

**STATE OF CALIFORNIA  
DEPARTMENT OF MANAGED HEALTH CARE**

**TITLE 28, CALIFORNIA CODE OF REGULATIONS  
DIVISION 1. THE DEPARTMENT OF MANAGED HEALTH CARE  
CHAPTER 2. HEALTH CARE SERVICES PLANS  
ARTICLE 7. STANDARDS**

**PROPOSED ADOPTION OF SECTION 1300.67.2.2**

**PROPOSED TEXT  
Control No. 2005-0203**

*Adopt new section 1300.67.2.2 as follows:*

**28 CCR § 1300.67.2.2 Timely Access To Health Care Services**

(a) Standards.

(1) Provide Timely Health Care. All health care service plans, including specialized plans (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 professionally recognized standards of practice. If plan providers provide appointments on a "same-day access" basis, as defined in subsection (b)(6), the plan will be in compliance with the requirements of this section in regard to providers operating on a same-day access basis. This section is not intended to create any basis for an individual cause of action not presently existing in law and is not intended to apply to emergency medical conditions and emergency care which are regulated and governed by other applicable law including Health and Safety Code section 1317.1. However, this section applies to timely access to needed health care services after the enrollee has received emergency services and has been stabilized, as described in section 1374.1 of the Act and section 1300.74.1 of the regulations.

(2) Documented Process For Timely Access. All plans shall have established and documented quality assurance processes and systems designed to achieve timely access in accordance with this section. All plans shall have written policies and procedures that include:

- (A) Standards for specified indicators of timely access to care;
- (B) Plan monitoring of compliance with timely access standards;
- (C) Corrective action to address timely access deficiencies;
- (D) Assessment of enrollee satisfaction with timely access to care; and
- (E) Annual reporting of timely access.

(3) Delegation and Responsibility. A plan that delegates to a contracting provider, a specialized plan, or other entity any aspect of the performance of the plan's timely access program shall retain ultimate responsibility for providing timely access to care and for all aspects of performance delegated.

(A) Every contract between a plan and a person or other entity to which the plan has delegated any part of the plan's obligation to implement and ensure timely access to health care services shall include terms and provisions sufficient to clearly specify the respective obligations of the parties, including but not limited to, the financial risk for additional plan-required services to provide timely access, and the plan's methods for monitoring the contractually delegated performance.

(B) No plan shall require a contacting health care provider or provider group to provide timely access to health care services that the provider or provider group does not have actual, employed or contracted capacity to provide.

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

(1) **Appointment waiting time** means the time from the initial request for health care services (whether to a provider, provider's office, or to the plan) to the time offered for the appointment for services, inclusive of: (A) time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its contracting providers; and (B) triage time, if triage is provided. The request for health care services may be by the enrollee, by a representative of the enrollee, or by a provider on behalf of the enrollee. Appointment waiting time for specialty care is exclusive of time to make diagnostic tests available to the specialist for diagnosis by the specialist and exclusive of time delay caused by the enrollee.

(2) **Office waiting time** means the time from the scheduled time of the appointment or the time the enrollee arrives in the provider's office, whichever is later, to the time the patient receives service from the provider, inclusive of waiting time in the examination room.

(3) **Preventive care** means health care provided for prevention and early detection of disease or illness, injury or other health condition.

(4) **Provider group** means a medical group, independent practice association, or any other organization of health care providers.

(5) **Routine care** means non-urgent care that is not preventive care.

(6) **Same-day access** means every enrollee is offered an appointment within one business day of the request for an appointment, except that follow-up appointments may be scheduled as clinically appropriate and non-urgent specialty and referral care appointments may be offered within five business days of the request for an appointment.

(7) **Telephone waiting time** means the time on the telephone waiting to speak to, including time waiting for a return call from, a physician, registered nurse, or other qualified health professional acting within his or her scope of practice who is trained to screen or triage an enrollee who may need care.

(8) **Urgent care** means health care for a condition which requires prompt attention, consistent with section 1367.01(h)(2).

(c) Timely Access Program Requirements. Every plan shall develop and implement a program for establishing, improving, maintaining, and monitoring timely access to health care, which shall comply with the requirements and standards established by the Act and these regulations.

(1) Indicators for Timely Access. Each plan's program for ensuring timely access to care shall include the following indicators for timely access:

(A) Appointment waiting time for all types of providers including primary care and specialty care physicians, and for routine care, preventive care, and urgent care appointments.

(B) Appointment waiting time in an episode of illness, injury or other health condition, including timeliness of referrals and obtaining other services.

(C) Telephone waiting time to speak to a physician, registered nurse, or other qualified health professional acting within his or her scope of practice who is trained to screen or triage.

(D) Office waiting time.

(2) Quality Assurance Standards for Timely Appointments. In addition to ensuring that covered health care services are provided in a timely manner appropriate for the nature of an enrollee's condition consistent with professionally recognized standards of practice as required by subsection (a), all plans shall establish quality assurance standards for timely delivery of health care services in accordance with this section. The appointment waiting time standards set forth below shall run concurrently with the requirements for utilization review timeframes set forth in Section 1367.01. Plans that provide services through a preferred provider organization network will be in compliance with this subsection if an appointment within the applicable waiting time standards is offered by at least one geographically accessible provider in the network appropriate for the enrollee's condition.

(A) Primary Care Accessibility. An appointment shall be offered with a primary care physician or, if appropriate for the enrollee's health care needs consistent with good professional practice, with a physician assistant, nurse practitioner, or certified nurse midwife, acting within his or her scope of practice, at the primary care location or provider group to which the enrollee is assigned or has selected or where the enrollee regularly receives care. Full-service plans shall monitor for provider compliance with the following appointment waiting time standards for primary care, consistent with the standard of care appropriate for the enrollee's needs:

- (i) For urgent primary care: within 24 hours.
- (ii) For routine primary care: within 10 days.
- (iii) For preventive primary care: within 30 days.

(B) Specialty Care Accessibility. An appointment shall be offered with a specialty care physician who is board certified, in the active examination process of a specialty board, or determined in accordance with the plan's written peer review credentialing/quality assurance policy to have training and/or experience essentially equivalent to board certification, and such physician's specialty is appropriate for the enrollee's health care needs and consistent with good professional practice. Full-service plans shall monitor for provider compliance with the following appointment waiting time standards for specialty care (excluding mental health care),

in-person or via electronic communications or telemedicine, consistent with the standard of care appropriate for the enrollee's needs:

- (i) For urgent specialty care: within 72 hours.
- (ii) For routine specialty care: within 14 days.
- (iii) For preventive specialty care: within 30 days.

(C) Mental Health Care Accessibility. An appointment shall be offered with a licensed mental health care provider appropriate for the enrollee's mental health care needs consistent with good professional practice. Where the enrollee requires services of a physician specializing in mental health care, access shall include a psychiatrist who is board certified, in the active examination process of a psychiatry specialty board, or determined in accordance with the plan's written peer review/quality assurance policy to have training and/or experience essentially equivalent to board certification. Full-service and specialized plans shall monitor for provider compliance with the following appointment waiting time standards for mental health care, in-person or via electronic communications or telemedicine, consistent with the standard of care appropriate for the enrollee's needs:

- (i) For urgent mental health care: within 48 hours.
- (ii) For routine mental health initial evaluation appointments: within 10 business days.
- (iii) For routine mental health subsequent appointments after an initial evaluation appointment: within 14 days from the date of the initial evaluation appointment.
- (iv) For routine mental health initial follow-up appointments after an inpatient stay for mental health care: within 7 days from date of discharge, unless either the referring mental health provider or the outpatient mental health provider or physician to whom the enrollee has been referred for continuation mental health care services has determined and documented that the enrollee may be offered an appointment at variance with this standard, consistent with professionally recognized standards of practice. Any such determination shall include a documented assessment of the enrollee's need to assure the enrollee's access to continuing medication.

(D) Ancillary and Other Provider Accessibility. An appointment with ancillary and other providers shall include access to licensed or certified non-physician providers of covered services, including but not limited to the following services: diagnostic and therapeutic radiology and imaging; diagnostic laboratory; other diagnostic services; physical, speech and occupational therapy; home health; and hospice. Access to ancillary and other provider services shall be appropriate for the enrollee's health care needs and consistent with good professional practice. Plans shall monitor for provider compliance with the following appointment waiting time standards for ancillary and other providers (excluding mental health care providers, hospitals and specialized plan providers), consistent with the standard of care appropriate for the enrollee's needs:

- (i) For diagnostic imaging, diagnostic laboratory and other diagnostic testing needed for urgent primary care and urgent specialty care: within 24 hours.
- (ii) For urgent ancillary and other provider care (including physical therapy, occupational therapy and speech therapy): within 72 hours.
- (iii) For routine ancillary and other provider care: within 7 days.
- (iv) For preventive ancillary and other provider care: within 30 days.

(E) Hospital Accessibility. Waiting time standards for admission to hospitals shall be appropriate for the enrollee's health care needs and consistent with good professional practice. Full-service plans shall monitor for provider compliance with the following appointment waiting time standards for hospital care, consistent with the standard of care appropriate for the enrollee's needs:

(i) For urgent hospital care: within 24 hours.  
(ii) For urgent outpatient diagnostic imaging, outpatient diagnostic laboratory and other diagnostic testing needed for urgent primary care and urgent specialty care: within 24 hours.

(ii) For routine hospital care including elective procedures, outpatient surgery, and outpatient procedures: the shortest time appropriate for the nature of the enrollee's condition, within the hospital's capacity, and consistent with professionally recognized standards of practice, unless a longer time is necessary or medically appropriate to the specific health care needs of the enrollee.

(F) Specialized Plan Accessibility. An appointment with a provider of a specialized plan network shall be offered with a licensed provider of the services covered by the specialized plan. Specialized plans shall monitor for provider compliance to determine whether enrollees are able to access services consistent with the standard of care appropriate for the enrollees' needs and with the following appointment waiting time standards for specialized plan providers (other than mental health care):

- (i) For urgent acupuncture care: within 72 hours.
- (ii) For routine acupuncture care: within 14 days.
- (iii) For preventive acupuncture care: within 30 days.
- (iv) For urgent chiropractic care: within 24 hours.
- (v) For routine chiropractic care: within 14 days.
- (vi) For preventive chiropractic care: within 30 days.
- (vii) For urgent dental care: within 48 hours.
- (viii) For routine dental care: within 42 days.
- (ix) For preventive dental care: within 180 days.
- (x) For urgent vision care: within 48 hours.
- (xi) For routine vision care: within 14 days.
- (xii) For preventive vision care: within 60 days.
- (xiii) For urgent other specialized plan provider care: within 72 hours.
- (xiv) For routine other specialized plan provider care: within 14 days.
- (xv) For preventive other specialized plan provider care: within 60 days.

(3) Quality Assurance Standards for Timely Telephone Access. All plans shall establish quality assurance standards for timely telephone access to a qualified health professional, acting within his or her scope of practice, who is trained to screen and triage. The plan need not require its providers to maintain specific recordkeeping to demonstrate compliance with telephone access standards, but a plan shall resolve and maintain records of any enrollee complaints and provider complaints the plan receives concerning telephone waiting time. Each plan's program and standards for timely telephone access shall include, but not be limited to, plan monitoring for compliance within the following telephone waiting time standards:

(A) During provider office hours, telephone waiting time to speak with a qualified health professional, acting within his or her scope of practice, who is trained to screen and triage: within 15 minutes.

(B) For providers using an after hours call service, telephone waiting time to speak with a qualified health professional, acting within his or her scope of practice, who is trained to screen and triage: within 30 minutes.

(C) During plan office hours, telephone waiting time to speak with a plan representative for referrals, complaints or for any other purpose: within 10 minutes.

(D) If a plan provides telephone triage after plan office hours, telephone waiting time to speak with a triage nurse or other qualified health professional, acting within his or her scope of practice, who is trained to screen and triage: within 10 minutes.

(E) If a plan does not provide telephone triage after plan office hours, telephone waiting time to speak with a plan representative: within 30 minutes.

(F) If a plan provides a telephone number identified for behavioral health or mental health care, telephone waiting time to speak with a qualified health professional, acting within his or her scope of practice, who is trained to screen and triage: within 10 minutes.

(G) If a telephone tree providing touch tone options for selection by the caller is used by a provider, provider group or plan, the telephone waiting time standards specified in this section shall not be extended due to the telephone tree.

(H) If a provider's office uses a recorded message to answer telephone calls, part of the recorded message shall state what to do in an emergency, and the provider's office shall attempt to contact the enrollee in a timely manner consistent with good professional practice. Where an answering machine allows recording of a caller's verbal message requesting a return call for health care direction, the return call or reply shall be within a reasonable time consistent with good professional practice.

(I) Telephone waiting time for providers calling to request prior authorization shall not exceed: during plan office hours, within 5 minutes; and after plan office hours, within 15 minutes.

(4) Quality Assurance Standards for Office Waiting Time. All plans shall establish quality assurance standards for office waiting time. Except for delay caused by exigent or unforeseen circumstances (for example, a physician called to a hospital or to handle an urgent or emergent patient condition), office waiting time standards shall be:

(A) For urgent care: within 15 minutes.

(B) For routine and preventive care: within 30 minutes.

(5) Appointment Changes or Cancellations. The quality improvement standards specified in this subsection are not intended to prohibit a provider from canceling or changing an appointment to address exigent scheduling needs. Plans shall have effective systems in place to ensure the enrollee is offered a replacement appointment in a timely fashion appropriate for the

nature of the enrollee's condition and consistent with the objectives of Section 1367.03 of the Act and this section.

(6) Follow-up or Standing Appointments. The quality improvement standards specified in this subsection do not apply when good clinical practice for scheduling follow-up, recurring or standing appointments requires a longer appointment waiting time than is provided in the standards and in order to provide care consistent with good professional practice for enrollees who need ongoing health care monitoring, follow-up preventive care, or specialized care on a periodic basis.

(7) Enrollee Requests for Specific Specialists. These quality improvement standards are not intended to prevent enrollees from selecting a desired specialist when the enrollee prefers to wait longer to see the specialist of his or her choice. When the plan becomes aware that the appointment waiting time for a specialist exceeds the timely access standards of this subsection due to enrollee choice of specialist, then the plan shall timely inform both the enrollee who is requesting referral to the selected specialist, and where applicable, the enrollee's referring physician, of the availability of a timely appointment with another plan-contracted provider of comparable specialty. Informing the enrollee may be delegated to the referring or specialist provider or provider group.

(8) More Stringent Standards. This section is not intended to preclude a plan from adopting more stringent waiting time standards than the standards described herein, including but not limited to more stringent standards that may be imposed upon a plan by federal or state statute or regulation or pursuant to a contract with a federal or state agency.

(9) Offering Appointments with Alternate Providers. When a plan becomes aware that a specific enrollee's appointment waiting time for a provider exceeds the standards of subsection (c)(2) or alternative standards as approved by the Department, the plan shall offer the enrollee a timely appointment with another geographically accessible provider of equivalent specialty, or the names of plan providers able to offer a timely appointment, which may include: (i) another plan-contracted provider, or (ii) a non-contracted provider, with the enrollee's financial responsibility (including financial responsibility to the plan and the provider) being limited to applicable copayments, coinsurance and/or deductibles that would apply had the enrollee seen a plan-contracted provider.

(d) Alternative Standards; Material Modification. A plan may propose alternatives to the timely access standards specified in this section. Plans must demonstrate that the proposed alternative standard is "more appropriate," as required by subdivision (c) of Section 1367.03 of the Act. Alternative timely access standards shall be proposed in writing in the applicant's license application or in a notice of material modification of a licensed plan.

(1) Facts and Circumstances Basis. Applications for proposed alternative standards shall address specific facts and circumstances justifying the proposed alternative standard – for example:

- (A) Circumstances of the plan's service area;
- (B) Provider shortage;

(C) Appointment scheduling systems which do not meet the definition of “same-day access” as specified in this section but which are requested to be considered in substantial compliance with same-day access as defined herein;

(D) Particular covered services as to which the time elapsed standards are inconsistent with good clinical practice; or

(E) A specific alternative standard which the plan demonstrates is more appropriate than the standards established by subsection (c) or more appropriate to ensure that enrollees have timely access to health care.

(2) Application Contents. The plan’s proposal for alternative timely access standards shall include:

(A) Specification of the portion of the plan’s service area, the specific category of provider, and if applicable, the specific type of affected covered services to which the alternative standards are proposed to apply;

(B) Description of the reasons justifying the alternative standards;

(C) Documentation sufficient to verify the facts and circumstances upon which the request is based;

(D) The specific steps the plan will take to provide timely access to enrollees within the affected service area including timely access education to the affected enrollees; and

(E) The period of time for which the plan desires the alternative standards to be approved, but not to exceed three years.

(3) Justification. The facts and circumstances to be included with the reasons justifying the alternative standards for timely access proposed by the plan shall include, to the extent relevant and practicable, but shall not necessarily be limited to the following:

(A) Whether the plan contract is a full-service or a specialized plan contract;

(B) The uniqueness of the services to be offered;

(C) Whether the affected service area involved is urban or rural;

(D) Population density in the affected service area;

(E) The distribution of enrollees in the affected service area;

(F) The availability and distribution of primary care physicians in the affected service area;

(G) The availability and distribution of other types of providers in the affected service

area;

(H) Patterns of practice in the affected service area;

(I) Driving times and distances to and between providers in the affected service area;

(J) Whether any other health care service plan currently is meeting the timely access standards in the affected service area; and

(K) Other factors of timely accessibility that the Director deems necessary or appropriate in the public interest and consistent with the intent and purpose of the Act as applied to specific facts or circumstances.

(e) Compliance Monitoring. All plans shall establish and file in accordance with subsection (h) a documented system for adequately monitoring and assuring timely access to covered health care services, which shall monitor for the indicators of timely access set forth in subsection (c)(1) and for compliance with the plan's standards in accordance with subsections (c)(2), (c)(3), (c)(4) and (d), as applicable. In monitoring for timely access, each plan's monitoring system shall focus upon identifying any patterns of noncompliance and egregious episodes of noncompliance. The monitoring system shall, at a minimum, include methods and mechanisms reasonably designed to accurately monitor for timely access. The plan shall demonstrate a valid and reliable methodology that assures the integrity of the reported monitoring results, and considers enrollee mix selection, sample size and statistical validity. The frequency and timing of the plan's monitoring shall be sufficient to enable the plan to form sound conclusions regarding compliance and noncompliance with the timely access standards by the plan's contracting providers. No plan shall require a contracting health care provider or provider group to maintain log books recording appointment waiting times, office waiting times and telephone waiting times for all enrollees served by the provider or provider group.

(1) For all providers, a plan's monitoring system shall include:

(A) An enrollee satisfaction survey as described at subsection (f).

(B) Review of enrollee grievances regarding accessibility and availability of covered services.

(C) Review of enrollee requests for plan assistance to obtain an appointment.

(D) Review of provider communications regarding concerns with or about timely accessibility and availability of covered services.

(E) Survey of disenrolled persons to determine whether lack of timely access was a reason for disenrollment.

(2) In addition, for providers not operating on a same-day access basis, a plan's monitoring system shall include the following methods, as appropriate for a plan's particular operations and types of provider networks. If one or more of these monitoring methods documents compliance with a standard to the satisfaction of the Department, the other methods need not be utilized for

that standard. However, if one or more of the monitoring methods identified in subsections (e)(1) or (e)(2) indicates noncompliance with a standard, then one or more of the other methods specified in subsection (e)(2) shall be utilized for that standard to identify compliance deficiency(ies) in anticipation of a corrective action plan in accordance with subsection (g).

(A) Audits of enrollees' records in providers' offices for data evidencing compliance or noncompliance with the standards of subsections (c) and (d).

(B) Non-anonymous telephone surveys of providers' offices.

(C) Anonymous (secret shopper) telephone audits of providers' offices.

(D) Provider surveys designed to identify problems with or about timely accessibility and availability of covered services.

(3) In addition, for providers operating on a same-day access basis, the plan shall monitor and confirm, on a quarterly basis, that those providers continue to maintain an effective same-day access appointment system. Such monitoring shall be sufficient to enable the plan to reasonably conclude that the providers are operating on a same-day access basis, and may include:

(A) Non-anonymous telephone surveys of providers' offices.

(B) Anonymous (secret shopper) telephone audits of providers' offices.

(4) In evaluating whether a plan's proposed compliance monitoring system is sufficient, the Department will consider the following factors:

(A) The size of the plan and of its enrollee population;

(B) The types of health care services provided by the plan, e.g. medical, dental, vision, etc.;

(C) The type of provider network, provider shortage, and methods of health care service delivery;

(D) The characteristics, demographics and variations of a plan's service area;

(E) The availability and distribution of providers within the plan's service area;

(F) The cost of a particular type of monitoring methodology and the impact on affordability of health care coverage; and

(G) A plan's implementation of best practices and utilization of existing and emerging technologies to increase monitoring accuracy, monitoring capability, and timely access to health care services.

(f) Plan's Enrollee Satisfaction Survey. Not less frequently than annually, all plans shall conduct a survey of enrollee satisfaction with respect to each of the indicators for timely access identified in subsection (c)(1). The timely access questions in the survey shall be designed to ascertain enrollee satisfaction with each of the indicators specified in subsection (c)(1) and shall be filed with the Department for prior approval. The plan shall demonstrate a valid and reliable survey methodology that assures the integrity of the reported results, and considers enrollee mix selection, sample size, statistical validity and demographics of the enrollee population. The required timely access questions may be used:

(1) As supplemental questions used with the Consumer Assessment of Health Plans Study (CAHPS), directed at ascertaining timely access to care data and which includes survey questions known as HEDIS (Health Plan Employer Data and Information Set) used for National Committee for Quality Assurance (NCQA) accreditation (or for behavioral health, the Experience of Care and Health Outcomes (ECHO) survey); or

(2) As or with another appropriate, valid and reliable survey instrument used or developed by the plan.

(g) Plan's Corrective Action. Plans shall correct deficiencies in compliance with the standards in accordance with this section, as soon as feasible. If the deficiency is not corrected within 60 days of identifying the deficiency, the plan shall file a corrective action plan with the Department not later than the 60<sup>th</sup> day and correct the deficiency within 120 days of identifying the deficiency. The corrective action plan shall be verified by an officer authorized to act on behalf of the plan but shall not be filed as an amendment to the plan application. Plans shall implement one or more of the following corrective actions as appropriate to correct deficiencies in compliance with the timely access standards of this section:

(1) Increase the number of plan-contracted providers in an affected service area to achieve timely access in accordance with subsection (c);

(2) Increase the number of enrollees referred to available non-contracting providers in the affected service area to achieve timely access in accordance with subsection (c), with the enrollee's financial responsibility being limited to applicable copayments, coinsurance and/or deductibles that would apply had the enrollee seen plan-contracted providers;

(3) Document increased communications between the plan and its contracting providers to facilitate the plan's timely assistance in referring enrollees when a provider is unable to meet the plan's timely access standards;

(4) Document increased communication to enrollees regarding the plan's applicable timely access standards and how to obtain the plan's assistance in obtaining timely appointments;

(5) Monitor the effectiveness of the corrective action; and

(6) Other corrective actions to resolve the deficiency and maintain compliance with Section 1367.03 and this section.

(h) Compliance and Implementation. Not later than one year after the effective date of this section, all plans shall be in compliance with Section 1367.03 and this section, and each plan shall file the following as an amendment to the plan's license application.

(1) The plan's written standards, policies and procedures implementing the plan's program for improving, maintaining and monitoring timely access to health care, including the plan's proposed timely access questions to be used in the plan's annual enrollee satisfaction survey, identified as Exhibit G-4.

(2) A description of the plan's educational program and disclosures added in the evidences of coverage and disclosure forms informing enrollees about the plan's indicators and standards for timely access, how to request the plan's assistance in obtaining timely appointments, and how to notify the plan regarding timely access problems identified as Exhibit G-4.

(3) Documentation sufficient to demonstrate compliance with Section 1367.03(f)(1), identified as Exhibit G-6.

(4) A plan that seeks approval of alternative standards pursuant to subsection (d) shall file the material modification required by subsection (d) not later than nine months after the effective date of this section.

(i) Annual Compliance Report. By March 31 of the year following the effective date of this section and by March 31 of each year thereafter, each plan shall file a verified timely access compliance report as an amendment to the plan's license application, which shall contain:

(1) A description of the plan's compliance with subsection (c) by the plan and the plan's contracting providers, in accordance with Section 1367.03(f)(2), including the monitoring methods used and patterns of noncompliance identified, if any. For providers using a same-day access appointment system, the description shall consist of a current list of providers using same-day access in the plan's service area.

(2) For full-service plans, the number and percentage of the plan's contracting primary care physicians and specialty care physicians using a same-day access appointment system. For purposes of same-day access in this subsection, each provider in a provider group is a separate provider and each facility (for example, a hospital or freestanding surgery center) is a separate provider.

(3) A description of the implementation and use by the plan and its contracting providers of triage, telemedicine, and health information technology to provide timely access to care.

(4) A summary of enrollee grievances received during the prior calendar year, regarding timely access.

(5) The results of the latest enrollee satisfaction survey and a comparison with the results of the prior year's survey.

(6) Corrective action implemented during the reporting year regarding timely access.

(j) Substantial Compliance. Except as described in Section 1367.03(g)(3)(A) & (B), a plan will be in compliance with the timely access standards set forth in subsections (c)(2), (c)(3) and (c)(4) if the plan demonstrates that it is in substantial compliance with those subsections. For purposes of this section and for providers not in compliance, a plan may achieve “substantial compliance” by completing either of the following:

(1) Corrective Action Compliance. The plan’s monitoring has identified noncompliance with the plan’s standards consistent with subsections (c)(2), (c)(3) and (c)(4) (other than operating on a same-day access appointment system) by the plan or the plan’s contracting providers, and the plan has in place a workable corrective action plan(s) designed to achieve full compliance within a specified and reasonable period of time not to exceed 120 days from the date the noncompliance was identified by the plan.

(2) Compliance with Alternative Standard. The plan obtained approval from the Department for an alternative standard in accordance with subsection (d), and the plan and the contracting providers to which the alternative standard is applicable are in full compliance with the alternative standard.

(k) No New Cause Of Action. This section is not intended to create any basis for an individual cause of action not presently existing in law.

(l) Alternative Monitoring and Reporting Requirements. A plan may file a written request for the Department’s prior approval for one or more of the following alternative monitoring and reporting requirements to apply.

(1) Same-Day Access. Where a plan has filed verified documentation sufficient to demonstrate that 80% or more of the plan’s contracting providers are operating on a same-day access appointment system, the plan’s annual compliance report for the immediately succeeding year need not include the information required by subsection (i)(1), (3) and (6), except for plan contracting providers that are not operating with a same-day access appointment system.

(2) Demonstrated Compliance With Standards. When a plan has filed verified documentation sufficient to demonstrate full compliance across its entire network with the timely access requirements of Section 1367.03 and of this section, the plan’s annual compliance report for the immediately succeeding year need not include the information required by subsection (i)(1), (3) and (6).

(3) Telemedicine to Improve Timely Access. If a plan has filed verified documentation to the satisfaction of the Department that the plan has implemented or made a significant contribution toward implementing telemedicine to provide timely access in a provider shortage area, by including but not limited to, providing technical support, telemedicine equipment, staffing and/or training, the plan’s annual compliance report for the immediately succeeding year need not include the information required by subsection (i)(1), (3) and (6) as to the specific service area where the telemedicine is implemented.

(4) Health Information Technology to Improve Timely Access. If a plan has filed verified documentation to the satisfaction of the Department that the plan has implemented health information technology with its contracting providers, including but not limited to, electronic

medical records and compatible software, electronic access to laboratory results, electronic prescriptions to pharmacies, radiologic imaging results, pathologic reports, and/or other test and medical reports including specialist consultant reports, to achieve compliance with the timely access standards of this section, the plan's annual compliance report for the immediately succeeding year need not include the information required by subsections (i)(1), (3) and (6) as to the specific service area where timely access compliance was achieved with the support of health information technology.

Authority: Sections 1344, 1346 and 1367.03, Health and Safety Code. Reference: Sections 1342, 1363, 1367, 1368, 1368.01, 1370, 1375.7, and 1380, Health and Safety Code. Cross Reference: Sections 1300.51(d)(Exhibits G, H, I, J, K), 1300.68, and 1300.70, Title 28, California Code of Regulations.