

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

TECHNICAL ASSISTANCE GUIDE

ACCESS AND AVAILABILITY OF SERVICES

ROUTINE MEDICAL SURVEY

OF

PLAN NAME

DATE OF SURVEY:

PLAN COPY

Issuance of this September 1, 2022 Technical Assistance Guide renders all other versions obsolete.

FULL SERVICE TAG

ACCESS AND AVAILABILITY OF SERVICES

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

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Requirement AA-001: Provider Network Adequacy

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

Staff responsible for the activities described above, for example:

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

DOCUMENTS TO BE REVIEWED

- Plan's most recent Exhibit I-4 (Calculation of Provider-Enrollee Ratios) and I-5 ((a) Access and Availability Policies and (b) Requests for Alternative Geographic Access Standards) approved by the Department.
- Record of periodic review of the standards for the number and distribution of primary care providers within the service area, including minutes of relevant Committee meetings (QM Committee, Public Policy Committee, etc.)
- Documents describing how the Plan monitors for compliance with network standards.
- Corrective action plans for areas where access does not meet the standards.
- Evidence of follow-up on CAPs

AA-001 - Key Element 1:

1. The Department has approved the Plan's standards for the geographic distribution of primary care providers (PCPs) and PCP to enrollee ratio requirements, and the Plan is monitoring for compliance with the approved standards.

CA Health and Safety Code section 1375.9(a); 28 CCR 1300.51(d)(H)(I); 28 CCR 1300.67.2(d) and (f); 28 CCR 1300.67.2.1(a); 28 CCR 1300.67.2.2(d)(2) and (3); 28 CCR 1300.70(a)(1) and (3).

Assessment Questions	
1.1	If the Plan has established an alternative standard (other than 15 miles or 30 minutes) for the geographic distribution of PCPs, has this standard been approved by the Department via the filing of a material modification? Rule 1300.51(d)(H)(I); Rule 1300.67.2.1(a)
1.2	Does the Plan document the monitoring of its PCP network to ensure compliance with approved time and distance standards (15 miles or 30 minutes or approved alternative standards) in accordance with the policies and procedures approved by the Department? Rule 1300.51(d)(H)(I); Rule 1300.67.2(f); Rule 1300.67.2.1(a); Rule 1300.67.2.2(d)(2); Rule 1300.70(a)(1) and (3)

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1.3	<p>Can the Plan demonstrate it is monitoring for compliance with the one full-time equivalent (FTE) PCP for each 2000 enrollees standard in accordance with its policies and procedures?</p> <p>Note: The ratio may be increased by up to 1000 additional enrollees for each FTE non-physician medical practitioner (e.g., nurse practitioner) supervised by that PCP.</p> <p>Section 1375.9(a); Rule 1300.51(d)(H)(I); Rule 1300.67.2.1(a); Rule 1300.67.2(d) and (f); Rule 1300.67.2.2(d)(2); Rule 1300.70(a)(1 and (3)</p>
1.4	<p>Can the Plan demonstrate it has implemented corrective action and follow-up when monitoring activities indicate the plan is out of compliance with time and distance or ratio standards?</p> <p>Rule 1300.67.2.2(d)(3); Rule 1300.70(a)(1) and (3)</p>

AA-001- Key Element 002:

- 2. The Plan monitors its network to ensure an adequate network of specialists, ancillary care providers, and ratio of physicians to enrollees. If health care services (including specialists and ancillary care) are unavailable in the service area or network, the Plan has a process to arrange for medically necessary services outside of the Plan's network or service area.**
- Health and Safety Code section 1367.03(a)(1) and (7); 28 CCR 1300.51 (d)(I)(4) and (6); 28 CCR 1300.67.2; 28 CCR 1300.67.2.2(d)(2) and (3) and (c)(7)(C); 28 CCR 1300.70(a)(1) and (3).**

Assessment Questions	
2.1	<p>Can the Plan demonstrate it is monitoring its specialist and ancillary care networks, in accordance with the standards, policies and procedures approved by the Department?</p> <p>Section 1367.03(a)(1) and (7); Rule 1300.51(d)(I)(5); Rule 1300.67.2(e) and (f); Rule 1300.67.2.2(d)(2)</p>
2.2	<p>Does the Plan have a process to arrange for specialty health care services outside the Plan's contracted network, if the service is not available in network, and medically necessary for the enrollee's condition?</p> <p>Section 1367.03(a)(7)(B)</p>
2.3	<p>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?</p> <p>Section 1367.03(a)(7)(B); Rule 1300.51(d)(I)(6); Rule 1300.67.2; Rule 1300.67.2.2(c)(7)(C)</p>
2.4	<p>Does the Plan have a process to ensure that the timeframes for obtaining out-of-network specialty services are consistent with the timeframes for obtaining in-network specialty services?</p> <p>Section 1367.03(a)(7)(B)</p>

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2.5	If the Plan operates in a service area that has a shortage of any type of providers, does the Plan refer enrollees to, or, in the case of a preferred provider network, assist the enrollee to locate available and accessible contracted providers in neighboring service areas? Section 1367.03(a)(7)(B)
2.6	Can the Plan demonstrate it is monitoring for compliance with the one FTE physician for each 1200 enrollees ratio/standard, in accordance with its policies and procedures? Rule 1300.51(d)(l)(4); Rule 1300.67.2(d) and (f); Rule 1300.67.2.2(d)(2); Rule 1300.70(a)(1) and (3)
2.7	Can the Plan demonstrate it implements corrective action and follow-up when monitoring activities indicate the Plan is out of compliance with the physician to enrollee ratio requirement? Rule 1300.67.2.2(d)(3); Rule 1300.70(a)(1) and (3)

AA-001 - Key Element 3:

- 1. The Department has approved the Plan's standards for the geographic distribution of hospitals and the Plan is monitoring for compliance with the approved standards.
28 CCR 1300.51(d)(H)(l); 28 CCR 1300.67.2(f); 28 CCR 1300.67.2.1(a); 28 CCR 1300.67.2.2(d)(2) and (3); 28 CCR 1300.70(a)(1) and (3).**

Assessment Questions	
3.1	Can the Plan demonstrate it is monitoring its network of hospitals to ensure compliance with approved time and distance standards (15 miles/30 minutes or approved alternative standards) in accordance with the policies and procedures approved by the Department? Rule 1300.51(d)(H)(l); Rule 1300.67.2.1(a); Rule 1300.67.2(f); Rule 1300.67.2.2(d)(2); Rule 1300.70(a)(1) and (3)
3.2	Can the Plan demonstrate it has implemented corrective action and follow-up when monitoring activities indicate the Plan is out of compliance with hospital time and distance standards? Rule 1300.67.2.2(d)(3); Rule 1300.70(a)(1) and (3)

End of Requirement AA-001: Provider Network Adequacy

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Requirement AA-002: Timely Access to Plan Services

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

Staff responsible for the activities described above, for example:

- Medical Director
- QM 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, 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
- Timely Access Policies and Procedures (Exhibit J-13) and Standards of Accessibility (Exhibit I-5)

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(d)**

Assessment Question	
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(d)

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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)(iii), (e)(6) and (f)(1); 28 CCR 1300.67.2.2.(b)(19), (20), (c)(8), and (d)(2).

Assessment Questions	
2.1	Did 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)
2.2	Did 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)
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) and (f)(1); Rule 1300.67.2.2(d)(2)
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 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)
2.5	If the Plan's triage services utilize unlicensed staff to handle enrollee calls, does the Plan or contracted network provider 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)

AA-002 - Key Element 3:

3. The Plan ensures timely access to customer service representatives.
28 CCR 1300.2.2(c)(10).

Assessment Question	
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)

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

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Requirement AA-003: Access to Care

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

Staff responsible for the activities described above, for example:

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

DOCUMENTS TO BE REVIEWED

- Timely Access Policies and Procedures (Exhibit J-13)
- Appointment availability studies
- Policies and procedures designed to ensure that the Plan's provider network is sufficient to provide accessibility, availability and continuity of covered health care services consistent with the Act.
- Compliance monitoring policies and procedures, previously filed with the Department, designed to accurately measure the accessibility and availability of contracted providers, which shall include:
 - Tracking and documenting network capacity and availability
 - Annual Enrollee and provider surveys
 - Not less than quarterly review and evaluation of information available regarding access, availability and continuity of care, grievances/ appeals, screening/ triage services, enrollee/ provider survey results.
- Policies and procedures for verifying advanced access programs reported by contracted provider groups, medical groups and IPAs to confirm appointments are scheduled consistent with the definition of advanced access.
- If Plan provides services through PPO, annual monitoring policies for the number of PPO primary and specialty Physicians in each county of the Plan's service area, G&A regarding timely access and rates of compliance with time elapsed standards.
- Provider waiting time studies.
- Enrollee and provider surveys designed to solicit from enrollees, providers and non-Physician mental health providers, concerns regarding compliance with the standards set forth in subsection (c) (standards for timely access).
- Reports on complaint and grievances.
- Telephone access studies from the Plan's telephone system or other methodologies (such as anonymous "mystery shopper" or random calling at various times and dates).
- Committee or applicable subcommittee minutes, prior two years.
- Corrective action plans and re-measurement of appointment availability to assure improvements are sustained.
- Corrective action plans when compliance monitoring discloses that the Plan's provider network is not sufficient to ensure timely access.
- Policies and procedures to confirm the Plan provides advance notice to all contracted providers affected by a corrective action plan, and includes: a

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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.

- Licensing filing(s) of the Plan’s access standards and confirm submission of appropriate policies and procedures
- Documents that demonstrate how the Plan ensures that appropriate mental health services are available without delays detrimental to the health of the enrollees.

AA-003 - Key Element 1:

1. **Each health care service plan shall have a system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments. CA Health and Safety Code 1367.03(a)(1), (5)(A)-(G), and (e)(1); 28 CCR 1300.67.2.2(c)(1), (d)(2)(D), and (d)(3); 28 CCR 1300.67.2.3(a)(2)(D)-(E); (a)(3).**

Assessment Questions	
1.1	Does the Plan rely on systems that provide advanced access to primary care appointments? Section 1367.03(a)(5)(K), (e)(1)
1.2	Does the Plan verify the Advanced Access Programs reported by contracted providers, medical groups and IPAs to confirm that appointments are scheduled consistent with the definition of advanced access? Section 1367.03(a)(5)(K), (e)(1); Rule 1300.67.2.3(a)(2)(E)
1.3	Does the Plan provide or arrange for the provision of covered services in a timely manner appropriate for the nature of the enrollee’s condition and in a manner consistent with good professional practice? Section 1367.03(a)(1); Rule 1300.67.2.2(c)(1)
1.4	Does the Plan monitor compliance with time elapsed appointment standards defined in section 1367.03(a)(5), ensuring that its contracted provider network has adequate capacity and availability of appointments? Section 1367.03(a)(5)
1.4.1	Does the Plan ensure adequate capacity and availability of urgent care appointments that do not require prior authorization within 48 hours and urgent care appointments that require prior authorization within 96 hours? Section 1367.03(a)(5)(A)-(B)
1.4.2	Does the Plan ensure adequate capacity and availability of non-urgent primary care appointments within 10 business days? Section 1367.03(a)(5)(C)
1.4.3	Does the Plan ensure adequate capacity and availability of non-urgent specialty appointments within 15 business days? Section 1367.03(a)(5)(D)

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1.4.4	Does the Plan ensure adequate capacity and availability of non-urgent appointments with nonphysician mental health care or substance use disorder provider within 10 business days? Section 1367.03(a)(5)(E)
1.4.5	Does the Plan ensure adequate capacity and availability of non-urgent follow-up appointments with nonphysician mental health care or substance use disorder provider within 10 business days of prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition? Section 1367.03(a)(5)(F)
1.4.6	Does the Plan ensure adequate capacity and availability of non-urgent appointments for ancillary services , including laboratory services, for diagnosis or treatment within 15 days? Section 1367.03(a)(5)(G)
1.5	Did the Plan demonstrate it reviews and evaluates data about access and availability on at least a quarterly basis? Rule 1300.67.2.2(d)(2)(D)
1.6	Did the Plan demonstrate it reviews and evaluates data about continuity of care on at least a quarterly basis? Rule 1300.67.2.2(d)(2)(D)
1.7	Did the Plan demonstrate its quarterly review of access/availability and continuity of care includes all information available to the plan regarding the plan's ability to meet timely access compliance and network adequacy requirements? Rule 1300.67.2.2(d)(2)(D); Rule 1300.67.2.3(a)(2)(D)
1.8	When the Plan's compliance monitoring reveals its network is not sufficient to ensure timely access, does it promptly investigate the cause and take action to bring its network into compliance? Rule 1300.67.2.2(d)(3); Rule 1300.67.2.3(a)(3)
1.9	When the Plan implements corrective action, does it confirm the corrective action brought the Plan's network into compliance Rule 1300.67.2.2(d)(3); Rule 1300.67.2.3(a)(3)
1.10	When the Plan implements corrective action, does it give advance written notice to all contracted providers affected by the Corrective Action Plan (CAP)? Rule 1300.67.2.2(d)(3); Rule 1300.67.2.3(a)(3)
1.11	Did the notice to affected providers, if applicable, include the following: 1. Description of identified deficiencies; 2. Rational for the CAP; and 3. Name and telephone number of person authorized to respond to provider concerns regarding the Plan's CAP? Rule 1300.67.2.2(d)(3); Rule 1300.67.2.3(a)(3)

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AA-003 - Key Element 2:

2. Each full service plan offering coverage for dental services shall ensure that contracted dental provider networks have adequate capacity and availability of licensed health care providers to offer enrollees appointments in accordance with requirements.
CA Health and Safety Code section 1367.03(a)(1), (6), (7); 28 CCR 1300.67.2.2(a)(2), (c)(6), (7) and (d)(2).

Assessment Questions	
2.1	Does the Plan monitor compliance with time elapsed appointment standards for dental services as defined in section 1367.03(a)(6)(A)-(C): 1. Urgent appointments within network within 72 hours of the time of the request. 2. Non-urgent appointment within network within 36 business days of the request. 3. Preventive dental care appointments shall be offered within 40 business days of the request. Section 1367.03(a)(1), (6), (7); Rule 1300.67.2.2(c)(6) and (7); Rule 1300.67.2.2(d)(2)
2.2	Does the Plan include monitoring adherence to access and availability and appointment wait times of the dental provider in the QA Program? Rule 1300.67.2.2(a)(2); Rule 1300.67.2.2(d)(2)

End of Requirement AA-003: Access to Care

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Requirement AA-004: Enrollee Health Education

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

Staff responsible for the activities described above, for example:

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

DOCUMENTS TO REVIEW

- Policies and procedures of the Health Education Program.
- Enrollee membership cards, confirm phone number for triage and screening services, or number for customer services.
- If applicable, listen to automated customer service telephone answering system, and the selection for screening and triage services.
- Health Education Program description which includes a reference to the 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., certificate of coverage member handbook.)
- Plan reviews of delegated entities' Health Education Programs and notification to enrollees of how to access services.

AA-004 - Key Element 1:

1. **The Plan regularly informs each enrollee how to obtain services. If delegated, the Plan must ensure the delegated entity informs enrollees how to access services.**

CA Health and Safety Code section 1367.03 (a)(1) and (8); CA Health and Safety Code section 1367.031(a), (b), and (d); CA Health and Safety Code section 1367.29; 28 CCR 1300.67.2.2(e)(1)-(2) and (g).

Assessment Questions	
1.1	Does the Plan inform enrollees about how to obtain provider services, including timely access standards? Rule 1300.67.2.2(e)(1); Rule 1300.67.2(g)
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(g)
1.3	Does the Plan inform enrollees of access standards for urgent and non-urgent appointment times? Section 1367.03(a)(1) and (5); Rule 1300.67.2(g)

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1.4	Does the Plan inform enrollees how to obtain emergency care? Rule 1300.67.2(g)
1.5	Does the Plan communicate timely access standards to enrollees? Section 1367.031(a), (b) and (d)
1.6	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	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	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; Rule 1300.67.2.2(e)(2)

End of Requirement AA-004: Enrollee Health Education

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Requirement AA-005: Provider Directories and 10% Network Change Reporting

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

Staff responsible for the activities described below, for example:

- Director of Contracting/Provider Relations
- Director of Quality Assurance (QA) and/or other persons responsible for QA.
- Individuals Responsible for AA survey/data analysis
- Individuals who can provide a systems demonstration to the Department (upon request)

DOCUMENTS TO BE REVIEWED

- Online version of the Plan's Provider Directory.
- Plan's Provider Directory Policies and Procedures (Exhibit J-14) and any other policies and procedures relevant to the update of contact information for contracted providers and the Plan's process for updating the Provider Directory.
- 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 and when responses were received.)
- Plan's log or list of all reports of inaccuracies received by the Plan, through online interface, email, and telephone.
- Evidence the Plan suppressed providers who failed to respond to the required notice in a timely manner.
- 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 contents when changes are submitted by providers and when investigations determine contents are inaccurate.
- Provider Directory Vendor contract (if applicable.)
- Amendment filings reflecting a 10% change in network(s).
- QA/AA 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.
- The Department may request a systems demonstration (onsite or remotely via webinar) for the routine survey.

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AA-005 – Key Element 1:

- 1. The Plan has adequate processes to ensure the accuracy of the information in the provider directory.**
CA Health and Safety Code section 1367.27(a), (e)(1)(A)-(C), (E), (l)(1), (n)(1)(2).

Assessment Questions	
1.1	Does the plan take appropriate steps to ensure the accuracy of the information concerning each provider listed in the Plan's provider directory or directories per Section 1367.27? Section 1367.27(l)(1)
1.2	Does the Plan review and update the entire directory or directories for each product offered, at least annually? Section 1367.27(l)(1)
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)
1.4	Is the Plan's online 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)
1.5	Is the Plan's online directory or directories updated at least weekly when informed of changes/upon confirmation that a provider is no longer accepting new patients for that product or an individual provider within a provider group is no longer accepting new patients? Section 1367.27(e)(1)(A)
1.6	Is the Plan's online directory or directories updated at least weekly when informed of changes/upon confirmation that any other information that affects the content or accuracy is inaccurate? Section 1367.27(e)(1)(E)
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 1367.27, how does the Plan retain responsibility for ensuring 1367.27 is satisfied? (i.e., how does the Plan monitor and oversee compliance) Section 1367.27(n)(1)-(2)

AA-005 - Key Element 2:

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

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Assessment Questions	
2.1	Does the Plan have a process to allow providers to promptly verify or submit changes to its directory information, including an online interface? Section 1367.27(m)(2)
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)
2.3	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)
2.4	Does the Plan notify its contracted providers every 6 months or at least once annually? Section 1367.27(l)(1)(A)-(B)
2.5	Does the Plan require an affirmative response from providers acknowledging the notification was received? Section 1367.27(l)(3)
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)
2.7	If the Plan does not receive an affirmative response and confirmation 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)
2.8	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)
2.9	Does the Plan ensure providers who do not respond are not included in the next required update of the provider directory? Section 1367.27(l)(4)

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AA-005 - Key Element 3:

3. The Full Service Health Plan properly maintains its online provider directory. Health and Safety Code section 1367.27(b) and (c).

Assessment Questions	
3.1	Is an online provider directory or directories available on the Plan's website? Section 1367.27(c)
3.2	Is the Plan's online directory or directories available to the public, potential enrollees, enrollees, and providers without any restrictions or limitation? Section 1367.27(c)(1)
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)
3.4	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)

AA-005 – Key Element 4:

4. The Plan's provider directory or directories contains all the required information. CA Health and Safety Code section 1367.27(h)(1)-(8) and (h)(10)-(12).

Assessment Questions	
4.1	Does the Plan's directory contain the provider's name, practitioner type, practice location or locations, and contact information? Section 1367.27(h)(1)-(2)
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)
4.3	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)

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4.4	Does the Plan's directory include the provider's office email address, if available? Section 1367.27(h)(6)
4.5	Does the Plan's directory include the name of each affiliated provider group currently under contract with the Plan through which the provider sees enrollees? Section 1367.27(h)(7)
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)
4.7	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)
4.8	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)
4.9	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)
4.10	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)
4.11	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)
4.12	Does the Plan's directory identify 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? Section 1367.27(h)(10)
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)
4.14	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)

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AA-005 - Key Element 5:

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

CA Health and Safety Code Section 1367.27(f), (j)(3), (m)(3) and (o)(1)-(2).

Assessment Questions	
5.1	Does the Plan have a telephone number and dedicated email address to receive reports of a potential directory inaccuracy? Section 1367.27(m)(3)
5.2	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)
5.3	Does the Plan have an electronic form to receive reports of a potential directory inaccuracy? Section 1367.27(m)(3)
5.4	Does the Plan's provider directory and website prominently display the hyperlink to report a potential directory inaccuracy? Section 1367.27(m)(3)
5.5	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)
5.6	Can the Plan provide evidence that its investigation includes contacting the affected provider within five business days? Section 1367.27(o)(2)
5.7	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)
5.8	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)
5.9	For printed provider directories, is the change made no later than the next required update? Section 1367.27(o)(2)

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AA-005 - Key Element 6:

- 6. The Plan's provider directory contains the required enrollee disclosures.
CA Health and Safety Code Section 1367.27(g)(1)-(2)**

Assessment Questions	
6.1	Does the Plan's provider directory or directories include a statement informing enrollees that they are entitled to language interpreter services at no cost, including information on how to obtain interpretation services? Section 1367.27(g)(1)
6.2	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)

AA-005 - Key Element 7:

- 7. The Plan properly updates and distributes its printed provider directory to enrollees.
CA Health and Safety Code Section 1367.27(d)(1) and (2).**

Assessment Questions	
7.1	Can a printed copy of the Plan's directory or directories be requested by enrollees, potential enrollees, providers, and members of the public via the Plan's toll-free telephone number, electronically, or in writing? Section 1367.27(d)(1)
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)
7.3	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)

AA-005 - Key Element 8:

- 8. The Plan monitors changes in names to the provider network and file updates with the Department, as required.
Section 1367.27(r); Rule 1300.52(f); Rule 1300.67.2.2(d)(2).**

Assessment Question	
8.1	Does the Plan monitor for a 10 percent change in the networks for a product in a region, and if determined, does the Plan file an amendment with the Department? Section 1367.27(r); Rule 1300.52(f); Rule 1300.67.2.2(d)(2)

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End of Requirement AA-005: Provider Directories and 10% Network Change Reporting

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Statutory/Regulatory Citations

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

(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 provider 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 contracted provider 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).

(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

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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 follow-up 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 follow up care, including standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac, mental health, or substance use disorder conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of their practice.

(J) A referral to a specialist by a primary care provider or another specialist shall be subject to the relevant time-elapsed standard in 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 contracted dental provider 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 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 contracted providers to maintain

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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 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 contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. A plan shall arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network if medically necessary for the enrollee's condition. Enrollee costs for medically necessary referrals to nonnetwork providers shall not exceed applicable 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 contracted 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 contracted 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 contracted primary care and mental health care or substance use disorder provider 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 contracted 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 needed, deliver urgent or emergency care.

(ii) A plan that arranges for the provision of triage or screening services through contracted 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

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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 contracted 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.

...

(e) For purposes of this section:

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

...

(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.

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

(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 1367.032, 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.

...

(d) The information required to be provided pursuant to this section shall be provided to an

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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 (l)(1)(A)-(B), (l)(2)(A)-(C), (l)(3)-(4) and (m)(2)

- (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

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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 he or she responds before the end of the 10-business-day notice period.

...

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

...

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

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

CA Health and Safety Code section 1367.29

(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 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

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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 TRICARE 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 1375.9(a)

(a) A health care service plan shall ensure that there is at least one full-time equivalent primary care physician for every 2,000 enrollees of the plan. The number of enrollees per primary care physician may be increased by up to 1,000 additional enrollees for each full-time equivalent nonphysician medical practitioner supervised by that primary care physician.

28 CCR 1300.51(d)(H)(I)

...

(d) Exhibits to Plan Application.

...

H. Geographical Area Served.

NOTE: The applicant is required to demonstrate that, throughout the geographic regions designated as the plan's Service Area, a comprehensive range of primary, specialty,

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institutional and ancillary services are readily available at reasonable times to all enrollees and, to the extent feasible, that all services are readily accessible to all enrollees.

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

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

(i) Primary Care Providers. All enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated primary care provider in such numbers and distribution as to accord to all enrollees a ratio of at least one primary care provider (on a full-time equivalent basis) to each 2,000 enrollees.

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

(iii) Hospital Staff Privileges. In the case of a full-service plan, there is a complete network of contracting or plan-employed primary care physicians and specialists each of whom has admitting staff privileges with at least one contracting or plan-operated hospital equipped to provide the range of basic health care services the plan has contracted to provide.

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

1. Description of Service Area. As Exhibit H-1, attach a narrative description of the applicant's service area and the geographic area in which its enrollees (actual and/or projected) live and work and list all U.S. Postal ZIP Code numbers included in the service areas. If the applicant has more than one service area, each service area should be separately described. To the extent possible, service areas should be delineated by political or natural boundaries. (If applicant uses sub-service areas or regions within its service areas for the purpose of allocating the provision of health care services by providers to enrollees, include that information in the description of the considerations which underlie the geographic distribution of the applicant's contracting and plan-operated providers.)

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28 CCR 1300.52(f)

(f) A list furnished pursuant to Items 13A, 13C or 24D of the old application or Item I-1, I-2 or I-3 of the new application need be amended only when 10 percent or more of the names contained in the list for a service area have been changed. When amended, the complete list (or the list for the service area) shall be furnished following the instructions for the particular item, with each added item “redlined” and the names of persons deleted from the list shown at the end under the heading “deletions.”

28 CCR 1300.67.2

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

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

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

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

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

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

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

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

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

28 CCR 1300.67.2.1(a)

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

(a) If, given the facts and circumstances with regard to any portion of its service area, a plan’s standards of accessibility adopted pursuant to Item H of Section 1300.51 and/or Section 1300.67.2 are unreasonably restrictive, or the service area is within a county with

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a population of 500,000 or fewer, and is within a county that, as of January 1, 2002, has two or fewer full service healthcare service plans in the commercial market, the plan may propose alternative standards of accessibility for that portion of its service area. The plan shall do so by including such alternative standards in writing in its plan license application or in a notice of material modification. The plan shall also include a description of the reasons justifying the less restrictive standards based on those facts and circumstances. If the Department rejects the plan's proposal, the Department shall inform the plan of the Department's reason for doing so.

28 CCR 1300.67.2.2.(b)(19)-(20), (c)(1) (6)-(8) and (10), (d)(2)-(3), (e)(1)-(2), (g)

...

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

...

(6) In addition to ensuring compliance with the clinical appropriateness standard set forth at subsection (c)(1), each dental plan, and each full service plan offering coverage for dental services, shall ensure that contracted dental provider 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, when 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); and

(C) Preventive dental care appointments shall be offered within 40 business days of the request for appointment.

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

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(A) This section does not modify the requirements regarding provider-to-enrollee ratio or geographic accessibility established by Sections 1300.51, 1300.67.2 or 1300.67.2.1 of Title 28.(B) A plan operating in a service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsing standards, by referring enrollees to, or, in the case of a preferred provider network, by assisting enrollees to locate, available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. Plans shall arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network, when medically necessary for the enrollee's condition. Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

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

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

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

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

a. Regarding the length of wait for a return call from the provider; and
b. How the caller may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

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

3. Unlicensed staff persons handling enrollee calls may ask questions on behalf of a licensed staff person in order to help ascertain the condition of an enrollee so that the enrollee can be referred to licensed staff. However, under no circumstances shall unlicensed staff persons use the answers to those questions in an attempt to assess,

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

...

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

...

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

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

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

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

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

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

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

(3) A plan shall implement prompt investigation and corrective action when compliance monitoring discloses that the plan's provider network is not sufficient to ensure timely access as required by this section, including but not limited to taking all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance. Plans shall give advance written notice to all

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contracted providers affected by a corrective action, and shall include: a description of the identified deficiencies, the rationale for the corrective action, and the name and telephone number of the person authorized to respond to provider concerns regarding the plan's corrective action.

(e) Enrollee Disclosure and Education

(1) Plans shall disclose in all evidences of coverage the availability of triage or screening services and how to obtain those services. Plans shall disclose annually, in plan newsletters or comparable enrollee communications, the plan's standards for timely access.

(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.

...

(g) Filing, Implementation and Reporting Requirements.

(1) Not later than twelve months after the effective date of this section, plans shall implement the policies, procedures and systems necessary for compliance with the requirements of Section 1367.03 of the Act and this section. Not later than nine months after the effective date of this section, each plan shall file an amendment pursuant to Section 1352 of the Act disclosing how it will achieve compliance with the requirements of this section, which shall include substantiating documentation, including but not limited to, quality assurance policies and procedures, survey forms, subscriber and enrollee disclosures, and amendments to provider contracts. The amendment shall also include documentation sufficient to confirm the plan's compliance, as of the date of filing, with existing requirements regarding physician-to-enrollee ratios, including but not limited to updated Exhibits I-1 and I-4 to the plan's license application. If a plan asserts prior Department approval of alternative physician-to-enrollee ratios or an alternative method of demonstrating network adequacy, the filing shall contain confirming documentation. A plan may concurrently request approval of alternative physician-to-enrollee ratios or an alternative method of demonstrating network adequacy by filing a notice of material modification pursuant to section 1300.67.2.1 of Title 28.

(2) By March 31, 2012, and by March 31 of each year thereafter, plans shall file with the Department a report, pursuant to subsection (f)(2) of Section 1367.03 of the Act, regarding compliance during the immediately preceding year. The first reporting period shall be the calendar year ending December 31, 2011. The reports shall document the following information:

(A) The timely access standards set forth in the plan's policies and procedures including, as may be applicable, any alternative time-elapased standards and alternatives to time-elapased standards for which the plan obtained the Department's prior approval by Order;

(B) The rate of compliance, during the reporting period, with the time elapsed standards set forth in subsection (c)(5), separately reported for each of the plan's contracted provider groups located in each county of the plan's service area. A plan may develop data regarding rates of compliance through statistically reliable sampling methodology, including but not limited to provider and enrollee survey

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28 CCR 1300.67.2.3

(a) Quality Assurance Processes for Measurement Year 2022. 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 section. In addition to the requirements established by Rule 1300.70, a plan's quality assurance program shall address:

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

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

(A) Tracking and documenting network capacity and availability with respect to the standards set forth in Rule 1300.67.2.2(c);

(B) Conducting an annual enrollee experience survey, which shall be conducted in accordance with a valid and reliable survey methodology and designed to ascertain compliance with the standards set forth at Rule 1300.67.2.2(c);

(C) Conducting an annual provider survey, which shall be conducted in accordance with a valid and reliable survey methodology and designed to solicit, from physicians and non-physician mental health providers, perspective and concerns regarding compliance with the standards set forth at Rule 1300.67.2.2(c);

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

(E) Verifying the advanced access programs reported by network providers, medical groups and independent practice associations to confirm that appointments are scheduled consistent with the definition of advanced access in Rule 1300.67.2.2(b)(1).

(F) A plan that provides services through a preferred provider organization network may, for that portion of its network, demonstrate compliance with subsections (a)(2)(A) and (D) of this Rule by monitoring, on not less than an annual basis the following: the number of PPO primary care and specialty physicians under contract with the plan in each county of the plan's network service area; enrollee grievances and appeals regarding timely access; and the rates of compliance with the time-elapsd standards established in Rule 1300.67.2.2, subsection (c)(5).

(3) A plan shall implement prompt investigation and corrective action when compliance monitoring discloses that the plan's network is not sufficient to ensure timely access as required by this section, including taking all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance. Plans shall give advance written notice to all 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.

(b)(1) The definitions in Rule 1300.67.2.2 shall apply for the purpose of this section, except as specified in Rule 1300.67.2.3, subsection (b)(2).

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(2) The definition set forth in Rule 1300.67.2.2(b)(12)(A) shall not apply to reports or reviews for compliance pursuant to this section.

(c) This section shall become inoperative on January 1, 2023.

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

(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.