

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) ~~(a)~~ Application. This section shall apply to all health care service plans that provide or arrange for the provision of hospital or physician services, including specialized mental health plans that provide physician or hospital services, or that provide mental health services pursuant to a contract with a full service plan.
- (1) The obligation of a plan to comply with this section shall not be waived when the plan delegates to its medical groups, independent practice associations, or other contracting entities any services or activities that the plan is required to perform.
- (2) This section clarifies requirements for plans to monitor and ensure the adequacy of contracted provider networks and does not establish performance requirements for individual health care providers. Plan and provider delegation contracts shall comply with the requirements of Section 1375.7 of the Act and section 1300.70(b)(2)(G) and (H) of Title 28.
- (3) This section does not create a new cause of action or a new defense to liability for any person.
- (b) Definitions. For purposes of this section, the following definitions apply.
- (1) “Advanced access” means the provision, by an individual provider, or by the medical group or IPA to which an enrollee is assigned, of: non-urgent appointments with a primary care physician on the same day the appointment is requested; non-urgent appointments with a specialist within 5 business days of the appointment request; and advance scheduling of appointments at a later date if the enrollee prefers not to accept the appointment offered on the same day (for primary care physicians) or within 5 days (for specialist physicians).
- (2) “Appointment waiting time” means the time from the initial request for health care services by an enrollee or the enrollee’s treating provider to the earliest date offered for

- the appointment for services inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its contracting providers.
- (3) “Preventive care” means health care provided for prevention and early detection of disease, illness, injury or other health condition and, in the case of a full service plan includes but is not limited to all of the basic health care services required by section 1300.67(f) of Title 28.
  - (4) “Provider group” has the meaning set forth in Section 1373.65(g) of the Act.
  - (5) “Referral time” means the time from an appointment with a contracted health care provider during which the provider determines the need to refer an enrollee to another provider (recipient provider) for additional examination, evaluation, treatment or other care, to the time the referring provider delivers, to the plan or to the recipient provider, a written request for the additional health care services.
  - (6) “Routine care” means care that is not emergency, urgent or preventive care, such as, but not limited to, care delivered during problem-oriented office consultations with primary care and specialist physicians, and periodic follow up care, monitoring and treatment for chronic conditions.
  - (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 and 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) Quality Assurance Processes. All plans shall have written quality assurance processes designed to achieve timely access in compliance with the requirements of this section. The written policies and procedures shall include, at a minimum:
- (1) Standards for the provision of covered services in a timely manner consistent with professionally recognized standards of practice, and established in accordance with the requirements set forth in subsection (d).
  - (2) Requirements for plan monitoring for compliance with the requirements of this section. A plan shall monitor its contracted provider network for patterns of non-compliance and for incidents of noncompliance resulting in substantial harm to an enrollee. The plan’s monitoring shall be 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 Act and this section, and in accordance with the plan’s timely access standards established pursuant to subsection (d). Plan monitoring shall include, at a minimum:
    - (A) An annual, statistically valid, enrollee satisfaction survey. The survey shall be conducted in accordance with valid and reliable survey methodology, and designed to ascertain enrollee satisfaction with respect to each of the indicators for timely access set forth in the plan’s policies and procedures. Plans that survey enrollees

with the Consumer Assessment of Health Plans Study (CAHPS) or the Experience of Care and Health Outcomes (ECHO) in connection with certification by the National Committee for Quality Assurance (NCQA), may meet the requirements of this subsection by including appropriate supplemental questions, as approved by the Department, with the NCQA survey.

- (B) An annual provider satisfaction survey of not less than 5% of the contracted primary care physicians and not less than 5% of the aggregate contracted specialty care providers in each county of a plan's service area. Plans and providers may cooperate to develop, subject to the Department's approval, uniform provider survey forms, and to share survey data to avoid redundant and duplicative surveys of provider groups, so long as these collaborative processes are designed to solicit and obtain responses from different providers in successive years.
  - (C) Review, on not less than a monthly basis, of the information regarding accessibility, availability and continuity of care available to the plan, including but not limited to, information developed from enrollee complaints and grievances, plan monitoring of provider performance, and screening and triage activities pursuant to subsection (d)(5).
  - (D) Contracts between a plan and a provider group shall require the provider group to cooperate with the plan as necessary to enable the plan to comply with the reporting requirements established by Section 1367.03(f)(1) of the Act and by subsection (e)(2).
- (3) A plan shall implement prompt investigation and corrective action when compliance monitoring identifies timely access deficiencies. A plan shall take all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance, including but not limited to, as applicable to the root cause, contracting with additional providers, increasing the application of advanced access within contracted provider groups, increasing access through expansion of telemedicine and other technological mechanisms, and delivering additional provider education and training regarding plan processes, procedures and systems that support the delivery of timely access by contracted providers.
- (4) Standards, procedures and systems to ensure that, if a contracted provider or provider group is unable to deliver timely access in accordance with the standards of this section, the plan or its delegated provider group shall arrange for the provision of a timely appointment with an appropriately qualified and geographically accessible provider within the plan's network. 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 provider.
- (d) Plan Standards for Access to Care.
- ~~(1) — (1) Provide Timely Health Care. All health care service plans, including specialized plans (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 good professional practice. 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 1371.4 of the Act and section 1300.71.4 of the regulations.~~

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

~~—Standards for specified~~

~~(a)(2) A plan's standards for timely access shall be established using the following indicators of timely access to care; unless the plan obtains the Department's prior approval by written Order for alternative standards through the process set forth in subsection (e)(5):~~

~~—(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;~~

~~(E) Assessment of provider satisfaction with timely access to care; and~~

~~(F) 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, for monitoring and oversight of the provider network of the plan, and for compliance of the network with the timely access standards of the plan and this section.~~

~~—(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 contracting health care provider or provider group to provide timely access to health care services that the provider or provider group does not have the employed or contracted capacity to provide. However, for purposes of this subsection, all providers and provider groups are presumed to have sufficient capacity to comply with the applicable standards specified in this section if they have sufficient number and type of applicable specialty(ies) of providers to provide covered health care services to their panel of the plan's enrollees. This subsection does not preclude plans from contractually requiring compliance with and enforcing the applicable standards specified in this section. This subsection does not preclude a plan and provider or provider group from negotiating and contractually agreeing to increase capacity to provide timely access to health care services.~~

~~— (4) **Exemption for Providers Using Advanced Access, Same Day Access or Open Access.** If plan providers provide appointments on an “Advanced Access” basis, a “same day access” basis, or an “open access” basis, as defined in subsections (b)(1) and (b)(5), the plan will be deemed to be in compliance with the appointment waiting time standards of subsection (c)(3), in regard to those providers operating on an Advanced Access basis, a same day access basis, or an open access basis. Accordingly, monitoring is limited to annual verification.~~

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

~~— (1) **Advanced Access** or same day access means every enrollee is offered an appointment on the day of the request for an appointment regardless of the reason for the appointment, or within one business day for non-urgent primary care and within five business days for non-urgent specialty care. If an enrollee does not want an appointment on the day she or he calls, the appointment may be scheduled on the day requested by the enrollee. An enrollee calling to request an appointment with a physician not present that day should be given the choice of seeing another physician that day or waiting for the next available appointment with the requested physician. Follow-up appointments and chronic disease monitoring appointments may be scheduled as clinically appropriate, or enrollees needing follow-up may be asked to call and make an appointment when they are ready to be seen.~~

~~— (2) **Appointment waiting time** means the time from the initial request for health care services (by an enrollee or provider to a provider, provider’s office, or to the plan) to the time offered for the appointment for services (or the provision of a report to referring provider), 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. Appointment waiting time is exclusive of time delay caused by the enrollee. 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.~~

~~— (3) **Business day** means every day of each year except Saturdays, Sundays and holidays identified in or declared in accordance with Civil Code Sections 7 and 9, and Government Code Sections 6700, 6701, 6703, and 6704.~~

~~— (4) **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.~~

~~— (5) **Open access** means every enrollee is offered an appointment on the day of the request for an appointment regardless of the reason for the appointment, or within five business days for non-urgent primary care and within seven business days for non-urgent specialty care. If an enrollee does not want an appointment on the day she or he calls, the appointment may be scheduled on the day requested by the enrollee. An enrollee calling to request an appointment with a physician not present that day should be given the choice of seeing another physician that day or waiting for the next available appointment with the requested physician. Follow-up appointments and chronic disease monitoring appointments may be scheduled as clinically appropriate, or enrollees needing follow-up may be asked to call and make an appointment when they are ready to be seen. Approximately fifty percent of appointment slots are open at the start of the workday for same-day or next-day appointments.~~

~~—(6) **Preventive care** means, for purposes of this section, health care provided for prevention and early detection of disease or illness, injury or other health condition.~~

~~—(7) **Provider group** means a medical group, independent practice association, or any other organization of health care providers.~~

~~—(8) **Routine care** means non-urgent care that is not preventive care.~~

~~—(9) **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.~~

~~—(10) **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, maintaining, monitoring and improving timely access to health care, which shall comply with the requirements and standards established by the Act and this section.~~

~~—(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.~~

~~(A) ~~—(B) Appointment waiting time~~Appointment waiting times, which shall be tracked separately for each of the following categories of providers: (i) primary care physicians; (ii) specialty care physicians; (iii) mental health providers; and (iv) providers of ancillary services, for each of the following categories of care: routine care, preventive care, and urgent care appointments;~~

~~(B) Referral times in an episode of illness, injury or other health condition, ~~including timeliness of referrals; and obtaining other services.~~~~

~~(C) ~~—(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~~times.~~

~~(3) ~~—(D) Office waiting time.~~A plan's standards for the indicators listed in subsection (d)(2):~~

~~(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 adopt 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 or at an urgent care center. Full service plans shall monitor for provider compliance with the following appointment waiting time standards for primary care, in person or via electronic communications or telemedicine, 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 8 business days.~~
- ~~———(iii) For preventive primary care: within 22 business 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 and enrollee request for a specific specialist whose appointment waiting time exceeds the standards), 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, subject to time, if any, reasonably allowable under Section 1367.01(h)(2) and (3).~~
- ~~———(ii) For routine specialty care: within 12 business days.~~
- ~~———(iii) For routine subspecialty and tertiary specialty care: within 22 business days.~~
- ~~———(iv) For preventive specialty care: within 22 business 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. If appropriate for the nature of an enrollee's condition consistent with professionally recognized standards of practice, access may include a licensed and certified psychiatric mental health nurse practitioner acting within his or her scope of practice. 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 (where a full service plan is providing these services by arrangement with a specialized plan, monitoring may be delegated in a manner consistent with subsection (a)(3)):~~

- ~~———(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 12 business days from the date of the initial evaluation appointment, unless a longer time is necessary or medically appropriate to the specific health care needs of the enrollee as determined by the treating mental health professional.~~

~~————(iv) For routine mental health initial follow-up appointments after an inpatient stay for mental health care: within 5 business 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; hospice; and durable medical equipment. 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 and reports 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, speech therapy, and durable medical equipment): within 72 hours.~~

~~————(iii) For routine ancillary and other provider care: within 6 business days.~~

~~——(iv) For preventive ancillary and other provider care: within 22 business 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.~~

~~——(iii) 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 clinically appropriate to the specific health care needs of the enrollee.~~

~~———— (F) Specialized Service Accessibility. An appointment for a specialized service with a provider of a specialized plan network or a provider of a full-service plan (if such specialized service is provided by the full-service plan) shall be offered with a licensed provider of the covered specialized services. 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 services (other than mental health care):~~

- ~~———— (i) For urgent acupuncture care: within 72 hours.~~
- ~~———— (ii) For routine acupuncture care: within 12 business days.~~
- ~~———— (iii) For preventive acupuncture care: within 22 business days.~~
- ~~———— (iv) For urgent chiropractic care: within 24 hours.~~
- ~~———— (v) For routine chiropractic care: within 12 business days.~~
- ~~———— (vi) For preventive chiropractic care: within 22 business days.~~
- ~~———— (vii) For urgent dental care: within 48 hours.~~
- ~~———— (viii) For routine dental care: within 36 business days.~~
- ~~———— (ix) For preventive dental care: within 180 calendar days.~~
- ~~———— (x) For urgent vision care: within 48 hours.~~
- ~~———— (xi) For routine vision care: within 12 business days.~~
- ~~———— (xii) For preventive vision care: within 60 calendar days.~~
- ~~———— (xiii) For urgent other specialized plan provider care: within 72 hours.~~
- ~~———— (xiv) For routine other specialized plan provider care: within 12 business days.~~
- ~~———— (xv) For preventive other specialized plan provider care: within 50 business days.~~

~~———— (3) Quality Assurance Standards for Timely Telephone Access. All plans shall adopt quality assurance standards for timely telephone access. If a telephone tree providing touch tone options for selection by the caller is used, the telephone waiting time standards shall not be extended due to the telephone tree.~~

~~———— (A) Telephone Access to Providers. Plans shall administer adopted telephone waiting time standards as guidelines for providers. Plans shall not require providers to maintain records to demonstrate compliance with telephone access standards. Based on enrollee complaints and provider complaints received concerning telephone waiting time, and other information resulting from monitoring in accordance with subsection (e)(3) and (4), plans shall provide provider education and appropriate corrective action to improve timely telephone access. Telephone waiting time guidelines shall include the following:~~

~~———— (i) 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 an enrollee who may need care:~~

~~———— (I) During provider office hours, within 15 minutes (or if no such qualified professional is available, the caller shall be advised of the approximate time a professional will return the call and what to do in an emergency); and~~

~~———— (II) After provider office hours where an answering service or similar telephone contact mechanism is used, within 30 minutes if a message is provided regarding what to do in an emergency or within 15 minutes if no such message is provided.~~

~~(ii) If a provider's office uses a message recording answering machine to answer telephone calls:~~

~~(I) The machine's recorded message shall include what to do in an emergency; and~~

~~(II) The provider's office shall attempt to contact the enrollee in a timely manner consistent with good professional practice.~~

~~(B) Telephone Access to Plans. Standards for telephone access to plans shall include:~~

~~(i) Telephone waiting time to speak with a plan representative for referrals, complaints, triage (if the plan provides telephone triage), or for any other purpose:~~

~~(I) During plan office hours, within 10 minutes; and~~

~~(II) After plan office hours, within 30 minutes if the plan provides after hours telephone service. If a plan representative is not available by telephone after plan office hours, the plan shall provide a recorded message or answering service message including what to do in an emergency and advising that enrollees may contact the plan during regular business hours and/or enable the enrollee to leave a message and request a return call on the next business day.~~

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

~~(iii) If a plan requires prior authorization for any covered service, telephone waiting time for providers calling to request prior authorization shall not exceed:~~

~~(I) During plan office hours, within 5 minutes; and~~

~~(II) After plan office hours, within 15 minutes, which may be through any reasonable and responsive arrangement the plan may have for such calls after hours including an on-call medical director or an automated system to give providers authorization.~~

~~(4) Quality Assurance for Office Waiting Time. All plans shall establish quality assurance guidelines for office waiting time. Except for delay caused by exigent or unforeseen circumstances (for example, a provider called to handle an urgent or emergent patient condition), a general office waiting time guideline shall be within 30 minutes. A rescheduled appointment may be offered with an explanation of the reason for the delay when excessive office waiting time is the result of exigent or unforeseen circumstances. Plans shall not require providers to maintain records of office waiting times unless the quantity of enrollee complaints indicates a substantial pattern of noncompliance with the 30-minute guideline by a provider or provider group and the plan includes such requirement as part of a corrective action plan for that provider or provider group.~~

~~(5) Enrollee Choice Regarding Appointment Time. An appointment waiting time standard is met if an appointment is offered within the appointment waiting time standards of this subsection. The appointment waiting time standards of this subsection are not intended to~~

~~prohibit a provider from accepting the enrollee's choice if the enrollee declines the offered timely appointment time and requests an appointment at a later time.~~

~~— (6) Appointment Changes or Cancellations. The quality assurance 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:~~

- ~~(A) Shall be developed with involvement from actively practicing health care providers;~~
  - ~~(B) Shall be consistent with sound clinical principles and processes;~~
  - ~~(C) Shall be evaluated, and updated if necessary, at least annually; and~~
  - ~~(D) May be uniform timely access standards based on industry best practices, developed cooperatively by plans and health care providers in accordance with the requirements of this section and subject to the Department's approval.~~
- ~~(4) A plan may demonstrate compliance with the requirements of this section through implementation of standards, processes and systems providing advanced access, as defined at subsection (b)(1), to appointments for health care services.~~
- ~~(5) A plan or delegated provider group that does not provide advanced access to appointments shall have systems and personnel sufficient to ensure that:~~
- ~~(A) A qualified health care professional, acting within the scope of his or her practice and trained to screen or triage, is readily available by telephone during normal business hours to provide prompt screening and triage, and to advise enrollees and providers regarding the time in which an enrollee should see a physician, or to receive ancillary care services, and to facilitate arranging for appointments in a timely manner as appropriate for the enrollee's condition and health care needs.~~
  - ~~(B) The screening and triage activities conducted pursuant to subsection (d)(5)(A) and the resulting appointments are documented, monitored, and evaluated through the plan's quality assurance program to ensure full compliance with the requirements of this section and with the plan's internal policies and procedures.~~
  - ~~(C) The telephone wait time for an enrollee or to speak with a qualified health care professional pursuant to subsection (d)(5)(A) regarding the enrollee's health care condition or need for an appointment shall not exceed five minutes. After hours and weekends, plan and provider medical advice and triage lines shall provide clear recorded instructions regarding how to obtain urgent or emergency care.~~
  - ~~(D) When it is necessary for a provider or an enrollee to cancel an appointment, the enrollee is offered an alternative appointment in a timely fashion appropriate for the nature of the enrollee's condition and is not subjected to multiple provider cancellations that may disrupt continuity of care or otherwise delay timely access contrary to the requirements of Section 1367.03 of the Act and this section.~~

~~——(A) To ensure the enrollee is offered a replacement appointment in a timely fashion appropriate for the nature of the enrollee's condition;~~

~~——(B) To avoid repetitive cancellations;~~

~~——(C) To provide prompt advance notice of the change or cancellation to the enrollee, and~~

~~——(D) To ensure consistency with the objectives of Section 1367.03 and this section.~~

~~——(7) Follow-up or Standing Appointments. The appointment waiting time standards specified in this subsection do not apply when good clinical practice for scheduling follow-up, recurring or standing appointments allows for longer appointment waiting times for enrollees who need ongoing follow-up or periodic health care services.~~

~~——(8) Enrollee Requests for Specific Specialists. The appointment waiting time standards of this section shall not apply when an 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.~~

~~——(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 assist the enrollee or the enrollee's referring provider in obtaining a timely appointment with another geographically accessible provider of equivalent specialty appropriate for the enrollee's condition, or provide 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.~~

~~——(10) 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.~~

~~(d) Alternative Standards; Material Modification. A plan may propose alternatives to the timely access standards specified in this section by filing the proposal in writing in the applicant's license application or in a notice of material modification of a licensed plan. The proposal shall include, to the extent relevant and practicable, but shall not necessarily be limited to the following:~~

~~——(1) Description and circumstances of the region or portion of the plan's service area affected.~~

~~—(2) Description of provider facts and circumstances relevant to the proposal—for example: the availability, distribution, and shortage of the category of provider; if applicable, the specific type of affected covered services to which the alternative standard is proposed to apply; reasons for not contracting with providers in the affected area; and patterns of practice in the affected area.~~

~~—(3) The distribution of enrollees in the affected service area.~~

~~—(4) The proposed alternative standard and a demonstration that the proposed alternative is “more appropriate.”~~

~~—(5) The clinical appropriateness of the proposed alternative standard and its application.~~

~~—(6) Appointment scheduling systems which do not meet the definition of “Advanced Access” or “open access” as specified in this section but which are requested to be considered in substantial compliance with, and receive the benefits of, Advanced Access or open access as defined herein.~~

~~—(7) Description of the reasons justifying the alternative standard and documentation sufficient to verify the facts and circumstances upon which the proposal is based.~~

~~—(8) The specific steps the plan will take to provide timely access to enrollees within the affected service area including education of the affected enrollees about their right to timely access under the alternative standard.~~

~~—(9) The period of time for which the plan desires the alternative standard to be approved, but not to exceed three years.~~

~~—(A) If the circumstances justifying the alternative standard are not remediable within three years, then the plan shall provide an undertaking committing the plan to include in the plan’s annual compliance report specified in subsection (i): (i) the status of timely access remediation regarding and operation of the alternative standard; and (ii) justification for a proposed revised period of time for continuation of the alternative standard.~~

~~—(B) Where a specialized plan justifies an alternative standard on the basis of fundamental differences between the delivery and practice of care within its discipline versus medical care, the specialized plan may request approval of the alternative standard for a longer period of time. Such approval shall be conditioned upon the specialized plan providing in its annual compliance report a review of enrollee grievances and other monitoring data which supports the efficacy of the alternative standard, and such approval is subject to review and modification by the Department at any time.~~

~~—(10) 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) Plan’s Compliance Monitoring. All plans shall establish and file in accordance with subsection (h) a documented system for monitoring achievement and maintenance of timely~~

~~access to covered health care services as measured by compliance with the plan's standards that are consistent with subsections (c)(2), (c)(3), (c)(4) and (d), as applicable.~~

~~— (1) Methodology and Timing of Monitoring. Each plan's timely access monitoring system shall focus upon identifying any patterns of noncompliance and egregious episodes of noncompliance. 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, substantial 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. A plan shall not be subject to enforcement action due to isolated episodes of noncompliance, absent egregious circumstances.~~

~~— (2) Each 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 to the plan regarding concerns with or about timely accessibility and availability of covered services.~~

~~— (E) For full-service plans, survey of disenrolled persons (excluding persons disenrolled due to group contract termination and termination of enrollee eligibility) to determine whether lack of timely access was a reason for disenrollment.~~

~~— (3) For providers operating on an Advanced Access basis or an open access basis, the plan shall monitor and confirm, on an annual basis, that those providers continue to maintain an effective Advanced Access or open access appointment system. Such verification shall be sufficient to enable the plan to reasonably conclude that the providers are operating on an Advanced Access basis or an open access basis, and may include:~~

~~— (A) Non-anonymous telephone surveys of providers' offices; or~~

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

~~— (4) For providers not operating on an Advanced Access basis or an open access basis, the plan's monitoring system shall include non-anonymous telephone surveys of providers at least annually, as follows:~~

~~— (A) Identify and list providers in each of the following provider categories:~~

~~— All Primary Care Physicians~~

~~Specialty Care Physicians in the following categories, each of which should be surveyed separately:~~

~~Allergy & Immunology  
Cardiology & Cardiovascular Disease  
Dermatology  
Gastroenterology  
Gynecology (non-PCP)  
Ophthalmology  
Otolaryngology (ENT)  
Radiation Oncology  
Surgery, Cardio/Thoracic  
Surgery, General  
Surgery, Orthopedic  
Urology~~

~~All other Specialty Care Physicians should be surveyed for plan internal review, annual reporting, and provider shortage substantial compliance.~~

~~The mental/behavioral health care providers are one category consisting of the following, which should be surveyed as a group: psychiatrists, psychologists, licensed clinical social workers, and certified psychiatric mental health nurse practitioners.~~

~~Ancillary and other provider categories may be surveyed by random sampling or by surveying all providers in the category.~~

~~Specialty plan service provider categories may be surveyed by random sampling or by surveying all providers in the category.~~

~~(B) Select providers to survey. Plans have discretion in determining providers to survey, including:~~

~~(i) Individual surveys. If a provider category is small (e.g., three physicians), plans may survey each provider individually.~~

~~(ii) Survey sampling. Plans may use statistically valid survey sampling as described in the “Statistically Valid Survey Sampling Guide” attached hereto and incorporated herein by reference—especially for large provider categories.~~

~~(iii) Provider categories with provider shortage. Plans should survey the provider category and achieve substantial compliance by reporting the shortage in accordance with subsection (j)(2).~~

~~(C) Use the following survey questions (unless alternative questions are approved by the Department). The office of a provider group may respond for the selected providers of the group (so that providers of the provider group need not be surveyed individually). Substitute the applicable category of provider for the words “category of provider” in the following questions.~~

~~(I) What is the approximate time to obtain an appointment for **urgent** [category of provider] care? In hours \_\_\_\_\_.~~

~~\_\_\_\_\_ (II) What is the approximate time to obtain an appointment for **routine** [category of provider] care? In business days \_\_\_\_\_.~~

~~\_\_\_\_\_ (III) What is the approximate time to obtain an appointment for **preventive** [category of provider] care? In business days \_\_\_\_\_. (For mental health, substitute “routine mental health care after an inpatient stay for mental health” for “preventive mental health care.”)~~

~~\_\_\_\_\_ (IV) During regular office hours, what is the approximate waiting time to speak by telephone to a qualified health professional who is trained to screen and triage? In minutes \_\_\_\_\_.~~

~~\_\_\_\_\_ (V) After regular office hours, what is the approximate waiting time to speak by telephone to a qualified health professional who is trained to screen and triage? In minutes \_\_\_\_\_.~~

~~\_\_\_\_\_ (D) Plans may cooperate and share results. Where a provider or provider group has contracts with two or more health plans, the plans may agree to authorize one of the plans (or an agent of the plans) to conduct the telephone survey so as to avoid duplication of survey questions being asked of the same provider or provider group, and the survey results shall be provided to each such plan for use in complying with this section.~~

~~\_\_\_\_\_ (E) Evaluating and achieving compliance. Determine compliance for the entire provider category by the number of questions for which compliance has been demonstrated for the provider category. If compliance for the provider category is demonstrated for four of the five questions, the provider category is 80% compliant; if compliance is demonstrated for three of the five questions, then the provider category is 60% compliant, and so forth. If the provider group is determined to be less than 80% compliant, then the plan may:~~

~~\_\_\_\_\_ (i) If the provider category was surveyed by sampling, then increase the sample size and survey additional providers in the provider category;~~

~~\_\_\_\_\_ (ii) Achieve substantial compliance in accordance with subsection (j)(4) by adding: plus 5% if the plan’s enrollee satisfaction survey indicates no dissatisfaction with timely access to the provider category determined by the survey to be less than compliant; plus 5% for the absence during the prior year of enrollee grievances regarding the appointment waiting time standards applicable to that provider category; and plus 5% for the absence during the prior year of provider communications to the plan regarding compliance with the appointment waiting time standards applicable to that provider category; or~~

~~\_\_\_\_\_ (iii) Implement a corrective action plan to establish substantial compliance in accordance with subsection (j)(1).~~

~~\_\_\_\_\_ (F) Follow-up auditing when indicated. If the plan has reason to question the validity, credibility or veracity of the responses to the non-anonymous telephone surveys of providers (for example, if the survey responses are materially inconsistent with reasonable conclusions drawn from the information collected by the plan pursuant to subsection (e)(3)) or upon the Department’s direction, then the plan shall use one or more of the following methods to resolve the question of validity, credibility or veracity:~~

~~—— (i) Written surveys of physician provider groups larger than five physicians, designed to identify problems with or about timely accessibility and availability of covered services.~~

~~—— (ii) Anonymous (secret shopper) telephone audits of providers' offices.~~

~~—— (iii) Audits of enrollees' records in providers' offices (which may include use of electronic health records consistent with limiting access and laws applicable to maintaining confidentiality of patient information) for data evidencing compliance or noncompliance with the standards of subsections (c) and (d). Such audits shall be arranged at mutually agreeable times during provider office hours.~~

~~—— (5) Alternative Methods. A plan may use alternative or experimental methods other than those described in this subsection, if such alternative methods achieve and maintain compliance or substantial compliance to the satisfaction of the Department. Use of flexible and workable methods developed cooperatively with providers and provider groups may be used if such methods are designed to, and do, achieve and maintain compliance or substantial compliance with the plan's timely access standards. Such methods should be intended to provide flexibility for plans and providers in deciding how compliance will be demonstrated for specific providers, to the satisfaction of the Department.~~

~~—— (6) For plans with preferred provider organization arrangements providing services through a preferred provider organization network, the plan shall monitor on an annual basis the number of PPO primary care providers and specialty physicians under contract with the plan in each region of the plan's service area and annually review enrollee complaints regarding timely access.~~

~~(f) Plan's Enrollee Satisfaction Survey. Not less frequently than annually, all plans shall conduct a survey to ascertain 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 or the plan shall file an undertaking that the plan will use standardized questions jointly prepared by multiple plans and approved by the Department. 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. As soon as feasible, plans shall correct patterns of noncompliance and egregious episodes of noncompliance with the standards adopted in accordance with this section. Except for subsection (j)(1)(where a corrective action plan is an element of the substantial compliance), a corrective action plan is not required if the plan demonstrates substantial compliance in accordance with subsection (j). If the pattern or egregious episode of noncompliance is not corrected within 60 days of identifying the deficiency(ies), the plan shall file a corrective action plan with the Department not later than the 60<sup>th</sup> day and correct the pattern or egregious episode of noncompliance within 120 days of identifying the deficiency(ies). The corrective action plan shall contain provision for monitoring the effectiveness of the corrective action. 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.~~

~~— (1) Corrective Actions. Plans shall implement one or more of the following corrective actions as appropriate to correct deficiencies in compliance with the timely access standards adopted in accordance with this section:~~

~~— (A) Provide additional education to noncomplying providers regarding how to achieve compliance with the timely access standards, especially where noncompliance is due in part to lack of provider understanding of the plan's timely access standards or how to achieve compliance with timely access standards.~~

~~— (B) Provide active assistance to referring providers to obtain timely appointments for referrals of enrollees to other providers.~~

~~— (C) In the region of the plan's service area in which the noncompliance is located, commence recruitment of additional providers with the objective of adding sufficient provider capacity to enable achievement of compliance with the timely access standards.~~

~~— (D) In the region of the plan's service area in which the noncompliance is located, commence negotiations with non-contracting providers in order to add providers at contracted rates of compensation comparable to the rates being paid to contracting providers in the region.~~

~~— (E) If lack of compliance with the timely access standards may be due to a "shortage of providers" in a region of the plan's service area:~~

~~— (i) Determine the nature and extent of the provider shortage;~~

~~— (ii) If feasible, consider assisting with recruitment of providers;~~

~~— (iii) Evaluate and assist with implementation of telemedicine capacity in the region in order to improve timely access; and~~

~~— (iv) Prepare for substantial compliance in accordance with subsection (j)(2).~~

~~— (F) Increase the number of enrollees referred to available non-contracting providers in the affected service area to achieve compliance with timely access standards, 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.~~

~~——(G) 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.~~

~~——(H) Apply for approval of an alternative standard in accordance with subsection (d).~~

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

~~——(2) Justification for Additional Time for Correction. If the pattern of noncompliance is not remediable within 120 days, then the corrective action plan shall include:~~

~~——(A) Request for approval of a proposed revised period of time to correct the deficiency(ies); and~~

~~——(B) Justification for the proposed revised period of time to complete corrective action.~~

~~(e) (h) Compliance and Filing, 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. and Reporting Requirements.~~

~~(1) ——(1) The plan's written standards, policies and procedures implementing the plan's program for improving, maintaining, monitoring and ensuring 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 with an applicable exhibit number under section 1300.51 or an undertaking that the plan will use standardized questions jointly prepared by multiple plans and approved by the Department. Not later than December 31, 2008, plans shall have implemented the policies, procedures and systems necessary for compliance with the requirements of Section 1367.03 and this section. Not later than October 1, 2008, 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:~~

~~(A) ——(2) A description of the plan's educational program and disclosures added in the evidences of coverage and disclosure forms informing enrollees about how to request the plan's assistance in obtaining timely appointments, how to file a complaint about a timely access problem, how to notify the plan regarding timely access problems, and generally describing the plan's indicators and standards for timely access, identified with an applicable exhibit number under section 1300.51. The plan's policies and procedures for ensuring timely access in accordance with the requirements of this section, including clinically appropriate access standards for all indicators set forth in the plans' policies and procedures, together with information in support of the standards; and for any variations proposed for geographic areas in which there are shortages of particular types of providers.~~

~~— (3) Documentation sufficient to demonstrate compliance with Section 1367.03(f)(1), regarding contracts with providers, identified with an applicable exhibit number under section 1300.51. The plan's forms of enrollee and provider satisfaction surveys and, if applicable, any supplemental questions to be included with enrollee surveys conducted pursuant to NCQA accreditation processes.~~

~~— (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. The disclosures in evidences of coverage and enrollee educational material informing enrollees how to obtain timely appointments and what to do if the enrollee encounters problems in scheduling appointments.~~

~~(B) (i) Annual Compliance Report. By March 31 of the first full 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: Amendments to provider and other contracts as necessary for compliance with Section 1367.03(f)(1) of the Act and with subsection (a).~~

~~— (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 By July 31, 2010, and by July 31 of each year thereafter, every full service plan shall file with the Department a report, pursuant to Section 1367.03(f)(2) of the Act, regarding compliance during the immediately preceding year. The first reporting period shall be the calendar year ending December 31, 2009. The reports shall document the following information:~~

~~(A) — (A) The percentage of total contracting providers operating in compliance (computed by adding total providers determined in compliance by using the statistical sampling methodology of subsection (e)(4)(A) plus providers using Advanced Access or open access systems, divided by total contacted providers); The plan's timely access standards for all indicators set forth in the plan's policies and procedures.~~

~~— (B) The monitoring methods used; The rate of compliance, during the reporting period, with each of the plan's timely access standards, separately reported for each of the plan's contracted provider groups located in each county of the plan's service area.~~

~~— (C) A certification that the statistical sampling methodology used was consistent with the specifications of subsection (e)(4)(F);~~

~~— (D) Patterns of noncompliance identified, if any; and~~

~~— (E) A current list of providers using an Advanced Access or open access appointment system in the plan's service area.~~

~~— (2) A description of the plan's substantial compliance in accordance with subsection (j), if any.~~

~~—(3) A description of the plan’s compliance with subsection (c)(3)(B)(Telephone Access to Plans).~~

~~—(4) For full-service plans, the number and percentage of the plan’s contracting primary care physicians and specialty care physicians using an Advanced Access or an open access appointment system. For purposes of Advanced Access or open 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.~~

~~—(5)~~

- ~~(B) Whether the plan identified, during the reporting period, any incidents of noncompliance resulting in substantial harm to an enrollee and, if so, a description of the incident, and a description of the plan’s investigation, determination and corrective action taken in response to each incident.~~
- ~~(C) Whether the plan identified, during the reporting period, any patterns of non-compliance identified by the plan during the reporting period and, if so, a description of each pattern of non-compliance, including the provider group affected and its location (county), and a description of the plan’s investigation, determination and corrective action taken in response to each identified pattern of non-compliance.~~
- ~~(D) A list of all provider groups and individual providers utilizing advanced access appointment scheduling.~~

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.

~~—(6) A summary of enrollee grievances received during the prior calendar year, regarding timely access.~~

~~(E) —(7) The results of the latest enrollee most recent annual enrollee and provider satisfaction surveys surveys and a comparison with the results of the prior year’s survey (if any), including a discussion of the relative change in satisfaction.~~

~~(2) —(8) A summary of provider communications to the plan during the prior calendar year regarding timely access. In approving or disapproving a plan’s proposed standards for timely access, the Department may consider all relevant factors, including but not limited to:~~

~~(A) —(9) Corrective action implemented during the reporting year regarding timely access, and provider education and corrective action provided to improve timely telephone access. The availability and distribution of primary care physicians, specialty physicians and other types of providers within a service area;~~

~~(B) (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) and not subject to enforcement action for patterns of noncompliance if the plan demonstrates that it is in substantial compliance with those subsections. For purposes of this section and for plans not able to achieve compliance in one or more parts of the plan's network, a plan may achieve "substantial compliance" for the specific part of the plan's network by completing any of the following and documenting such substantial compliance in the plan's annual compliance report: The adequacy of a plan's mechanisms to make alternative arrangements for enrollees when contracting providers are unable to meet the standards;~~

~~(C) — (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 an Advanced Access or an open 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 correct the deficiency(ies) within a specified and reasonable period of time not to exceed 120 days from the date the noncompliance was identified by the plan, unless extended pursuant to subsection (g)(2). The adequacy of a plan's mechanisms for evaluating and responding to sudden changes in utilization patterns;~~

~~(D) — (2) Compliance in Provider Shortage Situations. For purposes of this subsection, "shortage of providers" means that the number or type of provider providing services in a region or portion of the plan's service area (or the available patient capacity of such provider) is insufficient to enable compliance with the timely access standards. The shortage may be due to shortage in a medically underserved area or a more extensive shortage due to lack of a certain specialty type. A plan may achieve substantial compliance for a shortage of providers by reporting the following in the plan's annual compliance report required under subsection (i). Such inclusion in the plan's annual compliance report is in lieu of applying for approval of an alternative standard under subsection (d). The factors set forth at Section 1367.03(d) and (e); and~~

~~(E) — (A) The shortage of providers, including the number of the type of provider providing services in the subject geographic area; Other factors that the Director deems appropriate in the public interest and consistent with the intent and purpose of the Act as applied to specific facts or circumstances.~~

~~(3) — (B) Actions the plan is planning or has taken to alleviate the shortage of providers, including direct recruiting or assistance with recruiting of providers; and In determining a plan's compliance or non-compliance with the requirements of this section, the Department will focus more upon patterns of non-compliance than isolated episodes of non-compliance and may consider all relevant factors, including but not limited to:~~

~~(A) — (C) Measures the plan is planning or has taken to achieve timely access in spite of the shortage of providers, for example, by implementing or encouraging the implementation of telemedicine. The efforts by a plan to evade the standards, such as referring enrollees to providers who are not appropriate for an enrollee's condition;~~

~~— (3) 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 compliance with the alternative standard.~~

~~— (4) Percentage Compliance.~~

~~— (A) Total Number of Providers. For purposes of determining the percentage of providers in compliance under this subsection (j)(4):~~

~~— (i) “Total number of providers in the plan’s network” means all plan providers whether or not operating on an Advanced Access basis or an open access basis.~~

~~— (ii) “Total number of providers determined to be in compliance” means total plan providers (excluding providers operating on an Advanced Access basis or an open access basis) determined to be in compliance by extrapolation in accordance with subsection (e)(4)(A)) plus total plan providers operating on an Advanced Access or open access basis (confirmed pursuant to subsection (e)(5)) and which are considered in compliance pursuant to subsection (a)(4)) plus providers determined to be in substantial compliance pursuant to the “shortage of providers” provisions of subsection (j)(2).~~

~~— (iii) Divide the “total number of providers in the plan’s network” into the “total number of providers determined to be in compliance” i.e.:~~

~~— 
$$\frac{\text{Total number of providers determined to be in compliance}}{\text{Total number of providers in the plan’s network}} \times 100 = \text{percentage}$$~~

~~— (B) For Full-Service Plans. A full-service plan will be in substantial compliance if the percentage as specified below of total number of providers in the plan’s network have appointment waiting times not longer than the appointment waiting time standards for the following (or an alternative standard approved in accordance with subsection (d)):~~

- ~~— Urgent primary care~~
- ~~— Routine primary care~~
- ~~— Preventive primary care~~
- ~~— Urgent specialty care~~
- ~~— Routine specialty care~~
- ~~— Preventive specialty care~~
- ~~— Urgent mental health care~~
- ~~— Routine mental health care initial evaluation appointments~~
- ~~— Routine mental health care subsequent appointments~~
- ~~— Routine mental health follow-up after inpatient stay~~
- ~~— Diagnostic imaging, diagnostic laboratory and other diagnostic testing needed for urgent primary care and urgent specialty care~~
- ~~— Urgent ancillary and other provider care (including physical therapy, occupational therapy and speech therapy)~~
- ~~— Routine ancillary and other provider care~~
- ~~— Preventive ancillary and other provider care~~
- ~~— Urgent hospital care~~

~~Urgent hospital outpatient diagnostic imaging, outpatient diagnostic laboratory and other diagnostic testing needed for urgent primary care and urgent specialty care.~~

~~(C) For Specialized Service Plans. A specialized service plan will be in substantial compliance if the percentage as specified below of total number of providers in the plan's network have appointment waiting times not longer than the appointment waiting time standards (specified in subsections (c)(2)(C) and (F)) for the following as applicable (or an alternative standard approved in accordance with subsection (d)):~~

- ~~Urgent acupuncture care~~
- ~~Routine acupuncture care~~
- ~~Preventive acupuncture care~~
- ~~Urgent chiropractic care~~
- ~~Routine chiropractic care~~
- ~~Preventive chiropractic care~~
- ~~Urgent dental care~~
- ~~Routine dental care~~
- ~~Preventive dental care~~
- ~~Urgent mental health care~~
- ~~Routine mental health care initial evaluation appointments~~
- ~~Routine mental health care subsequent appointments~~
- ~~Routine mental health follow-up after inpatient stay~~
- ~~Urgent vision care~~
- ~~Routine vision care~~
- ~~Preventive vision care~~

~~(D) Percentages Qualifying for Substantial Compliance.~~

~~(i) Beginning the second year following the effective date of this section and continuing until two full calendar years have elapsed: Seventy percent.~~

~~(ii) For the full calendar year commencing immediately after the end of the period specified in subsection (j)(4)(C)(i) above: Seventy-five percent.~~

~~(iii) For the full calendar year commencing immediately after the end of the period specified in subsection (j)(4)(C)(ii) above: Eighty percent.~~

~~(iv) For each calendar year after the period specified in subsection (j)(4)(C)(iii) above: Eighty-five percent.~~

~~(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) Advanced Access or Open Access. Where a plan has filed verified documentation sufficient to demonstrate that 50% or more of the plan's contracting providers are operating on an Advanced Access appointment system or an open access appointment system, the plan's annual compliance report for the immediately succeeding year need not include the information required by subsection (i)(2), (5) and (9), except for plan contracting providers that are not operating with an Advanced Access or an open 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 including applicable substantial compliance, the plan's annual compliance report for the immediately succeeding year need not include the information required by subsection (i)(2), (5) and (9).~~

~~— (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)(2), (5) and (9) 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)(2), (5) and (9) as to the specific service area where timely access compliance was achieved with the support of health information technology~~

- ~~(B) The nature and extent of a plan's efforts to avoid or correct non-compliance;~~
- ~~(C) The nature and extent to which a single instance of non-compliance results in, or contributes to, serious injury or damages to an enrollee;~~
- ~~(D) The extent to which non-compliance is the result of an urgency or emergency affecting a provider or provider group;~~
- ~~(E) The occurrence of sudden changes in utilization patterns; that are not reasonably foreseeable by a plan or within a plan's control, and which result in provider shortages which cannot be addressed through referrals to other providers; and~~
- ~~(F) Other factors established in relevant provisions of law, and other factors that the Director deems appropriate in the public interest and consistent with the intent and purpose of the Act as applied to specific facts or circumstances.~~

(4) A plan may propose, by filing a notice of material modification, for the Department's prior approval by written Order, timely access standards other than time elapsed standards for the indicators listed in subsection (d)(2). The notice of material modification shall include a comprehensive explanation of: the plans' clinical and operational bases for the proposed alternative standard; the expected impact on clinical outcomes and on contracted health care providers; and reliable and verifiable data supporting the plan's proposed alternative standards. The burden shall be on the plan to demonstrate and substantiate why a proposed alternative standard is more appropriate than time elapsed standards.

Authority: Sections 1344, 1346 and 1367.03, Health and Safety Code.

Reference: Sections 1342, ~~1363~~, 1367, ~~1368~~, ~~1368.1367.01~~, 1367.03, 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.~~

## **STATISTICALLY VALID SURVEY SAMPLING GUIDE**

~~1. Statistically valid survey sampling. Providers may be surveyed by using a statistically valid random method of sample selection and a determination of provider category compliance. The following method may be used or another method may be used if approved by the Department.~~

~~— (a) Randomize the lists of provider categories to be surveyed by statistically valid sampling. Each list of provider categories to be surveyed by using statistically valid samples must be rearranged in random order, using randomizing software or methodology—for example, use an EXCEL spreadsheet for each such provider category list, as follows:~~

~~— (i) In a column of an EXCEL spreadsheet, enter (or copy and paste) the list of providers in the provider category.~~

~~— (ii) In the column next to the column of providers, enter or paste the function: =RAND(). This is EXCEL’s way of putting a random number between 0 and 1 in the cells.~~

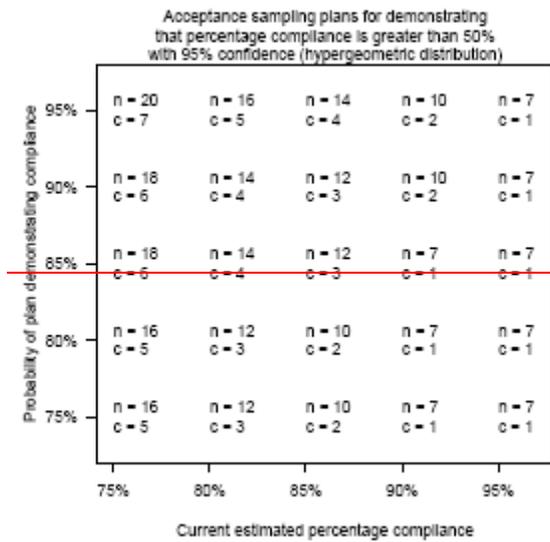
~~— (iii) Sort both columns—the list of names and random numbers—by the column containing the random numbers. This rearranges the list of providers in random order from the lowest to the highest random number. The sampling plan (described below) will identify “n” as the number of providers to survey, so that the first “n” providers on the randomized list of providers in each provider category are selected for survey.~~

~~— (b) Determine the current estimated percentage compliance. For each provider category, determine the “current estimated percentage compliance” of provider category from the Sampling Plan Chart. For the first year of such survey, use 90%. In subsequent years, the plan may select the percentage (most likely based on the percentage of compliance of the previous year).~~

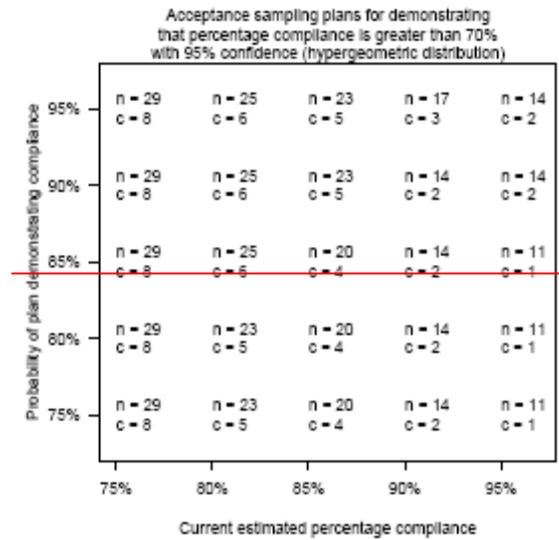
~~— (c) Determine the desired probability of successful demonstration. For each or all provider categories, determine the desired “probability of plan demonstrating compliance.” For the first year, use 90%. In subsequent years, the plan may select another percentage based on the plan’s desired probability of successful demonstration.~~

~~— (d) Select the Sampling Plan Chart below for the size of the provider category to be surveyed. For Provider Categories of 1 to 30 Providers, there are two charts: One for compliance greater than 50% (usable through December 31, 2010, in order to accommodate smaller sample sizes with a variety of specialists including those for which shortage exists), and a second for compliance greater than 70% which is the same as all the other charts.~~

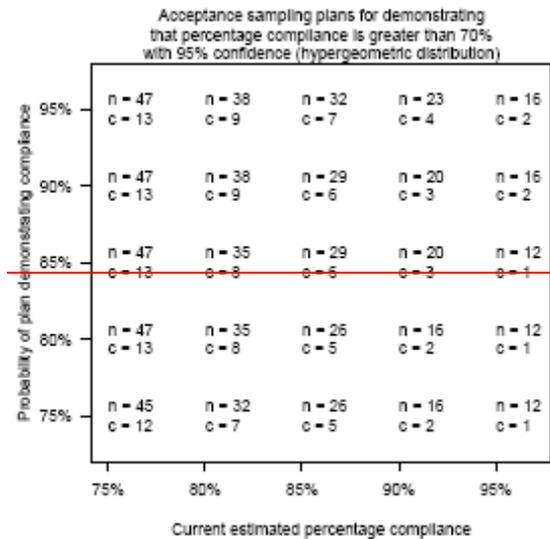
**PROVIDER CATEGORIES of 1 to 30  
Providers (usable through 12/31/2010)**



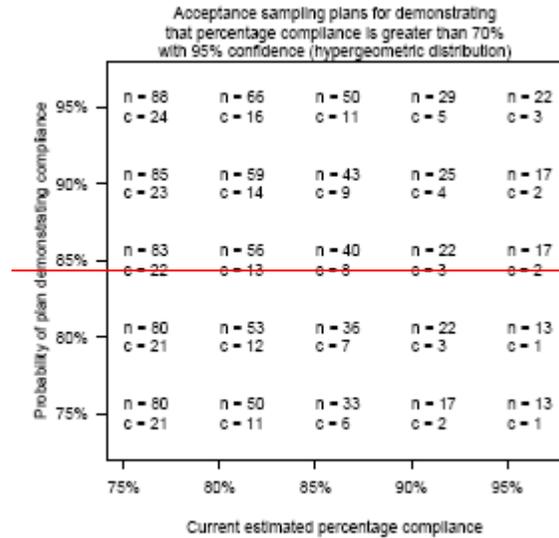
**PROVIDER CATEGORIES of 1 to 30  
Providers**



**PROVIDER CATEGORIES of 31 to 50  
Providers**

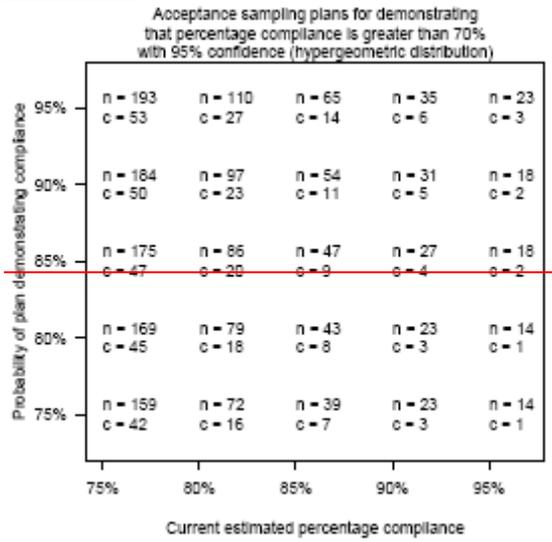


**PROVIDER CATEGORIES of 51-100  
Providers**



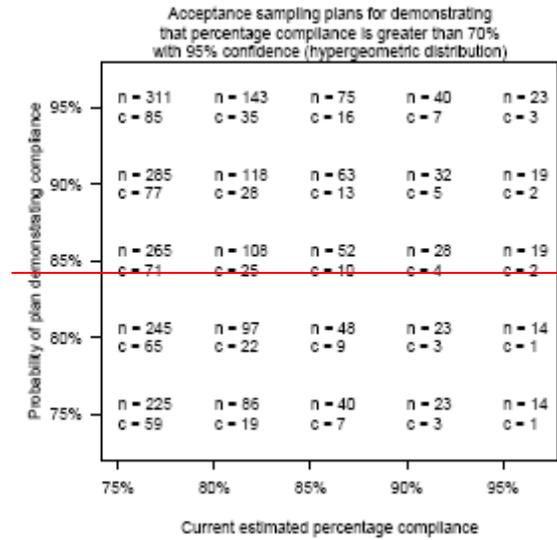
**PROVIDER CATEGORIES of 101-250**

**Providers**



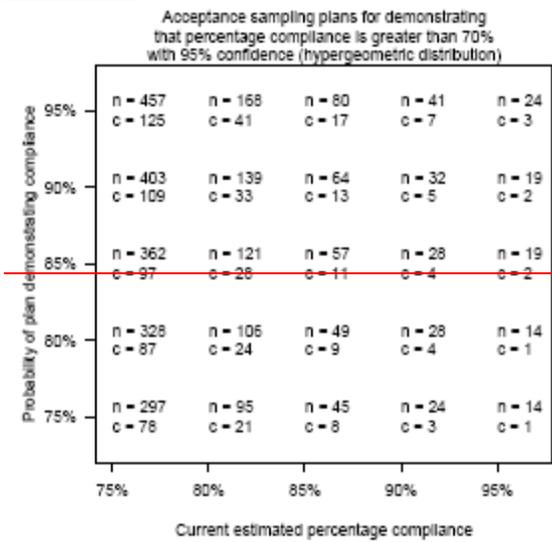
**PROVIDER CATEGORIES of 251-500**

**Providers**



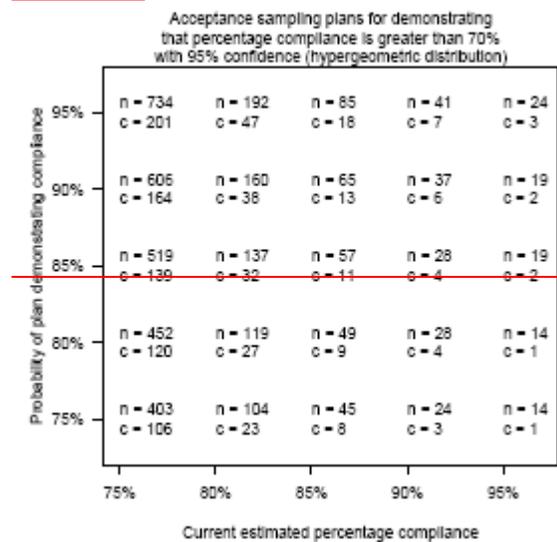
**PROVIDER CATEGORIES: 501-1000**

**Providers**

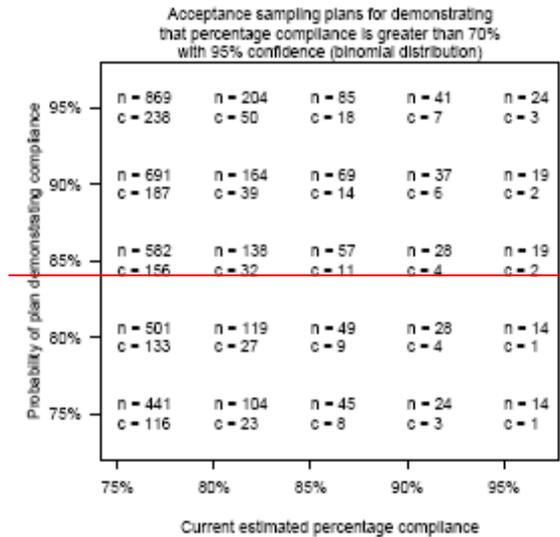


**PROVIDER CATEGORIES: 1001-5000**

**Providers**



**PROVIDER CATEGORIES of 5001 and more Providers**



~~(e) Choose the sampling plan from the selected Sampling Plan Chart. In the applicable Sampling Plan Chart, “n” is the number of providers to survey in the provider category, and “c” is the maximum number of providers not meeting the applicable standard. Identify n = \_\_\_ and c = \_\_\_ by the numbers at the intersection of the selected “probability of plan demonstrating compliance” with the selected “current estimated percentage compliance.” For example, in the 251–500 providers chart, if the selected “probability of plan demonstrating compliance” is 90% and the selected “current estimated percentage compliance” is 90%, then the sample size n = 32, and the maximum number of noncomplying providers is c = 5.~~

~~(f) Determine the providers to survey. From the randomized list of the provider category, select the first “n” providers to survey.~~

~~(g) Determine results of sampling survey and provider category compliance.~~

~~(i) For each question, determine the number of providers in the provider category not meeting the applicable standard. That number is designated as “x.”~~

~~(ii) For each question, compare “x” to “c” from the intersection in the Sampling Plan Chart as specified in subsection (4)(B)(v), above.~~

~~(iii) For each question, if x is less than or equal to c, then compliance has been demonstrated. If x is greater than c, then compliance has not been demonstrated.~~

~~2. Extrapolate survey results to plan’s entire contracted provider capacity. The survey responses shall be extrapolated to the entire contracted provider capacity of the plan (exclusive of providers operating on an Advanced Access or open access basis) by apply the results of the survey to all providers. This is to demonstrate the percentage of the total number of such providers in the plan’s network that are in compliance with the timely access standards identified in this section (or an alternative standard approved in accordance with subsection (d)). The demonstration of percentage of compliance shall be reported in the description of compliance in the plan’s annual compliance report.~~

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