

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

TECHNICAL ASSISTANCE GUIDE

**ACCESS AND AVAILABILITY OF SERVICES
ROUTINE MEDICAL AND BEHAVIORAL HEALTH
SURVEY
OF
PLAN NAME**

DATE OF SURVEY:

PLAN COPY

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

FULL SERVICE TAG

ACCESS AND AVAILABILITY OF SERVICES

TABLE OF CONTENTS

Requirement AA-001: Access Monitoring and Out of Network Provider Coverage	_ 2
Requirement AA-002: Timely Access to Plan Services	_____ 5
Requirement AA-003: Enrollee Health Education	_____ 8
Requirement AA-004: Provider Directories	_____ 11
Statutory/Regulatory Citations	_____ 20

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.

FULL SERVICE/BEHAVIORAL HEALTH TAG

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:

- Medical 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 a 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.
- 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 outside of the Plan's service area or network.

CA Health and Safety Code section [1367.03\(a\)\(7\)](#); section [1374.72\(d\)](#); 28 CCR [1300.67.2.2\(c\)\(7\)\(C\)](#), ; 28 CCR [1300.70\(a\)\(1\)](#), (3)

FULL SERVICE/BEHAVIORAL HEALTH TAG

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have a process to arrange for covered health care services outside the Plan’s contracted network, if the service is not available in network, and is medically necessary for the enrollee’s condition? Section 1367.03(a)(7)(C); Rule 1300.67.2.2(c)(7)(C)			
1.1 Comments			
1.2 Does the Plan have a process to ensure enrollee costs for medically necessary referrals to non-network providers do not exceed applicable co-payments, co-insurance, and deductibles? Section 1367.03(a)(7)(C); Rule 1300.67.2.2(c)(7)(C)			
1.2 Comments			
1.3 Does the Plan have a process to ensure that the timeframes for obtaining out-of-network covered services are consistent with the timeframes set forth in 1367.03(a)(5) for obtaining in-network services? Section 1367.03(a)(7)(B)			
1.3 Comments			
1.4 If medically necessary treatment of a mental health or substance use disorder is not available in network within the geographic and timely access standards, does the Plan arrange coverage outside the Plan’s network to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services meet those geographic and timely access standards. Section 1367.03(a)(7)(C); Section 1374.72(d) .			
1.4 Comments			
1.5 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)			
1.5 Comments			

AA-001 - Key Element 2:

2. 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.

CA Health and Safety Code section [1367.03\(a\)\(1\)](#); 28 CCR [1300.67.2.2\(a\)\(4\), \(c\)\(1\), \(d\), \(d\)\(2\)\(D\), \(d\)\(3\)](#); 28 CCR [1300.68\(b\)\(1\), \(c\), \(e\)\(1\), \(2\)\(b\)\(1\), \(c\), \(e\)\(1\), \(2\)](#)

FULL SERVICE/BEHAVIORAL HEALTH TAG

Assessment Questions	Yes	No	N/A
2.1 Does the Plan track and monitor complaints about access to care to ensure compliance with timely access and network adequacy standards? Section 1367.03(a)(1) ; Rule 1300.67.2.2(a)(4), (c)(1), (d) ; Rule 1300.68(e)(1), (2)			
2.1 Comments			
2.2 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)			
2.2 Comments			
2.3 Does the Plan demonstrate it improves plan policies and procedures upon identification of emergent patterns of access to care grievances and implement prompt investigation and corrective action when monitoring demonstrates timely access and network adequacy have not been sufficient? Rule 1300.67.2.2(d)(2)(D), (d)(3) ; Rule 1300.68(b)(1)			
2.3 Comments			
2.4 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)(2)(D) ; Rule 1300.68(c)			
2.4 Comments			

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

FULL SERVICE/BEHAVIORAL HEALTH TAG

Requirement AA-002: Timely Access to Plan Services

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

Staff responsible for the activities described above, for example:

- Medical 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

- Plan’s policies and procedures describing triage and screening arrangements, including but not limited to the means of triage, e.g., Plan-operated, medical advice service, or provider network.
- Delegation agreements (if the Plan delegates any of these responsibilities to medical groups or management service organizations (MSO)).
- Committee meeting minutes and any referenced monitoring reports, studies, and audits (of any/all appropriate committees).
- Evidence of Corrective Action Plans (for the Plan itself or any entity to which the tasks in the assessment questions are delegated).
- Provider Manual or other methods to communicate triage requirements, if applicable, to providers.

AA-002 - Key Element 1:

1. The Plan is reasonably staffed to ensure all services offered by the Plan are accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees.

28 CCR [1300.67.2\(f\)](#)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan’s staff include both administrative and health professional staff who are responsible for authorizing the delivery of services? Rule 1300.67.2(f)			
1.1 Comments			

AA-002 - Key Element 2:

2. The Plan provides or arranges for the provision—24 hours per day, 7 days per week—of triage or screening services.

CA Health and Safety Code section [1367.03\(a\)\(1\), \(a\)\(8\)\(A\) and \(B\), \(e\)\(6\), \(f\)\(1\)](#); 28 CCR [1300.67.2.2\(b\)\(19\) and \(20\), \(c\)\(8\), \(d\)\(2\)](#)

FULL SERVICE/BEHAVIORAL HEALTH TAG

Assessment Questions	Yes	No	N/A
<p>2.1 Does the Plan demonstrate its telephone triage or screening services are provided in a timely manner, appropriate for the enrollee's condition, and consistent with the policies and procedures approved by the Department? Section 1367.03(a)(1) and (8)(A); Rule 1300.67.2.2(b)(19), (20), (c)(8), and (d)(2)</p>			
2.1 Comments			
<p>2.2 Does the Plan demonstrate its telephone triage or screening service wait time does not exceed 30 minutes? Section 1367.03(a)(8)(A) and (e)(6); Rule 1300.67.2.2(c)(8)(A)</p>			
2.2 Comments			
<p>2.3 If the Plan arranges for triage/screening via contracted network providers, does the Plan monitor the contracted network providers for compliance with screening and triage requirements, consistent with the policies and procedures approved by the Department? Section 1367.03(a)(8)(B) and (f)(1); Rule 1300.67.2.2(d)(2)</p>			
2.3 Comments			
<p>2.4 If the Plan's triage services utilize unlicensed staff to handle enrollee calls, does the Plan or contracted network provider (if applicable) have policies and procedures to ensure the unlicensed staff does not, under any circumstances, use enrollee answers to assess, evaluate, advise, or make a decision regarding the condition of an enrollee, and can the Plan demonstrate it has implemented/is following those procedures? Section 1367.03(a)(8)(B)(iii); Rule 1300.67.2.2(d)(2); Rule 1300.67.2.2(c)(8)(B)(iii)</p>			
2.4 Comments			
<p>2.5 If the Plan's triage services utilize unlicensed staff to handle enrollee calls, does the Plan or contracted network provider (if applicable) have procedures to ensure the unlicensed staff does not, under any circumstances, use enrollee answers to determine when an enrollee needs to be seen by a licensed medical professional, and can the Plan demonstrate it has implemented/is following those procedures? Section 1367.03(a)(8)(B)(iii); Rule 1300.67.2.2(c)(8)(B)(iii)</p>			
2.5 Comments			

AA-002 - Key Element 3:

3. The Plan ensures timely access to customer service representatives. 28 CCR [1300.67.2.2\(c\)\(10\)](#)

FULL SERVICE/BEHAVIORAL HEALTH TAG

3.1	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)			
3.1 Comments				
3.2	Does the Plan ensure that its customer service representatives are knowledgeable and competent regarding the enrollees' questions? Rule 1300.67.2.2(c)(10)			
3.2 Comments				

AA-002 - Key Element 4:

- 4. For Full-Service Plans Only: The Plan's call center has information to identify which in-network providers have affirmed they offer and provide gender-affirming services.**
CA Health and Safety Code section [1367.28](#)

4.1	Does the Plan's call center have accessible information that identifies which of its in-network providers have affirmed that they offer and have provided gender-affirming services? Section 1367.28			
4.1 Comments				

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

FULL SERVICE/BEHAVIORAL HEALTH TAG

Requirement AA-003: 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.
- Enrollee membership (ID) cards. (Confirm phone number for triage and screening services, or number for customer services.)
- Health Education Program description, which includes a reference to the Plan’s screening and triage processes and the Plan’s standards for timely access.
- Plan and delegate websites.
- Patient education materials regarding the accessibility of service, including screening and triage services and how to obtain those services (e.g., evidence of coverage member handbook).
- Plan reviews of delegated entities’ Health Education Programs and notification to enrollees of how to access services.

AA-003 - Key Element 1:

1. The Plan regularly informs each enrollee how to obtain services.

CA Health and Safety Code sections [1367.03\(a\)\(5\), \(8\)](#); [1367.031\(a\), \(b\), \(d\)](#); [1367.29](#); 28 CCR [1300.67\(f\)\(8\)](#); 28 CCR [1300.67.2.2\(e\)\(1\)-\(2\)](#); 28 CCR [1300.67.2\(e\), \(k\)](#)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan inform enrollees about how to obtain provider services, including timely access standards and information related to interpreter services, no less than annually? Section 1367.031(a), (b) ; Rule 1300.67.2.2(e)(1) ; Rule 1300.67.2(k)			
1.1 Comments			
1.2 Does the Plan inform enrollees how to obtain screening and triage services 24 hours per day, 7 days per week? Section 1367.03(a)(8) ; Rule 1300.67.2(k)			
1.2 Comments			

FULL SERVICE/BEHAVIORAL HEALTH TAG

1.3	Does the Plan inform enrollees of access standards for urgent and non-urgent appointment times? Section 1367.03(a)(5) ; Section 1367.031(c) ; Rule 1300.67(f)(8)		
1.3 Comments			
1.4	Does the Plan inform enrollees how to obtain emergency care? Rule 1300.67.2(e), (k)		
1.4 Comments			
1.5	Is the information provided to the enrollee pursuant to Section 1367.031 provided in the following manner: <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. Section 1367.031(d)		
1.5 Comments			
1.6	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)		
1.6 Comments			
1.7	Do enrollee ID cards include the screening and triage number or the number for customer service? Rule 1300.67.2.2(e)(2)		
1.7 Comments			
1.8	Do enrollee ID cards include information on how to access mental health services, such as 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? Section 1367.29 ; Rule 1300.67.2.2(e)(2)		
1.8 Comments			

FULL SERVICE/BEHAVIORAL HEALTH TAG

1.9 Do enrollee ID cards include: The enrollee's identification number, the name of the Health Plan, and the Plan's website address? Section 1367.29			
1.9 Comments			

End of Requirement AA-003: Enrollee Health Education

FULL SERVICE TAG

Requirement AA-004: 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.
- Systems demonstration of the Plan's provider directory.
- 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 (annual/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/provider complaints filed with the Department related to provider directories.

FULL SERVICE TAG

AA-004 - 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\(a\), \(e\)\(1\)\(A\), \(C\), \(E\), \(l\)\(1\), \(n\)\(1\),\(2\)](#)

Assessment Questions	Yes	No	N/A
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(l)(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(l)(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 (h) or (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)			

FULL SERVICE TAG

1.7 Comments			
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AA-004 - 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 sections [1367.27\(l\)\(1\)\(A\), \(B\), \(l\)\(2\)\(A\)-\(C\), \(l\)\(3\)-\(4\),\(m\)\(2\)](#) and [1367.28](#)

Assessment Questions	Yes	No	N/A
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)? <ul style="list-style-type: none"> • 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 or at least once annually? 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)			

FULL SERVICE TAG

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				
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				
2.10	For Full-Service Plans Only: Does the Plan update its provider directory or directories when an in-network provider requests its inclusion or exclusion as a provider that offers and provides gender-affirming services? Section 1367.28			
2.10 Comments				

AA-004 - 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		Yes	No	N/A
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)			

FULL SERVICE TAG

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				
3.4	Does the Plan’s public website allow provider searches by, at a minimum: <ul style="list-style-type: none"> • 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-004 – Key Element 4:

4. The Plan’s provider directory or directories contains all required information. CA Health and Safety Code section [1367.27\(h\)\(1\)-\(8\)](#) and [\(h\)\(10\)-\(12\)](#), CA Health and Safety Code section [1367.28](#)

Assessment Questions		Yes	No	N/A
4.1	Does the Plan’s directory contain the provider’s name, practitioner type, practice location or locations, and contact information? Section 1367.27(h)(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(h)(3)-(4)			
4.2 Comments				
4.3	Does the Plan’s directory include the area of specialty, including board certification (if any) as applicable to each listed provider? Section 1367.27(h)(5)			

FULL SERVICE TAG

4.3 Comments				
4.4	Does the Plan's directory include the provider's office email address, if available? Section 1367.27(h)(6)			
4.4 Comments				
4.5	Does the Plan's directory include the name of each affiliated provider group that is currently under contract with the Plan and through which the provider sees enrollees? Section 1367.27(h)(7)			
4.5 Comments				
4.6	Does the Plan's directory include, for physicians and surgeons, the provider group and admitting privileges (if any) at hospitals contracted with the Plan? Section 1367.27(h)(8)(A)			
4.6 Comments				
4.7	Does the Plan's directory contain listings for all nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers, as defined in Section 1374.73, nurse midwives, and dentists, contracted with the Plan? Section 1367.27(h)(8)(B)			
4.7 Comments				
4.8	Does the Plan's directory include the names of any contracted federally qualified health centers or primary care clinics? Section 1367.27(h)(8)(C)			
4.8 Comments				
4.9	Does the Plan's directory include, for any provider described in 4.6 and 4.7 who is employed by a federally qualified health center or primary care clinic, and to the extent their services may be accessed and are covered through the contract with the Plan, the name of the provider, and the name of the federally qualified health center or clinic? Section 1367.27(h)(8)(D)			
4.9 Comments				
4.10	Does the Plan's directory list facilities, including but not limited to general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, and inpatient rehabilitation facilities? Section 1367.27(h)(8)(E)			
4.10 Comments				

FULL SERVICE TAG

4.11	Does the Plan's directory list pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services? Section 1367.27(h)(8)(F)			
4.11 Comments				
4.12	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(h)(10)			
4.12 Comments				
4.13	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(h)(11)			
4.13 Comments				
4.14	If the Plan uses tiered networks, does the Plan's directory include the network tier to which the provider is assigned, if the provider is not in the lowest tier, as applicable? Section 1367.27(h)(12)			
4.14 Comments				
4.15	For Full-Service Plans Only: Does the directory include information that identifies which of the Plan's in-network providers have affirmed that they offer and have provided gender-affirming services? Section 1367.28			
4.15 Comments				

AA-004 - 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\(f\), \(j\)\(3\), \(m\)\(3\), \(o\)\(1\)-\(2\)](#)

Assessment Questions		Yes	No	N/A
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				

FULL SERVICE TAG

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(j)(3) and (o)(1)		
5.4 Comments			
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: <ul style="list-style-type: none"> • 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-004 - 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)

FULL SERVICE TAG

Assessment Questions	Yes	No	N/A
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			

AA-004 - 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	Yes	No	N/A
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? Section 1367.27(d)(1)			
7.1 Comments			
7.2 Does the Plan's printed directory or directories contain the provider information required by Section 1367.27(h)? Section 1367.27(d)(1)			
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? Section 1367.27(d)(1)			
7.3 Comments			
7.4 Does the Plan update its printed directory or directories at least quarterly? Section 1367.27(d)(2)			
7.4 Comments			

End of Requirement AA-004 Provider Directories

FULL SERVICE TAG

Statutory/Regulatory Citations

CA Health and Safety Code section 1367.03(a), (c), (e)(6), (f)(1)

AA-001 [KE1](#), [KE2](#)

AA-002 [KE2](#)

AA-003 [KE1](#)

(a) 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 that provides mental health services pursuant to a contract with a full service plan, shall comply with the following timely access requirements:

(1) A health care service 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. A health care service plan that uses a tiered network shall demonstrate compliance with the standards established by this section based on providers available at the lowest cost-sharing tier.

(2) A health care service plan 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 an enrollee in a timely manner appropriate for the enrollee's condition and in compliance with this section.

(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 this section and the regulations adopted thereunder.

(4) Interpreter services required by Section 1367.04 of this code and Section 1300.67.04 of Title 28 of the California Code of Regulations 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 without imposing delay on the scheduling of the appointment. This subdivision does not modify the requirements established in Section 1300.67.04 of Title 28 of the California Code of Regulations, or approved by the department pursuant to Section 1300.67.04 of Title 28 of the California Code of Regulations for a plan's language assistance program.

(5) In addition to ensuring compliance with the clinical appropriateness standard set forth in paragraph (1), a health care service 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 subparagraph (H).

(B) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in subparagraph (H).

(C) Nonurgent appointments for primary care: within 10 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

FULL SERVICE TAG

(D) Nonurgent appointments with specialist physicians: within 15 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(E) Nonurgent appointments with a nonphysician mental health care or substance use disorder provider: within 10 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(F) Commencing July 1, 2022, nonurgent followup 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 subparagraph (H). This subparagraph does not limit coverage for nonurgent followup appointments with a nonphysician mental health care or substance use disorder provider to once every 10 business days.

(G) Nonurgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within 15 business days of the request for appointment, except as provided in subparagraphs (H) and (I).

(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, as defined in subdivision (e), and periodic followup 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 subparagraph (A), (B), or (D), unless the requirements in subparagraph (H) or (I) are met, and shall be subject to the other provisions of this section.

(K) A plan may demonstrate compliance with the primary care time-elapsed standards established by this subdivision through implementation of standards, processes, and systems providing advanced access to primary care appointments, as defined in subdivision (e).

(6) In addition to ensuring compliance with the clinical appropriateness standard set forth in paragraph (1), 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) Nonurgent appointments shall be offered within 36 business days of the request for

FULL SERVICE TAG

appointment, except as provided in subparagraph (C).

(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 ratio or geographic accessibility established by Section 1300.51, 1300.67.2, or 1300.67.2.1 of Title 28 of the California Code of Regulations.

(B) A plan operating in 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-elapsing standards, by referring an enrollee to, or, in the case of a preferred provider 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 nonnetwork providers shall not exceed applicable in-network copayments, coinsurance, 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 health care service plan shall arrange coverage outside the plan's network in accordance with subdivision (d) of Section 1374.72.

(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 in subdivision (e).

(A) A plan 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, telephone medical advice services pursuant to Section 1348.8, the plan's primary care and mental health care or substance use disorder network, or another method that provides triage or screening services consistent with this section.

(i) A plan that arranges for the provision of telephone triage or screening services through network primary care, mental health care, and substance use disorder 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:

(I) Regarding the length of wait for a return call from the provider.

(II) How the caller 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

FULL SERVICE TAG

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-elapsing standards established in subparagraph (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.

(iii) An unlicensed staff person handling enrollee calls may ask questions on behalf of a licensed staff person to help ascertain the condition of an insured so that the enrollee may be referred to licensed staff. However, an unlicensed staff person shall not, under any circumstances, use the answers to those questions in an attempt to assess, evaluate, advise, or make a decision regarding the condition of an enrollee or determine when an enrollee needs to be seen by a licensed medical professional.

(9) Dental, vision, chiropractic, and acupuncture plans shall ensure that network providers employ an answering service or a telephone answering machine during nonbusiness hours, which provide 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 phone, 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 10 minutes.

...

(c) 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 subdivision (b) and paragraph (2) of subdivision (h) of Section 1375.7.

...

(e) For purposes of this section:

(6) "Triage or screening waiting time" means the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage an enrollee who may need care.

...

(f)(1) Contracts between health care service plans and health care providers shall ensure compliance with the standards developed under this chapter. These contracts shall require reporting by health care providers to health care service plans and by health care service plans to the department to ensure compliance with the standards.

FULL SERVICE TAG

CA Health and Safety Code section 1367.031(a), (b) and (d)

AA-003 [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.

...

(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](#), [KE2](#), [KE3](#), [KE4](#), [KE5](#), [KE6](#), [KE7](#)

(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).

FULL SERVICE TAG

(c)(1) An online provider directory or directories shall be available on the plan's internet website 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 website 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 website 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:

(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.

...

(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 website.

(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.

(h) A full service health care service plan and a specialized mental health plan shall include all of the following information in the provider directory or directories:

FULL SERVICE TAG

- (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.
- (5) The area of specialty, including board certification, if any.
- (6) The provider's office email address, if available.
- (7) The name of each affiliated provider group currently under contract with the plan through which the provider sees enrollees.
- (8) A listing for each of the following providers that are under contract with the plan:
 - (A) For physicians and surgeons, the provider group, and admitting privileges, if any, at hospitals contracted with the plan.
 - (B) Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers, as defined in Section 4999.200 of the Business and Professions Code, nurse midwives, and dentists.
 - (C) For federally qualified health centers or primary care clinics, the name of the federally qualified health center or clinic.
 - (D) For a provider described in subparagraph (A) or (B) who is employed by a federally qualified health center or primary care clinic, and to the extent their services may be accessed and are covered through the contract with the plan, the name of the provider, and the name of the federally qualified health center or clinic.
 - (E) Facilities, including, but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, and inpatient rehabilitation facilities.
 - (F) Pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services.
- (9) The provider directory or directories may note that authorization or referral may be required to access some providers.
- (10) Non-English language, if any, spoken by a health care provider or other medical 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.
- (11) Identification of providers who no longer accept new patients for some or all of the plan's products.
- (12) The network tier to which the provider is assigned, if the provider is not in the lowest tier, as applicable. Nothing in this section shall be construed to require the use of network tiers other than contract and noncontracting tiers.
- (13) All other information necessary to conduct a search pursuant to paragraph (2) of subdivision (c).
 - (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.

FULL SERVICE TAG

- (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 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:
 - (A) The provider is not accepting new patients.
 - (B) If the provider had previously not accepted new patients, the provider is currently accepting new patients.
 - (2) If a provider who is not accepting new patients is contacted by an enrollee or potential enrollee seeking to become a new patient, the provider shall direct the enrollee or potential enrollee to both the plan for additional assistance in finding a provider and to the department to report any inaccuracy with the plan's directory or directories.
 - (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.
- (k)(1) On or before December 31, 2016, the department shall develop uniform provider directory standards to permit consistency in accordance with subdivision (b) and paragraph (2) of subdivision (c) and development of a multiplan directory by another entity. Those standards shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), until January 1, 2021. No more than two revisions of those standards shall be exempt from the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) pursuant to this subdivision.
 - (2) In developing the standards under this subdivision, the department shall seek input from interested parties throughout the process of developing the standards and shall hold at least one public meeting. The department shall take into consideration any requirements for provider directories established by the federal Centers for Medicare and Medicaid Services and the State Department of Health Care Services.
 - (3) By July 31, 2017, or 12 months after the date provider directory standards are developed under this subdivision, whichever occurs later, a plan shall use the standards developed by the department for each product offered by the plan.

FULL SERVICE TAG

(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 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 they respond before the end of the 10-business-day notice period.

(5) General acute care hospitals shall be exempt from the requirements in paragraphs (3) and (4).

(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

FULL SERVICE TAG

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...

(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.

...

(o)(1) Whenever a health care service plan receives a report indicating that information

FULL SERVICE TAG

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 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.

CA Health and Safety Code section 1367.28

AA-002 [KE4](#)

AA-004 [KE2](#)

Within six months after the department issues guidance pursuant to paragraph (1) of subdivision (e) of Section 1367.043, and no later than March 1, 2025, a full service health care service plan shall include information within or accessible from the plan's provider directory, and accessible through the plan's call center, that identifies which of a plan's in-network providers have affirmed that they offer and have provided gender-affirming services, including, but not limited to, feminizing mammoplasty, male chest reconstruction, mastectomy, gender-confirming facial surgery, hysterectomy, oophorectomy, penectomy, orchiectomy, feminizing genitoplasty, metoidioplasty, phalloplasty, scrotoplasty, voice masculinization or feminization, hormone therapy related to gender dysphoria or intersex conditions, gender-affirming gynecological care, or voice therapy related to gender dysphoria or intersex conditions. This information shall be updated when an in-network provider requests its inclusion or exclusion as a provider that offers and provides gender-affirming services. Nothing in this act alters any business establishment's obligation to provide full and equal services to customers or patients regardless of their sex and other protected characteristics, pursuant to the Unruh Civil Rights Act (Section 51 of the Civil Code) and other applicable law.

CA Health and Safety Code section 1367.29

AA-003 [KE1](#)

(a) On and after July 1, 2011, in accordance with subdivision (b), a health care service plan that provides coverage for professional mental health services, including a

FULL SERVICE TAG

specialized health care service plan that provides coverage for professional mental health services, shall issue an identification card to an 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 if 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 a change in the enrollee's coverage that impacts the data content or format of the card.

(c) This section does not require 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) This section does not 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, 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 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.

CA Health and Safety Code section 1374.72(d)

AA-001 KE1

FULL SERVICE TAG

(d) If services for the medically necessary treatment of a mental health or substance use disorder are not available in network within the geographic and timely access standards set by law or regulation, the health care service plan shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary followup services that, to the maximum extent possible, meet those geographic and timely access standards. As used in this subdivision, to “arrange coverage to ensure the delivery of medically necessary out-of-network services” includes, but is not limited to, providing services to secure medically necessary out-of-network options that are available to the enrollee within geographic and timely access standards. The enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from an in-network provider.

28 CCR 1300.67(f)(8)

AA-003 [KE1](#)

...

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

...

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

28 CCR 1300.67.2 (e)-(f), (k)

AA-002 [KE1](#) **AA-003** [KE1](#)

(a) The definitions set forth in Rule 1300.67.2.2(b), and the documents incorporated therein, are applicable to this section and shall apply to the plan's requirement to meet network adequacy with respect to all required filings, including those specified in Health and Safety Code sections 1352, 1367.03, 1367.035, 1371.31, 1374.141 and Rules 1300.51, 1300.52, 1300.52.4, and 1300.67.2.1.

...

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

(f) The ratio of enrollees to staff within a network, including physicians and other 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. The ratio standards established in this section set forth minimum standards of accessibility that a plan must meet in order to establish network adequacy. A plan must arrange for a greater number of providers or additional provider types within its network, if necessary to reasonably assure that all covered services will be accessible to enrollees

FULL SERVICE TAG

on an appropriate basis without delays detrimental to the health of the enrollee.

...

(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(a)(4), (b)(19)-(20), (c)(1) (6)-(8) and (10), (d)(2)-(3), (e)(1)-(2),

AA-001 [KE1](#), [KE2](#)

AA-002 [KE2](#), [KE3](#)

AA-003 [KE1](#)

(a)Application.

...

(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 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.

...

(b) Definitions.

For purposes of this section, the following definitions apply.

...

(19) "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 their 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.

(20) "Triage or screening waiting time" means the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within their scope of practice and who is trained to screen or triage an enrollee who may need care.

...

(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.

...

(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

FULL SERVICE TAG

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-elapsing 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 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

FULL SERVICE TAG

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.

...

(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.

Effective January 1, 2023, each plan shall have written quality assurance systems, policies, and procedures designed to ensure that the plan's network is sufficient to provide accessibility, availability, and continuity of covered health care services as required by the Knox-Keene Act and this Rule. In addition to the requirements established by Rule 1300.70, a plan's quality assurance program shall address:

...

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

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

(i) Subsections (c)(1)-(4), (c)(5)(H)-(K), (c)(6), and (c)(8)-(10) of this Rule, except as provided by subsection (d)(2)(F) of this Rule;

FULL SERVICE TAG

- (ii) Subsection (c)(7) of this Rule; and
 - (iii) Subsection (c)(5)(A)-(G) of this Rule by administering the Provider Appointment Availability Survey, pursuant to subsection (f) of this Rule.
- (B) Conducting an annual Enrollee Experience Survey. The Enrollee Experience Survey shall:
- (i) Be conducted in accordance with a statistically valid and reliable survey methodology.
 - (ii) Obtain enrollees' perspectives and concerns regarding their experience obtaining health care services within the standards set forth in subsection (c) of this Rule.
 - (iii) Inform enrollees of their right to obtain an appointment within each of the time-elapsing standards set forth in subsections (c)(1) and (5) of this Rule, and their right to receive interpreter services at that appointment, as required by subsection (c)(4) of this Rule. The requirement to notify enrollees who are surveyed about their right to obtain a timely appointment shall be in addition to the notice requirements set forth in section 1367.031 of the Knox-Keene Act. The notice may be included in the survey or in a document attached to the survey.
 - (iv) Evaluate the experience of limited English proficient enrollees in obtaining interpreter services by obtaining the enrollee's perspectives and concerns regarding:
 - a. Coordination of appointments with an interpreter;
 - b. Availability of interpreters who speak the enrollee's preferred language; and
 - c. Quality of interpreter services received.
 - (v) Be translated into the enrollee's preferred language, in those situations where:
 - a. The plan is aware of the enrollee's preferred language; and
 - b. The enrollee's preferred language is one of the top 15 languages spoken by limited English proficient individuals in California as determined by the Department of Health Care Services.
- (C) Conducting an annual Provider Satisfaction Survey, which shall be conducted in accordance with a statistically valid and reliable survey methodology and designed to obtain, from physicians and non-physician mental health providers, perspectives and concerns regarding compliance with the standards set forth in subsection (c). In addition, the Provider Satisfaction Survey shall evaluate provider perspectives and concerns with the plan's language assistance program regarding:
- (i) Coordination of appointments with an interpreter;
 - (ii) Availability of an interpreter, based on the needs of the enrollee; and
 - (iii) The ability of the interpreter to effectively communicate with the provider on behalf of the enrollee.
- (D) The plan's process for reviewing and evaluating, on not less than a quarterly basis, all the information available to the plan regarding the plan's ability to meet timely access compliance and network adequacy requirements set forth under the Knox-Keene Act, including accessibility, availability, continuity of care, and network capacity requirements. The plan's review and evaluation shall include, at a minimum, the information from its quality assurance processes required under sections 1367, 1367.03, 1370 of the Knox-Keene Act, and Rules 1300.67.2, 1300.67.2.2, 1300.68, and 1300.70. The plan's process for reviewing and evaluating available information shall ensure that enrollees have access to the full range of covered services through an adequate network, as required under this

FULL SERVICE TAG

Rule, and sections 1367, 1367.03, 1367.035, and 1375.9 of the Knox-Keene Act, and Rules 1300.51(d), items H., I., and J., and 1300.67.2.

(E) Verifying, at least once every three years, the advanced access programs reported by network providers and provider groups by confirming that appointments are scheduled consistent with the definition of advanced access in subsection (b)(1). The plan shall require network providers to give written notice to the plan no later than 30 calendar days immediately following the date upon which a network provider no longer provides advanced access appointments to enrollees. The plan shall also review the available information related to access and availability for providers offering advanced access appointments, including enrollee grievances and appeals, pursuant to subsection (d)(2)(D) of this Rule.

(F) A plan that provides services through a preferred provider organization line of business may, for that product line, demonstrate compliance with the timely access and continuity of care requirements of subsection (d)(2)(A)(i) of this Rule by monitoring, on not less than an annual basis: enrollee grievances and appeals regarding timely access; the results of the Provider Appointment Availability Survey; the results of the Enrollee Experience Survey; and the results of the Provider Satisfaction Survey. This subsection does not exempt a plan that provides services through a preferred provider organization line of business from all other requirements set forth in subsection (d)(2).

(3) A plan's process for documenting and implementing prompt investigation and corrective action when compliance monitoring discloses that the plan's network is not sufficient to ensure timely access and network adequacy as required by this Rule. A plan's quality assurance process shall ensure the plan takes all necessary and appropriate action to identify the cause(s) underlying identified timely access and network adequacy deficiencies and to bring its network into compliance. A plan shall give advance written notice to all network 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.

(e) Enrollee Disclosure and Education.

(1) A plan shall disclose in all Evidences of Coverage the availability of triage or screening services and how to obtain those services. A plan shall disclose standards for timely access in the manner required under section 1367.031 of the Knox-Keene Act.

(2) The telephone number at which enrollees can access triage and screening services shall be included on enrollee membership cards. A plan or its delegated provider group may comply with this requirement through an additional selection in its automated customer service telephone answering system, where applicable, so long as the customer service number is included on the enrollee's membership card.

28 CCR 1300.68

AA-001 KE2

...

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

FULL SERVICE TAG

(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.

28 CCR 1300.70(a)(1) and (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.