that provides physician or hospital services, or provides mental health services pursuant to a contract with a full-service plan, shall comply with the requirements of this section. A specialized mental health plan includes a plan only licensed to provide the services set forth in Health and Safety Code section 1374.72(a)(3).
- (2) A specialized dental, vision, chiropractic, or acupuncture plan shall comply with this subsection and subsections (b), (c)(1), (c)(3), (c)(4), (c)(7), (c)(9), (c)(10), (d)(1), (d)(3), (g)(1), (h)(1)(B), (h)(5), and (h)(9) of this Rule. Such plans shall also comply with those provisions of subsections (i), (j) and (k) of this Rule where relevant to the requirements applicable to these plans, as set forth herein. These specialized plans shall comply with the network access profile requirements in subsections (h)(2) and (h)(8) of this Rule, and documents incorporated within this Rule, as specified. Dental plans shall also comply with subsection (c)(6).
- (3) The obligation of a plan to comply with this section shall not be waived if the plan delegates to its provider groups 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 Health Care Providers' Bill of Rights, and a material change in the obligations of a plan's network providers shall be considered a material change to the provider contract, within the meaning of subsections (b) and (h)(2) of section 1375.7 of the Knox-Keene Act.
- (4) This section confirms requirements for plans to provide or arrange for the provision of health care services in a timely manner, and establishes additional metrics for

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measuring and monitoring the adequacy of a plan's network to provide enrollees with timely access to needed health care services. This section does not:

- (A) Establish professional standards of practice for health care providers;
 - (B) Establish requirements for the provision of emergency services; or
 - (C) Create a new cause of action or a new defense to liability for any person.
- (5) All reports and information submitted by the plan pursuant to this section shall be timely, accurate and complete.
- (6) A plan that uses a tiered network shall demonstrate compliance with the standards established by section 1367.03 of the Knox-Keene Act and this Rule based on providers available at the lowest cost-sharing tier.

(c) Standards for Timely Access to Care.

- (1) A plan 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. A plan shall establish and maintain networks, policies, procedures, and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.
- (2) A plan shall ensure that all plan and provider processes necessary to obtain covered health care services, including the processes required under section 1367.01 of the Knox-Keene Act, are completed in a manner that assures the provision of covered health care services to an enrollee in a timely manner appropriate for the enrollee's condition and in compliance with the requirements of this Rule.
- (3) If 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 Knox-Keene Act and the requirements of this Rule.
- (4) Interpreter services required by section 1367.04 of the Knox-Keene Act and Rule 1300.67.04 shall be coordinated by the plan, its delegated network provider, or other delegated entity with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment without imposing delay on the scheduling of the appointment. This subsection does not modify the requirements established in Rule 1300.67.04 or approved by the Department pursuant to Rule 1300.67.04 for a plan's language assistance program.
- (5) In addition to ensuring compliance with the clinical appropriateness standard set forth in subsection (c)(1) of this Rule, a plan shall ensure that its network has adequate 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 subsection (c)(5)(H) of this Rule;
 - (B) Urgent care appointments for services that require prior authorization: within 96

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- hours of the request for appointment, except as provided in subsection (c)(5)(H) of this Rule;
- (C) Non-urgent appointments for primary care: within ten business days of the request for appointment, except as provided in subsection (c)(5)(H) and in subsection (c)(5)(I) of this Rule;
 - (D) Non-urgent appointments with specialist physicians: within fifteen business days of the request for appointment, except as provided in subsection (c)(5)(H) and in subsection (c)(5)(I) of this Rule;
 - (E) Non-urgent appointments with a non-physician mental health care provider or substance use disorder provider: within ten business days of the request for appointment, except as provided in subsection (c)(5)(H) and in subsection (c)(5)(I) of this Rule;
 - (F) Nonurgent follow up appointments with a nonphysician mental health care or substance use disorder provider: within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition, except as provided in subsection (c)(5)(H) of this Rule. This subsection does not limit coverage for nonurgent follow up appointments with a nonphysician mental health care or substance use disorder provider to once every 10 business days.
 - (G) 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 subsection (c)(5)(H) and in subsection (c)(5)(I) of this Rule;
 - (H) 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 their 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;
 - (I) Preventive care services and periodic follow up care, including standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac, mental health, or substance use disorder 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 their practice;
 - (J) A referral to a specialist by a primary care provider or another specialist shall be subject to the relevant time-elapsed standard in subsection (c)(5)(A), (B), or (D) of this Rule, unless the requirements in subsection (c)(5)(H) or (I) of this Rule are met, and shall be subject to the other provisions of this section; and
 - (K) 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) of this Rule.

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- (6) In addition to ensuring compliance with the clinical appropriateness standard set forth in subsection (c)(1) of this Rule, each dental plan, and each full-service plan offering coverage for dental services, shall ensure that dental networks have adequate capacity and availability of licensed health care providers to offer enrollees appointments for covered dental services in accordance with the following requirements:
- (A) Urgent appointments within the dental plan network shall be offered within 72 hours of the time of request for appointment, if consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice;
 - (B) Non-urgent appointments shall be offered within 36 business days of the request for appointment, except as provided in subsection (c)(6)(C) of this Rule; and
 - (C) Preventive dental care appointments shall be offered within 40 business days of the request for appointment.
- (7) A plan shall ensure it has sufficient numbers of network providers to maintain compliance with the standards established by this section.
- (A) This section does not modify the requirements regarding provider-to-enrollee ratios or geographic accessibility established by Rules 1300.51, 1300.67.2 or 1300.67.2.1.
 - (B) A plan operating in a network service area, or a portion of a network 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 organization or point-of-service network, by assisting an enrollee to locate, available and accessible network providers in neighboring network service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs.
 - (C) A plan shall arrange for the provision of covered services from providers outside the plan's network if unavailable within the network, if medically necessary for the enrollee's condition. A plan shall ensure that enrollee costs for medically necessary referrals to non-network providers under this Rule shall not exceed applicable in-network 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 network provider. If medically necessary treatment of a mental health or substance use disorder is not available in network within the geographic and timely access standards set by law or regulation, a plan shall arrange coverage outside the plan's network in accordance with subsection (d) of section 1374.72 of the Knox Keene Act.
- (8) A plan 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)(19) of this Rule.
- (A) A plan shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the enrollee's condition, and 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

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services through one or more of the following means: plan-operated telephone triage or screening services consistent with subsection (b)(19) of this Rule; telephone medical advice services pursuant to Health and Safety Code section 1348.8; the plan's primary care and mental health care or substance use disorder network providers; or another method that provides triage or screening services consistent with the requirements of this subsection.

- (i) A plan that arranges for the provision of telephone triage or screening services through primary care, mental health care, and substance use disorder network 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, an answering service, or office staff, that shall inform the caller of both of the following:
 - 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 telephone, or if needed, deliver urgent or emergency care.
- (ii) A plan that arranges for the provision of triage or screening services through network primary care, mental health care and substance use disorder providers who are unable to meet the time-elapsed standards established in subsection (c)(8)(A) shall also provide or arrange for the provision of plan-contracted or plan-operated triage or screening services, which shall, at a minimum, be made available to enrollees affected by that portion of the plan's network.
- (iii) An unlicensed staff person 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 may be referred to a licensed staff person. However, an unlicensed staff person shall not, under any circumstances, use the answers to those questions 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.
- (9) A plan that provides dental, vision, chiropractic, or acupuncture services shall ensure that network providers delivering these health care services employ an answering service or a telephone answering machine during non-business hours that provides instructions regarding how an enrollee 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 telephone, or if needed, deliver urgent or emergency care.
- (10) A plan 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....
- (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

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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.

28 CCR 1300.68 (b)(1), (c), (e)(1-2)

AA-001 [KE3](#)

(b) The plan's grievance system shall include the following:

(1) An officer of the plan shall be designated as having primary responsibility for the plan's grievance system whether administered directly by the plan or delegated to another entity. The officer shall continuously review the operation of the grievance system to identify any emergent patterns of grievances. The system shall include the reporting procedures in order to improve plan policies and procedures.

(c) Through periodic medical surveys under Section 1380 of the Act, the Department shall periodically review the plan's grievance system, including the records of grievances received by the plan, and assess the effectiveness of the plan policies and actions taken in response to grievances.

(e) The plan's grievance system shall track and monitor grievances received by the plan, or any entity with delegated authority to receive or respond to grievances. The system shall:

(1) Monitor the number of grievances received and resolved; whether the grievance was resolved in favor of the enrollee or plan; and the number of grievances pending over 30 calendar days. The system shall track grievances under categories of Commercial, Medicare and Medi-Cal/other contracts. The system shall indicate whether an enrollee grievance is pending at: (1) the plan's internal grievance system; (2) the Department's consumer complaint process; (3) the Department's Independent Medical Review system; (4) an action filed or before a trial or appellate court; or (5) other dispute resolution process. Additionally, the system shall indicate whether an enrollee grievance has been submitted to: (1) the Medicare review and appeal system; (2) the Medi-Cal fair hearing process; or (3) arbitration.

(2) The system shall be able to indicate the total number of grievances received, pending and resolved in favor of the enrollee at all levels of grievance review and to describe the issue or issues raised in grievances as (1) coverage disputes, (2) disputes involving medical necessity, (3) complaints about the quality of care and (4) complaints about access to care (including complaints about the waiting time for appointments), and (5) complaints about the quality of service, and (6) other issues.

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28 CCR 1300.70(a)(1),(3)

AA-001 [KE1](#)

(a) Intent and Regulatory Purpose.

(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

(3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.