

Department of Managed Health Care

TIMELY ACCESS TO HEALTH CARE SERVICES (2005-0203)

RESPONSES TO COMMENTS

Comment Period #3, December 10, 2007 – December 26, 2007

#	COMMENT	DEPARTMENT RESPONSE
1-1	Thank you for a responsible and sensible solution. As a small plan with limited resources, I can work to intergrate these regulations into my present work.	No change requested.
2-2	Insurance companies (healthnet) and especially medical are unavailable or intentionally delay getting approval then deny the claim because they did not provide preapproval for medical emergencies. they even deny that their representative talked to us, even though I have recordings of the conversation, which they granted permission and then say that is not allowed in court, but I take them to small claim court anyway, then they lie in court too. get tough with these folks!!!	No change requested. However, with respect to the stated concerns regarding utilization review (prior authorization) processes, the requirements of Section 1367.01 apply, and section 1371.4 prohibit plans from requiring prior authorization for emergency services. Enrollees with complaints regarding a plan's denial of covered services may submit their complaints to the Department's Help Center. The Help Center may be contacted toll free at 888-466-2219 or on line at www.dmhc.ca.gov . Health care providers may submit complaints regarding a plan's denial or non-payment of a claim to the Department's Provider Complaint Unit. The Provider Complaint Unit may be contacted at (877) 525-1295 or by e-mail at pcu@dmhc.ca.gov .
3-3	The Plan appreciates the efforts taken by the Department to more closely align the regulations on "Timely Access" to NCQA (National Committee on Quality Assurance) standards. By allowing Health Plans to follow these continually updated standards and practices members have the assurance of quality while the Department effectively reduces impact to health care costs by avoiding duplicative efforts.	No change requested.
3-4	<p>The following are comments, suggestions, and or requests for clarification requested by the Plan. The excerpts from the proposed regulations are included in bold-italic text while the Plan's responses are included in plain text.</p> <p><u>Comment 1.</u> <i>(b)(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.</i></p>	<p>Decline: The suggested revision is not necessary to clarify the regulation, or to address the stated concerns. The revised text retains a requirement for time elapsed standards for the access indicators enumerated in Section 1367.03.</p> <p>The definition of waiting time accounts for situations in which the plan is in compliance by offering an appointment within the time elapsed standard for the particular indicator, but the enrollee prefers a later appointment, e.g. if the enrollee prefers to wait for an appointment with a preferred qualified specialist rather than accept an earlier appointment with another qualified specialist.</p>

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	<p>As discussed in previous comments and testimony, the proposed regulations will require potentially significant and costly changes in provider systems. The software currently in use at the appointment call centers within the Kaiser Permanente Medical Care Program does not have the capability to document and track offered appointments and whether an enrollee accepts or declines the initial offered appointment. To implement a system with such capabilities in just our Southern California appointment call centers would cost over \$17 million, which includes the purchase of hardware and software, the hiring of additional staff, and annual maintenance of the system. The \$17 million estimate does not include the costs of ongoing resources required to track offered appointments that are scheduled directly with specific clinical departments or those appointments that are scheduled through the Kaiser Permanente website.</p> <p>The costs and burden associated with complying with these standards would be prohibitive and would not be offset by any benefit to the health care system or our members. The Plan believes the member satisfaction surveys, provider surveys, and continual monitoring of complaints outlined in these regulations will be sufficient for health plans, surveyors, and regulators to monitor access and readily identify any issues surrounding appointment waiting times.</p> <p>Recommended language:</p> <p>(b)(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.</p>	<p>The regulation is unlikely to require an extensive overhaul of existing health IT systems in order to achieve the performance standards established in the regulation for quality assurance monitoring. The regulation provides appropriate flexibility for plans to develop cost effective methods and mechanisms for achieving the performance standards and documenting compliance.</p> <p>Many plans are also participating in the statewide collaborative effort (Cal-RHIO) to increase health IT capabilities of health plans and providers provides. Plans and their delegated medical groups can and should consider the capacity and flexibility of new IT systems to accommodate changes in their respective operations, including changes required as a result of new statutes and regulations requiring improved monitoring of accessibility to covered services.</p>
3-5	<p><u>Comment 2.</u></p> <p><i>(b)(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.</i></p> <p>The Plan understands that the language in this section takes into consideration</p>	<p>Decline: The suggested revision is not necessary to address the stated concerns. The term "written" is commonly understood to encompass electronic and facsimile writings.</p>

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	<p>that, in some instances, members may hold on to referral requests until such time that they chose to make an appointment. Additionally, some providers utilize electronic-referral systems to transmit appointment requests. Therefore, such electronic submission requests are not made in written form. To accommodate such systems, the Plan suggests a minor modification to allow for electronic referral systems, used by some providers, including Kaiser Permanente:</p> <p>Recommended language:</p> <p>(b)(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.</p>	
3-6	<p>COMMENT 3.</p> <p>(c) <i>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), (2) (A)(B)(C)(D):</i></p> <p>The regulation specifies four components for monitoring compliance. For some health plans the compliance monitoring outlined in this section is practical, however, it does not work well for all health plan models. The strict monitoring components in the regulation would not provide sufficient or meaningful data to the Plan or the Department. By allowing health plans to propose alternative compliance methodology, the Department will recognize that differences exist in the health care delivery market. The Plan suggests adopting the following revised language.</p> <p>Recommended language:</p> <p>(c) (3)A plan may propose, by filing a notice of material modification, for the Department's prior approval by written Order, <u>alternative methodology to the</u></p>	<p>Decline: The monitoring requirements established by subsection (c)(2)(A)-(D) are performance standards rather than prescriptive requirements, which provide plans with appropriate flexibility to develop implement the monitoring requirements in a cost-effective manner that is workable in the context of a particular plan's operations and provider network. It is unlikely that performance standards will be burdensome for a plan that has adequate administrative capacity, as required by Section 1367(h), to adequately perform the plans mission critical functions, such as ensuring the timely delivery of covered services, conducting quality assurance monitoring and ensuring regulatory compliance. Please see Sections 1367(g) and 1370 of the Act, and Rule 1300.70 of title 28.</p>

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	above proposed compliance monitoring standards.	
3-7	<p><u>COMMENT 4.</u></p> <p><i>(c) (2) (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.</i></p> <p>The Plan does not believe it necessary or appropriate to add supplemental questions to the CAHPS survey. CAHPS is a nationally standardized survey. Questions in this survey are revised and updated as needed by AHRQ (Agency for Healthcare Research and Quality) sponsored by the US Department of Health and Human Resources. If supplemental questions are added to the validated survey, it will call into question the statistical validity of the survey. In addition the Department does not have oversight over all health plan members. If the questions used for commercial members are not consistent with those used for all membership types this will lead to confusion regarding survey data and resulting corrective actions if needed.</p> <p>Recommended language:</p> <p>(c)(2)(A) An annual, statistically valid, enrollee satisfaction survey. The survey must 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</p>	<p>Decline: The questions in the CAHPS survey that relate to accessibility and timeliness of services are not specific to the access indicators to be monitored and reported by the plans pursuant to this regulation. The information reported by plans and their contracted medical groups must be sufficient to permit consumers to compare their respective performance and compliance in delivering timely access. Please reference Section 1367.03(f)(2).</p> <p>At this time, relatively few plans participate in NCQA accreditation. To permit these plans to use the non-specific NCQA questions and require the rest of the plans to develop specific questions will not provide for a consistent approach with readily comparable results. Accordingly, the regulation requires all plans to survey enrollees with questions designed to measure satisfaction regarding the specific indicators for each specified categories of covered health care service.</p> <p>The Department notes that the comments submitted by NCQA regarding this regulation during the third comment period do not raise concerns regarding detrimental impact on the NCQA survey results, and the NCQA has a process for including supplemental questions. The regulation’s implementation timeline is sufficient to permit plans to develop survey questions, including collaboratively developed uniform survey questions, obtain the Department’s approval of the proposed survey questions, and to access the NCQA processes for including supplemental questions.</p>

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	<p>appropriate supplemental questions, as approved by the Department, with the NCQA survey.</p>	
<p>3-8</p>	<p><u>COMMENT 5.</u></p> <p><i>(c) (2) (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.</i></p> <p>Clarification is needed to understand what the Department is looking to measure, and who is expected to provide this information. The term “Provider” and “Provider Group” are used in this section interchangeably, and therefore makes this section ambiguous. We interpret this section to mean that the Department recognizes that some health plans may only have this methodology to for monitoring patient access. If this is the case, it further supports the Plan’s recommendation that alternative compliance-monitoring methodology be allowed for introduction and approval by the Department. The following proposed revised language would allow the Department to more accurately assess a Plan’s regulatory compliance.</p> <p>Recommended language:</p> <p>(c)(2)(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. <u>Plans may also submit for Department approval, alternative methods for compliance monitoring.</u></p>	<p>Decline: The suggested revision is not necessary to clarify the application of subsection (c)(2), because the objective of the provider survey is clear within the context of this regulation, that is, to solicit input from the plan’s contracted providers regarding satisfaction with the timeliness of obtaining needed health care services within the plan’s provider network. This provision is stated as a performance standard because health care providers have the clinical knowledge and experience to assess whether services are available within the plan’s network in a timely manner appropriate for their patients’ condition and health care needs consistent with professionally recognized standards of practice. To mitigate the likelihood of multiple different versions of surveys that consume excessive provider time, the regulation permits the collaborative development of uniform surveys, subject to the Department’s approval.</p> <p>The suggested revision does not propose to modify the terms “provider” and “provider group”, which terms are stated as the basis for the concerns raised in this comment. The interpretation suggested in this comment is not the intended application for this subsection. The regulation is clear that plans must meet all of the performance standards established in subsection (c)(2) for quality assurance monitoring.</p>

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<p>3-9</p>	<p><u>COMMENT 6.</u></p> <p><i>(e) (2) (F) 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.</i></p> <p>The information requested in this section does not fit the requirements for Health Plan timely access reporting. The reports provided to the Department should be focused on results and outcomes, not on the methods and tools used to achieve them. Telemedicine and other health information technology are simply methods used to assist Plans in achieving successful outcomes. The Plan recommends this section be stricken.</p> <p>Recommended language:</p> <p>(e) (2) (F) 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.</p>	<p>Decline: The referenced reporting requirement is appropriate and is consistent with the intent of the regulation. Information regarding a plan's use of, and advances in the use of, new and emerging technologies for ensuring access to health care services is necessary for the Department's: oversight of plan compliance and the methods utilized by a plan to achieve compliance; reporting to the state legislature; and providing comparative information to consumers with respect to: the relative accessibility of health care services; and the methods utilized by a plan to provide timely access.</p>
<p>3-10</p>	<p><u>Comment 7.</u></p> <p><i>(d)(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):</i></p> <p><i>(A) 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;</i></p> <p>As stated, the Department's timeliness standards closely mirror those set and established by NCQA. However, the NCQA access standards do not monitor performance standards for preventative care appointments. The NCQA</p>	<p>Decline: Section 1367.03 of the Act does not limit the access indicators that the Department may establish. Rather, it requires that the Department "shall consider the [three enumerated items] as indicators of timeliness of access to care." Similarly, Section 1367.03 does not limit the categories of covered services that should be included in access monitoring. Rather, it enumerates several categories of services that should be considered, including "the timeliness of referrals and other services." Ancillary services are "other services." Timely access to covered ancillary services is critical to ensure timely diagnosis and treatment of an enrollee's health care condition and needs. For example, primary care and specialist physicians rely on ancillary services such as diagnostic laboratory and imaging services in determining the next steps for referral to other providers, for treatment and for determining the relative urgency of need for additional health care services.</p> <p>NCQA standards do not provide a basis for ignoring the statutory</p>

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	<p>standards are limited to urgent and routine care. Preventative care is captured within the "Routine" category. The Plan asks that for accuracy the Department remove the category of preventative from the listing outlined above. In addition, the Plan believes the enabling statute, Health and Safety Code section 1367.03 (1), limits tracking of appointment waiting times to physicians; including Primary and Specialty Care. It is unreasonable for the Department to require Health Plans to track appointment waiting times for all ancillary services provided to patients throughout the continuum of care.</p> <p>Recommended language:</p> <p>(d)(2)(A)Appointment waiting times, which shall be tracked separately for each of the following categories of <u>Physicians</u>: (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;</p>	<p>mandate established by Section 1367.03. Access to preventive services is critical to the early diagnosis and detection, of disease, illness etc., and therefore critical to early treatment and better health outcomes. The August 26, 2002 amendments to AB 2179 included revisions to the legislative intent set forth at Section 1342, to specify that the legislative intent includes the promotion also of "the quality" of care.</p> <p>The enactment of Section 1367.03 demonstrates that it is not unreasonable for this regulation to establish performance standards requiring plans to (1) develop quality assurance standards in the form of time-elapsd standards for the enumerated access indicators for the enumerated categories of services, and (2) to monitor through effective mechanisms whether covered health care services are being provided within those time frames. Plans have appropriate flexibility to develop necessary mechanisms to achieve and document compliance with the time elapsed standards.</p>
3-11	<p><u>Comment 8.</u></p> <p><i>(d)(2)(B)Referral times in an episode of illness, injury or other health condition; and</i></p> <p>The Plan requests that this section be clarified by adding language stating that section (B) relates only to outpatient care and not to members that are in hospitals and may need ongoing care by multiple specialists. The following recommended language would more accurately reflect that information which the Department seeks to track.</p> <p>Recommended language:</p> <p>(d)(2)(B)Referral times <u>for medical office visits</u> in an episode of illness, injury or other health condition; and</p>	<p>Decline: Section 1367.03 does not differentiate between an enrollee's need for timely access to covered services while hospitalized or not hospitalized during an episode of illness or injury. Medically necessary covered services must be provided in a timely manner appropriate for the enrollee's condition consistent with good professional practice regardless if the clinical setting in which they are needed, e.g. inpatient or outpatient/ambulatory care. See for example, Section 1367 and Rule 1300.67. A plan is obligated to ensure an adequate network and processes, including when the plan delegates performance of its statutory obligation to contracted medical groups or hospitals. The plan remains ultimately responsible for performance of its statutory obligations, including but not limited to the obligation to ensure timely access to covered health care services, including but not limited to timely referrals during an episode of illness or injury. Please see the last sentence in Section 1367 of the Act, which was added to Section 1367 with the August 26, 2002 amendments to AB 2179.</p>
3-12	<p><u>Comment 9.</u></p>	<p>Decline: The referenced provision establishes the requirement</p>

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	<p><i>(e) (1) 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:</i></p> <p><i>(C) 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</i></p> <p>Disclosure materials can only be developed after final policies and procedures supporting the new regulations are completed. The Department gave health plans until October 1, 2008, to complete this work. The Plan requests the Department allow sufficient production time of Evidence of Coverage (EOC) documents by allowing a phased in process with alternative enrollee materials available by October 1, 2008, and EOCs upon their normal renewal schedule.</p> <p>Recommended language:</p> <p>(C)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.</p>	<p>for a plan to file its proposed enrollee disclosures together with the proposed policies and procedures, which will be subject to Department review and approval. If the proposed disclosures are inadequate to demonstrate compliance, the plan will be required to revise them as necessary to achieve compliance. If the plan cannot obtain Department approval in time to include the disclosures in the EOC booklet or subscriber contract before it goes to print, the disclosures, when approved by the Department, can be distributed as an addendum to the plan's 2008 EOC.</p> <p>It is unlikely that a plan will need to delay developing appropriate EOC and subscriber contract disclosures until after the Department's approval of the plan's detailed policies and procedures. Current statute and regulations already require plans to deliver timely access to covered health care services, including referrals to specialists and other covered services consistent with professionally recognized standards of practice. See Section 1367(d) and Rule 1300.70. These regulations clarify plan performance standards and reporting requirements related to timely access. Plan customer service mechanisms should already be in place to inform enrollees regarding how to obtain timely appointments and what to do if the enrollee encounters problems in scheduling appointments. Nonetheless, as noted above, if the Department requires revisions that cannot be included in printed EOCs that have been distributed before the plan obtains approval, the required disclosure can be promptly distributed as an addendum to the EOC and/or subscriber contract.</p>
3-13	<p><u>Comment 10.</u></p> <p><i>(e)(1)(D) Amendments to provider and other contracts as necessary for compliance with Section 1367.03(f)(1) of the Act and with subsection (a).</i></p> <p>The Plan can have "set" standards within the stated timeframe (December 31, 2008), but requests the Department allow for provider contracts to be amended as the contracts are issued, amended, or renewed in order to</p>	<p>Decline: The suggested delay is not consistent with the intended implementation timeframe and is not necessary to ensure adequate time for plans to identify and negotiate any necessary provider contract revisions. Plans have previously filed time elapsed standards pursuant to Rule 1300.70, together with representations that the plans are adequately monitoring for compliance with the filed time-elapsd standards. Accordingly, provider contracts, including delegation contracts, should</p>

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	<p>conform with the Provider Bill of Rights.</p> <p>Under California law, general obligations to abide by a health plan’s policies and procedures are only applicable to the extent that these obligations have been communicated to the contractor. If requirements have not been communicated prior to the inclusion of the contracted provisions, then the provider retains the right to object to the requirements when they are communicated to them and may invoke the provider’s right to terminate the contract immediately.</p> <p>The requirement to amend provider contracts should be phased in after health plans develop policies and procedures that support the timely access regulations. Such a chronology will enable health plans to appropriately communicate the specific requirements to their contracted providers and to allow for the appropriate provisions to be included in the provider contracts as needed.</p> <p>Recommended language:</p> <p>(e)(1)(D) Amendments to provider and other contracts as necessary for compliance with Section 1367.03(f)(1) of the Act and with subsection (a), <u>as contracts are issued, amended, or renewed on or after January 1, 2009.</u></p>	<p>already have provisions describing the plans existing quality assurance standards for timely access, including time elapsed standards for appointment waiting times. Please see Rules 1300.51(d)(Exhibits J and K) and 1300.70. Section 1367.03 was effective 1/1/03, and plans and providers have been participating in the development of these regulations since that date. The final text of this regulation will be available to the public by January 11, 2008, and plans need not wait until October 2008 to file their proposed time-elapsed standards and related quality assurance policies and procedures to ensure timely access. Please note that the regulations do not establish performance requirements for individual providers, and it is the plan’s ultimate responsibility to ensure timely access to covered services. There are a number of mechanisms a plan can implement to ensure compliance before the implementation due date established in the regulation. See also Section 1375.6(b)(1) regarding material changes to a provider contract “necessary to comply with state or federal law or regulations...”</p>
<p>3-14</p>	<p><u>Comment 11.</u></p> <p><i>(e)(5) 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.</i></p> <p>Some Health Plans have provider models where the proposed access standards and compliance monitoring is not appropriate or applicable. The</p>	<p>Decline: The revision suggested by this comment does not reflect the intended application of the referenced provision, which is that any alternative proposed standards should be regarding the timeliness of providing covered services, as opposed to, for example, geographic accessibility. In addition, the suggested revision is not necessary to address the stated concerns regarding the need for flexibility to accommodate variations in plan network models. The regulation as revised already provides for appropriate flexibility for variations in plan operations, service areas, and provider networks.</p>

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<p>Plan believes the Department should allow for Health Plans to establish and propose alternative standards, subject to the Department's approval.</p> <p>Recommended language:</p> <p>(e)(5) A plan may propose, by filing a notice of material modification, for the Department's prior approval by written Order, <u>alternatives to the above proposed standards</u>, 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.</p>	
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<p>4-15</p>	<p>Your response to comment 1-22 says:</p> <p>"The regulation is not intended to be a basis for finding negligence per se."</p> <p>WHO at DMHC doesn't "intend" for patients to be able to enforce their own rights? Final letters to grievants often say essentially: "We have found no violation of the Knox Keene Act of 1975. This does not limit your option to pursue other legal action."</p> <p>WHY should grievants not be able to use evidence of violation of regulations as evidence of negligence? To win a case, they'd still have to prove damages and causation.</p> <p>'Negligence per se' is the default. Why would DMHC go OUT OF ITS WAY to interpose unnecessary difficulties for grievants trying to enforce their rights under the Knox Keene Act?</p> <p>This would seem to indicate an intention on the part of DMHC that they aren't really serious about compliance with these regulations, and are trying to protect HMOs from action by those enrollees they've wronged.</p> <p>You should delete section "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" and any similar sections.</p> <p>DMHC should EMPOWER enrollees - not take pre-existing rights away!</p>	<p>Decline: The requested revision is outside the scope of this regulation. Section 1367.03 directs the Department to adopt regulations to ensure timely access to covered health care services, not to establish a new cause of action for health plan liability. Causes of action against health plans are already established by other provisions of law, for example, California Civil Code section 3428. Enrollees and providers who have complaints regarding their health plans may also file a complaint with the Department pursuant to Section 1368(b) of the Act, and may request independent medical review pursuant to Sections 1370.4 and 1374.30 et seq., of the Act, which are rights established by statute, not by regulation.</p>
<p>5-16</p>	<p>CADP wishes to express its strong support for the significant change reflected in the third draft of Section 1300.67.2.2(a), which now excludes dental plans from the operation of this regulation. This change reflects a crucial understanding that the dental (as well as vision, chiropractic and acupuncture) plan marketplace is significantly different from that of full service plans. This change will enable thousands of Californians to continue to enjoy dental coverage that is both affordable and delivered in a timely manner.</p>	<p>No change requested.</p>

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6-17	<p>We appreciate that the regulation now recognizes that <i>health plans</i> have the obligation to arrange timely access to care for their enrollees. We believe §§1300.67.2.2(a)(2) and (c)(2) implement the Legislature’s intent and the plain meaning of the authorizing statute by requiring plans to monitor and ensure the adequacy of contracted provider networks, and to not establish performance requirements for individual health care providers. This will prevent certain circumstances in which health plans maintain only token networks and phantom panels, and then push down their responsibility to provide access to their contracting providers that do not have the capacity to provide the volume of services promised by the plan to its enrollees.</p>	No change requested.
6-18	<p>The problems regarding access to health care services which the Legislature sought to remedy by enacting AB 2179 can be addressed by expanding the number of providers available in the network to care for enrollees. §1300.67.2.2(c)(3) appropriately states that one way to resolve an access deficiency is to contract with additional providers. Subdivision (c)(4) is also important because it states that if a contracted provider is unable to deliver timely care, then the obligation is on the health plan to arrange for an appointment with an appropriately qualified and geographically accessible provider.</p>	No change requested.
7-19	<p>On behalf of Delta Dental of California, I am writing to support the changes that are proposed for the third and final comment period for the timely access regulation.</p> <p>As revised, this regulation reflects that, where dental benefits are concerned, access to providers is an uncommon complaint, yet also a high priority for dental plans given the needs and demands of our customers and a highly competitive marketplace. Delta Dental also well recognizes its duty under Section 1367.2 et seq. of the Act to assure that services are readily available at reasonable times to each enrollee consistent with good professional practice.</p> <p>Thank you once again for the Department’s responsive and well-considered changes.</p>	No change requested.
8-20	<p>On behalf of Latino Issues Forum (LIF) I write in response to the Department’s recently released amendments to the proposed regulations for timely access to health care. LIF has worked very closely with you and your staff over the past several years to develop the language access regulations, ensuring the plan surveys developed by the Office of Patient Advocate are consistent with consumers’ needs and most recently on these regulations. With such a productive and collaborative history of working together, I am writing to express our sincere disappointment with the current version of the timely access regulations.</p> <p>Not only were a number of concerns raised in our last letter not addressed, but this current version of the regulations has been changed so substantively that it now appears to be vague and unenforceable. I urge you to re-consider the Department’s position on these regulations and re-adopt the previous version, which was much stronger and provided critical evaluation tools to measure timely access. The following are specific issues LIF raises for your consideration:</p>	<p>Decline: The regulation retains requirements for time-elapsed standards. Please see subsections (d)(2) and (3) and (b)(2), (5) and (7). The specific detailed time elapsed standards are to be developed by the plans in accordance with the performance standards established by the regulation. See subsections (d)(3) and subject to the Department’s review and approval. In addition to the performance standards set forth at subsection (d)(3), the Department may, in reviewing and approving a plan’s proposed timely access standards, all relevant factors as outlined at subsection (e)(3).</p> <p>During the course of this rulemaking action, it became clear that an approach involving specifying in the regulation text the</p>

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	<p><u>Deletion of Time-Elapsed Standards</u> LIF strongly rejects the Department’s deletion of the previously proposed time-elapsed standards. Without specific measurement tools the Department will not be able to fulfill its role as a regulator of managed health care plans and adequately measure compliance. The current version steps far away from the previous version by calling for plans to develop standards consistent with “good practice.” Specifically section (d) states: “(1) Plans shall provide or arrange for the provision of covered health care services in a timely manner for the nature of the enrollee’s condition that is consistent with <i>good professional practice</i>.” (emphasis added). Such a vague requirement defeats the purpose of this process and the reason for regulations. Later in section (3), the regulations call for standard indicators to “be consistent with sound clinical principles and processes.” Again the vagueness of this “requirement” and lack of reference to professional standards or specific tools/times could result in indicators that do not effectively measure access. Suggestion: LIF supports deleting the provisions proposed in the latest draft of the regulations and re-adopting the specific time-elapsed standards from the previous version.</p>	<p>numerous detailed prescriptive time elapsed standards, and exceptions attempting to address variations in plan operations, service areas and provider networks, was unworkable. The second version of regulation text was more complicated, cumbersome and unworkable than the first version, and rather than lessening concerns about unintended consequences, clarity and consistency, the second version generated additional concerns. The regulation meets the statutory objective by establishing performance standards to ensure access to needed health care services in a timely manner for enrollees. The Department has established definitive performance standards, amenable to documentation and reporting, by which plans will develop time-elapsed standards and propose them for the Department’s approval. The time-elapsed standards approved by the Department will also be amenable to documentation and reporting. Because the performance standards established in the regulation and the time-elapsed standards approved by the Department are amenable to documentation and reporting, they will be amenable to compliance oversight monitoring and enforcement by the plans, their delegated provider groups and the Department.</p>
8-21	<p><u>Exemption from providing timely access</u> Section (5) of the regulations essentially exemptions provider groups and plans from the timely access regulations by allowing them to develop practices that do not ensure patients receive the most appropriate and timely access to care. Suggestion: Adopt the alternative standards/modifications language from the previous version coded: Section (10)(d) “Alternative Standards; Material Modifications”. Furthermore, LIF urges you to adopt the following provisions that would greatly strengthen the regulations:</p>	<p>Decline: The referenced provision does not permit plans to adopt any alternative standards except as may be approved by the Department upon a showing, as described in the regulation, that the proposed alternative is consistent with the performance standards established in the regulation and more appropriate than time elapsed standards.</p>

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<p>8-22</p>	<p><u>Increase the connection of the Timely Access regulations to the Language Assistance regulations</u></p> <p>The issues of timeliness and language assistance are very interconnected for limited-English proficient (LEP) enrollees. This connection has been recognized in legislation, Senate Bill 853, and by the Department of Managed Health Care (“the Department”) in the recently approved language access regulations. For example, SB 853 specifies that plans should develop “standards to ensure the quality and <i>timeliness</i> of oral interpretation services provided by the health care services plans” (Section (b)(1)(D)(4)). Further, the final adopted version of the regulations states that plans must provide:</p> <p style="padding-left: 40px;">(v) A description of the arrangements of the plan will make to provide or arrange for the provision of <i>timely</i> interpretation services at no charge to the LEP enrollees at all points of contact where language assistance is needed. For purposes of this subsection “<i>timely</i>” means in a manner appropriate for the situation in which language assistance is needed. Interpretation services are not <i>timely</i> if delay results in the effective denial of the service, benefit, or right at issue. A plan’s language assistance program shall specify quality assurance standards for <i>timely</i> delivery of language assistance services for emergency, urgent, and routine health care services, and shall include standards for coordinating interpretation services with appointment scheduling.”</p> <p>These are clear requirements for the development of timely access standards that are in alignment with and complement the provision of language access services. During LIF’s work with the Department in crafting the Language Assistance regulations, the Department noted that there was no need for specific time periods because this would be addressed in the Timely Access regulations, creating a void that does not meet the needs of our communities.</p> <p>Suggestion: LIF strongly supports a direct reference to the requirements health care plans have in providing <i>timely, language access</i> to health care services. Specifically, LIF would like to see a reference to the specific amount of time that health care plans and providers have to provide language assistance in a timely manner such as 15 minutes or less. In addition, LIF supports a reference requiring <i>qualified</i> interpreters are made available within the timely access timeframe and that plans are not accepting the utilization of an enrollee’s family, friends or non-qualified interpreters.</p>	<p>Decline: Outside the intended scope of the proposed regulations. The suggested revisions are not necessary to address concerns regarding access to language assistance services. Language assistance programs are addressed by Section 1367.04 of the Act and Rule 1300.67.04. The stated concerns are already specifically addressed by the requirements of Rule 1300.67.04(c)(2)(G)(v).</p>
<p>8-23</p>	<p><u>Translation of Survey and Other Compliance Mechanisms</u></p> <p>The Department is heavily relying on enrollee satisfaction surveys, enrollee grievances, and enrollee requests for assistance to ensure plans’ compliance with these regulations. LIF recommends that these tools must be available to LEP enrollees. The number of LEP enrollees participating in HMOs and PPOs continues to increase; if the Department is to have a clear and accurate picture of whether or not health care services are being provided in a timely manner, language should not become a barrier in identifying both good and harmful practices.</p> <p>Suggestion: LIF supports a provision that would ensure surveys, grievances, and requests for assistance are available in languages other than English, especially for those groups that meet the threshold languages.</p>	<p>Decline: Outside the intended scope of the proposed regulations. The suggested revisions are not necessary to address concerns regarding access to language assistance services. Requirements regarding language assistance programs, including the documents that plans must translate into threshold languages, are established by Section 1367.04 of the Act and Rule 1300.67.04.</p>

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<p>9-24</p>	<p>On behalf of PrimeCare Medical Network, and its eleven contracted IPAs (cumulatively referred to as "PrimeCare") we are pleased to submit comments on the proposed regulation for Timely Access to Health Care Services ("Proposed Access Regulations").</p> <p>PrimeCare thanks the Department for its tireless work in an effort to ensure that these Proposed Access Regulations improve healthcare in California. Many of the new changes found in the latest version of the Proposed Access Regulations reflect the Department's thoughtful responses to those comments made by stakeholders to prior versions of this regulation.</p> <p>In response to this latest version of the Proposed Access Regulations, PrimeCare requests consideration of an important issue in order to protect provider groups from unintended harm and to create a more balanced and fair regulation. Section 1300.67.2.2(c)(2)(D) states in relevant part that, "Contracts between a plan and 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)". We are concerned that the over broad requirement to "comply", without qualification, does not provide any safeguards to ensure that compliance is <i>reasonably</i> required of a provider group by a plan. Accordingly, while a plan's QI Access Program may itself be reasonable, the details of the downstream requirements associated with compliance with that program may <i>not</i> be reasonable. Under the current language, plans will have unbridled discretion to require the providers to implement procedures that may be overly burdensome, unreasonable or impossible. In response to this we are simply requesting a reasonableness standard be applied, not to suggest that the provider group should not comply with the plan's overall program, but to permit some negotiation or protection in <i>how implementation is to be accomplished</i>. We request that the language in the text be modified as follows, "Contracts between a plan and provider group shall require the provider group to cooperate with the plan as <i>reasonably</i> 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)". We implore the Department to make this minor language change to shield provider groups from foreseeable, potential harm, without undermining the intent of the regulation.</p>	<p>Decline: The suggested revision is not necessary to address the concerns. Section 1367(h) already requires that the terms of provider contracts be fair and reasonable, and revised provider contracts are subject to the Department's compliance review. If a provider has a complaint about a plan's attempt to impose unfair and unreasonable contract terms, or contract terms and conditions inconsistent with the requirements of the Act and Rules, the provider may file a complaint with the Department's Provider Complaint Unit. The Provider Complaint Unit may be contacted at (877) 525-1295 or by e-mail at pcu@dmhc.ca.gov.</p>
<p>9-25</p>	<p>Further, PrimeCare supports those additional suggestions made by the California Association of Physician Groups in that Comment Letter on the Proposed Access Regulations. We will not reiterate those arguments here in order to not minimize the importance of the issue set forth above.</p> <p>PrimeCare respectfully requests serious consideration of this "reasonableness" standard, and once again appreciates the opportunity to participate in the stakeholder process.</p>	<p>No change requested, however, please see the responses to the referenced comments from CAPG at Comment Nos. 20-131 through 20-136.</p>

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<p>10-26</p>	<p>The California legislature, through AB 2179 (Cohn, 2002), enacted Health & Safety Code §1367.03(a), tasking the Department of Managed Health Care (“Department”) with the development and adoption of regulations ensuring that health plan enrollees have proper access to needed health care services in a timely manner. In enacting AB 2179 the legislature <i>clearly</i> intended that it be the Department’s responsibility to develop the timely access standards, and not delegate those responsibilities to the Plans.¹ Through the proposed adoption of §1300.67.2.2, the Department has attempted to fulfill their obligation per H&S Code §1367.03 and AB 2179. Unfortunately, the December 10, 2007th Third Comment Period proposed regulations of §1300.67.2.2 utterly fails to meet the H&S Code §1367.03 requirement, as well as the legislative intent behind AB 2179.</p> <hr/> <p>¹ AB 2179 Senate floor analysis dated August 27, 2002 states that the bill would, among other things: A) Require the DMHC, in adopting the regulations, to develop indicators for the following: waiting times for appointments with physicians, including primary care and specialty physicians; timeliness of care in an episode of illness, including the timeliness of referrals and obtaining other services, if needed; and, waiting times to speak to a physician, a 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. B) Require DMHC, in developing these standards for timeliness of access, to consider: clinical appropriateness; the nature of the specialty; the urgency of care; the requirements of other provisions of law that may affect timeliness of access; and, what generally constitutes sufficient compliance those standards by plans and contracting providers. C) Allow DMHC to adopt standards other than the time elapsed between the time an enrollee seeks health care and obtains care; but if DMHC chose a standard other than the time elapsed between the time an enrollee first seeks health care and obtains it, DMHC would have to demonstrate why that standard is more appropriate. In developing these standards, the department was to consider the nature of the plan network.</p> <p>Through the First and Second Comment Period drafts of §1300.67.2.2, as well as proposed November 29th Third Comment Period working draft, the Department made great strides in putting out comprehensive regulations that were a first step in ensuring proper access to timely health care. However, the regulations released December 10th is substantially different than any previous proposals released in 2006 or 2007, and thus violates the statutory public notice requirement of the California Administrative Procedure Act.</p> <p>In the Department’s Third Comment Period Notice, the Department states that it “has determined that the noticed changes are sufficiently related to the original text so that the public was adequately placed on notice that the changes could result from the originally proposed regulatory action.” We, as a group, disagree that the December 10th Third Comment Period draft is sufficiently related to the original text, or any follow up draft.</p>	<p>The necessity for the provisions in the final revised text and for the changes made to the text that was initially published, are explained in the Final Statement of Reasons under the heading “Specific Purpose of the Regulation.”</p> <p>Section 1367.03 required the Department to consider multiple factors to ensure the regulations accounted for variations in plan operations and networks. The prior versions of the regulations included many exceptions and mechanisms for plan to request additional exceptions to the time elapsed standards set forth in the regulation as well as alternatives to time-elapsed standards. The final revised regulation text accomplishes the objectives of Section 1367.03 and the Department’s rulemaking intent through a simplified approach that includes additional performance standards not in the two prior versions of regulation text.</p> <p>The regulation retains requirements for time elapsed standards for the categories of health care and the access indicators enumerated at Section 1367.03(a) and (b), and establishes performance standards for their development by the plans and clarifies the criteria and factors for the Department’s review and approval.</p> <p>Please see also the response to Comment No. 17-104.</p>
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	<p>The original December 29, 2006 proposal was 14 pages long, with specific and detailed "time elapsed standards." The August 8, 2007 proposal was approximately 20 pages long, with additional standards delineated. The November 29, 2007 working draft was 17 pages long with even greater standards put forward. However, the December 10th proposal, was significantly reduced down to 7 pages in addition to being stripped of any and all specific time standards. The December 10th proposed regulations are a wholly different body of law than what was previously proposed. According to Title 1 C.C.R. §42, changes to the original text of a regulation shall be deemed to be "sufficiently related," as that term is used in Gov. Code §11346.8, if a reasonable member of the directly affected public could have determined from the notice that these changes to the regulation could have resulted. No reasonable person, or business entity, could possibly have envisioned the December 10th draft could result from the originally proposed regulatory action as drafted in the December 29th, August 8th and Nov 29th versions. Accordingly, under Gov. Code §11346.8(c), the Department <u>may not</u> adopt §1300.67.2.2 without publishing a new notice with a 45-day comment period.</p>	
	<p>In summary, the Department has failed to carry out the mandate of H&S Code §1367.03(a) to develop indicators of timeliness of access to care. Instead, the proposed regulations delegate development of the indicators to health care service plans. Therefore the draft regulations violate the consistency standard of Gov. Code §11349.1(a) because they fail to comply with H&S Code §1367.03(a).</p>	
<p>11-27</p>	<p>The California Society of Anesthesiologists, whose members include most California anesthesiologists, again requests that the Department adopt a regulation which complies with the statutory mandate to assure access to care. The third revised proposal focuses entirely on timeliness of services, assuming that access to services exists. If comments by Department staff asserting that balance billing by non-contracted physicians, particularly hospital based physicians, is of real concern, it is incumbent upon the Department to adopt requirements for access which will bring those physicians within the ambit of Section 1379, so that balance billing does not occur. That can be accomplished only if plans must contract with physicians reasonably anticipated to be providing needed services to enrollees. The Department has been ineffective in enforcement of such a requirement, even though the legislature has instructed the Department to do so. Instead, in proposed regulations 2007-1253, the Department seeks to impose a structure which de facto requires non-contracted providers to provide access under conditions which preclude balance billing, even though the Department has no authority to do so. If the Department views balance billing by hospital based physicians as a serious concern, it is incumbent upon the Department to require plans to provide for access to these services.</p> <p>The Department clearly prefers to interpret Section 1367.03 as dealing only with timeliness of access. This was not the Legislature's intent. The plain language of Section 11367.03 addresses access itself and not just timeliness of service once arrangements for access are in place. The Department's response to our prior comments expresses concern about "unintended consequences" of a prescriptive requirement that plans arrange for the provision of care by physicians likely to be providing that care, at best a tremulous approach to safeguarding the interests of enrollees. Specific time elapsed standards are not sufficient or appropriate in measuring access to anesthesia services.</p> <p>We again call attention to the statutory requirements, in Section 1367.03, and the language we have italicized for emphasis:</p> <p style="padding-left: 40px;">1367.03. (a) Not later than January 1, 2004, the department shall develop and adopt regulations to ensure that enrollees have access to needed health care</p>	<p>Decline: The stated concerns, regarding numbers of contracted providers and geographic access are outside the intended scope of this regulation. Section 1367.03 does not require these regulations to specify standards for provider-to-enrollee ratios or other requirements regarding the number of contracted providers in a plan's network. Further, it is not necessary to include such requirements in this regulation. These issues are already addressed by existing regulations, e.g., Rules 1300.51(d)(Ex. H), 1300.67.2 and 1300.67.2.1.</p> <p>Timely access for emergency care, which does not require prior authorization by a plan or appointment scheduling by plans or providers, is outside the intended scope of this rulemaking action. Requirements regarding emergency services are established in other provisions of law and regulation, including but not limited to Section 1371.4 of the Act, section 1300.71.4 of title 28, and section 1317.1 of the Health and Safety Code.</p>

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	<p>services in a timely manner. In developing these regulations, the department shall develop indicators of timeliness of access to care and, in so doing, shall consider the following as indicators of timeliness of access to care:</p> <ol style="list-style-type: none">(1) Waiting times for appointments with physicians, including primary care and specialty physicians.(2) Timeliness of care in an episode of illness, including the timeliness of referrals and obtaining other services, if needed.(3) 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. <p>(b) In developing these standards for timeliness of access, the department shall consider the following:</p> <ol style="list-style-type: none">(1) Clinical appropriateness.(2) The nature of the specialty.(3) The urgency of care.(4) The requirements of other provisions of law, including Section 1367.01 governing utilization review, that may affect timeliness of access. <p>(c) <i>The department may adopt standards other than the time elapsed between the time an enrollee seeks health care and obtains care. If the department chooses a standard other than the time elapsed between the time an enrollee first seeks health care and obtains it, the department shall demonstrate why that standard is more appropriate. In developing these standards, the department shall consider the nature of the plan network.</i></p> <p>(d) The department shall review and adopt standards, as needed, concerning the availability of primary care physicians, specialty physicians, hospital care, and other health care, so that consumers have timely access to care. In so doing, the department shall consider the nature of physician practices, including individual and group practices as well as the nature of the plan network. The department shall also consider various circumstances affecting the delivery of care, including urgent care, care provided on the same day, and requests for specific providers. If the department finds that health care service plans and health care providers have difficulty meeting these standards, the department may make recommendations to the Assembly Committee on Health and the Senate Committee on Insurance of the Legislature pursuant to subdivision (i).</p> <p>(e) <i>In developing standards under subdivision (a), the department shall consider requirements under federal law, requirements under other state programs, standards adopted by other states, nationally recognized accrediting organizations, and professional associations.</i> The department shall further consider the needs of rural areas, specifically those in which health facilities are more than 30 miles apart and any requirements imposed by the State Department of Health Services on health care service plans that contract with the State Department of Health Services to provide Medi-Cal managed care.</p>	
	<p>In subsection (c), the Legislature recognized that a time elapsed standard may not be appropriate to all settings or situations. In subsection (d), the Legislature instructed the Department to adopt standards concerning <u>availability of specialty physicians</u> which consider the nature of the</p>	

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<p>physician practice and the circumstances affecting the delivery of care. The Department should understand that anesthesiologists seldom determine the time frame for the provision of their services. It is the surgeon who determines when a procedure will be undertaken and scheduled. A regulation which focuses on timing of services misses the point where the services of an anesthesiologist are concerned. The proposed regulation entirely ignores the nature of anesthesiology and other hospital-based practice, where services are generally provided by groups of physicians who are part of a single entity, who will provide the specialty services necessary in the facility. The Department is interested only in time elapsed standards, even though reality is that access to anesthesia services can not be measured by such standards.</p>	
<p>With respect to emergency services anesthesiologists have special concerns as they routinely assure coverage for emergencies. The assurance of coverage is a cornerstone of the emergency care system. This fact of life is not acknowledged in this proposed regulation or in the 2007-1253 proposal. The Department clearly has not considered the state and federal regulations which require emergency coverage, including Health and Safety Code Section 1317 et seq. and 42 U.S.C.1395dd, as implemented by 42 C.F.R 489.24. Hospitals must assure the availability of emergency services, therefore physicians, particularly anesthesiologists, must accept the obligation to provide coverage and respond, either under medical staff rules or by contract with the hospital, in order to practice. The Department, in addressing access, wholly ignores these requirements, even though health plan patients will necessarily be receiving services from non-contracted physicians unless the health plan has arranged for access within the structure of the health plan. Section 1367.03(e) instructed the Department to recognize real world requirements, including regulatory requirements, in order to adopt access standards which are appropriate to the needs of enrollees. The Department has not done so.</p>	
<p>The flaccid regulation which is now proposed fails to implement the legislative direction. The California Society of Anesthesiologist and its members have sought to address problems in the delivery of care, in order to protect patients.</p> <p>It is unfortunate that the Department will not require plans to arrange for access to services provided by physicians, including anesthesiologists, which are essential to the provision of surgical or other covered services, at least when those physicians are likely to be providing care to plan enrollees because of the network which the plan has constructed.</p>	

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<p>12-28</p>	<p>Brown & Toland Medical Group is an Independent Practice Association (IPA) of 1,500 physicians – including community-based private practitioners and UCSF faculty physicians -- serving over 200,000 HMO and 100,000 PPO patients in San Francisco and surrounding areas. Recognized as a prestigious leader of chronic care programs, including coordinating care for patients with diabetes, HIV, or asthma, Brown & Toland is a multi-specialty, clinically-integrated physician network that provides the highest quality of care to our patients, who are covered under HMO or PPO health plans, including Medicare Advantage plans.</p> <p>Brown & Toland applauds the Department of Managed Health Care for its comprehensive consideration of public comments received for the second period draft of the Timely Access to Health Care Services regulations. And, as part of this third comment period, I now respectfully submit Brown & Toland’s comments pertaining to the Department’s proposed revised draft of the Timely Access to Health Care Services regulations, as follows:</p> <ul style="list-style-type: none"> • <u>Section 1300.67.2.2(a)(1) and (2)</u>: On behalf of physicians and health care professionals and risk-bearing physician organizations, Brown & Toland applauds the Department for tying these regulations to the health plans’ obligations pursuant to the Health Care Provider Bill of Rights. Additionally, we commend the Department for clarifying that health plans – who, after all, are the entities selling benefits coverage to enrollees – cannot waive their obligations for the Timely Access to Health Care Services to delegated medical groups and IPAs. This will ensure that health plans commit to contracting with a comprehensive network of health care providers. 	<p>No change requested.</p>
<p>12-29</p>	<ul style="list-style-type: none"> • <u>Section 1300.67.2.2(b)(1)</u>: The proposed definition of “Advanced access” is unnecessarily overly narrow and restrictive, especially given the realities of the availability of certain physician services in certain markets. Therefore, please 	<p>Decline: The definition at subsection (b)(1) reflects the Department’s current intended “safe harbor” provision for the development of time-elapsd standards. This safe harbor provision does not affect the ultimate performances standards, which is based on clinical appropriateness. The regulation does not prohibit plans from proposing, for DMHC review and approval, the time-elapsd standards suggested in this comment for the referenced categories of physicians.</p>

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	<p>consider the following revision to the definition (changes colored in red), including expanding the time frame from same day” to “36 hours” from when the appointment is request (if requested during business hours), to recognize that some requests may be submitted during a latter half of a business day; also, the Department needs to recognize that the hospital-based providers are outside the scope of the advanced access model:</p> <ul style="list-style-type: none"> ○ “Advanced access” means the provision, by an individual provider, or by the medical group or IPA to which an enrollee is assigned, of: routine non-urgent appointments with a primary care physician on the same day within 36 hours from when the appointment is requested (if requested during business hours); routine non-urgent appointments with a non-hospital based specialist within 5 business days of the appointment request (if requested during business hours); and advance scheduling of appointments at a later date if the enrollee prefers not to accept the appointment offered on the same day within 36 hours (for routine non-urgent rendered by primary care physicians) or within 5 business days (for routine non-urgent rendered by non-hospital based specialist physicians). 	
<p>12-30</p>	<ul style="list-style-type: none"> • <u>Section 1300.67.2.2(b)(2)</u>: The proposed definition of “Appointment waiting time” does not recognize that, when an appointment for services is being arranged, there is a negotiation process between provider and patient or, at times, between provider and another provider and a patient – and the time frame arranged for the rendering of health care services must be at a minimum appropriate to the nature of the medical urgency surrounding the medically necessary care. What should be considered as pertinent to these regulations is that the appointment or time frame arranged for the provision of medically necessary care is appropriate <u>and</u> that there is minimum threshold for unnecessary “waiting” time -- or time that exceeds the arranged time frame for the provision of care. Therefore, I ask that the Department consider the following changes to the definition of “appointment waiting time”: ○ “Appointment time” and “Appointment waiting time”: “Appointment time” means the time frame arranged for the provision of medically necessary care. And “Appointment waiting time” means the time that exceeds the arranged time frame for the provision of medically necessary care. 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 An Appointment time is inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its contracting providers-provider groups. 	<p>Decline: The suggested revision does not reflect the intended application of the existing definition or with this access indicator as described in Section 1367.03. Please see also the response to Comment Nos. 3-4 and 14-54.</p>
<p>12-31</p>	<ul style="list-style-type: none"> • <u>Section 1300.67.2.2(b)(5)</u>: Please consider broadening the definition to acknowledge that referral requests are also issued via telephone, fax, and web portals, as follows: 	<p>Decline: The suggested revision is not necessary because the meaning of “written” is commonly known to include electronic and facsimile writings. Further, existing requirements of the Act and regulations require plans to document referrals. Please see</p>

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	<ul style="list-style-type: none"> ○ “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 medically necessary care, to the time the referring provider delivers, to the plan or to the provider group or to the recipient provider, a written request -- submitted in writing, via fax, telephone, or web portal -- for the additional health care services. 	<p>for example Rule 1300.67.1 (e), which requires an “adequate method of documentation of referrals to physicians or other health care professionals.” Accordingly, the regulation does not prohibit phone referrals, but plans must demonstrate adequate documentation of the phone referral, that is, written documentation. Such documentation is necessary for adequate quality assurance monitoring regarding accessibility, availability, continuity and quality of care.</p> <p>It is not necessary to add the term “medically necessary” because the regulation is directed to the timely provision of covered services. If a plan evidence of coverage defines covered services as being services that are medically necessary, then that component is already incorporated without being specified in the regulation text.</p> <p>It is not necessary to add the term medical group, because that is implicit in the term “recipient provider” if the plan’s policies and procedures for ensuring timely access, and the plan’s oversight of delegated medical groups, are sufficient to ensure timely access when the medical group is treated as the recipient provider.</p>
12-32	<ul style="list-style-type: none"> • <u>Section 1300.67.2.2(b)(7)</u>: “Telephone waiting time”: This definition should be deleted in its entirety, as the requirement to track Telephone waiting times is unenforceable and would require prohibitively expensive systems and resources. 	<p>Decline: The definition established at subsection (b)(7) is necessary to clarify the requirements established at subsection (d)(5) regarding telephone triage and screening services, and the access indicator enumerated at Section 1367.03(a)(3), and at subsection (d)(2)(C). This comment does not provide information substantiating the assertions regarding prohibitive cost. It is commonly known that customer assistance call centers within virtually all service industries use telephone systems that track the time a caller spends waiting on hold. In today’s business climate, this level of quality assurance monitoring is commonly considered to be basic and necessary to deliver responsive and effective customer service. The comment also does not explain why the 5 minute requirements for telephone waiting time for triage and screening services is “unenforceable.” It is a definitive standard amenable to documentation and tracking through readily available phone</p>

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		<p>systems. Plans have the ultimate responsibility to provide or arrange for the provision of timely access, and may not delegate the responsibility to any medical group that lacks the administrative capacity or financial viability to fulfill the delegated Knox Keene requirement. Please see for example the last sentence in Section 1367 of the Act, which sentence was added to Section 1367 with the August 26, 2002 amendments to AB 2179.</p> <p>Contracts between plans and providers that provide for delegation of administrative or other services, must incorporate the Knox-Keene standards applicable to the delegated services, and must contain terms and conditions sufficient to ensure the plan's authority to maintain oversight and enforcement of the contractual obligation, and the plan must document how it will provide the services if the contracted provider fails to perform the contract. Reference Rules 1300.51(d)(Exhibits K and N), and 1300.70.</p>
12-33	<ul style="list-style-type: none"> • <u>Section 1300.67.2.2(c)(2)</u>: The concept of plan monitoring of its contracted provider network for patterns on non-compliance with the plan's timely access standards is in opposition to the appropriate premise in Section 1300.67.2.2(a)(1) and (2) that makes it explicitly clear that a plan cannot waive its compliance obligations to these regulations to delegated provider groups. To rectify this conceptual disconnect <u>and</u> to enable a plan to monitor <u>its</u> own compliance with these regulations, we ask the Department to consider the following changes: <ul style="list-style-type: none"> ○ Requirements for plan monitoring for <u>its</u> 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: 	<p>Decline: The suggested revisions are not necessary to address the stated concern. The referenced provisions are not inconsistent. Subsection (c)(2) requires plans to monitor their respective provider networks to identify , for example, whether the <u>plan</u> is out of compliance with the requirements of this regulation, due to for example, an inadequate number of providers, inadequate provider education regarding plan processes, etc.. Another example is whether the plan is out of compliance because one or more delegated programs is out of compliance with the plan's contractual requirements that incorporate the requirements of this regulation. Plans remain ultimately responsible for ensuring timely access, including for delegated programs.</p>

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	<ul style="list-style-type: none"> • <u>Section 1300.67.2.2(c)(2)(C)</u>: The concept of plan monitoring of its contracted provider network for patterns on non-compliance with the plan’s timely access standards is in opposition to the appropriate premise in Section 1300.67.2.2(a)(1) and (2) that makes it explicitly clear that a plan cannot waive its compliance obligations to these regulations to delegated provider groups. To rectify this conceptual disconnect <u>and</u> to enable a plan to monitor <u>its</u> own compliance with these regulations, we ask the Department to consider the following changes: <ul style="list-style-type: none"> ○ 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). 	
	<ul style="list-style-type: none"> • <u>Section 1300.67.2.2(c)(2)(D)</u>: The concept of plan monitoring of its contracted provider network for patterns on non-compliance with the plan’s timely access standards is in opposition to the appropriate premise in Section 1300.67.2.2(a)(1) and (2) that makes it explicitly clear that a plan cannot waive its compliance obligations to these regulations to delegated provider groups. To rectify this conceptual disconnect <u>and</u> to enable a plan to monitor <u>its</u> own compliance with these regulations, we ask the Department delete this section in its entirety, for no contract language is necessary since regulations prohibit a plan from waiving its obligations to these regulations on to delegated providers. 	
<p>12-34</p>	<ul style="list-style-type: none"> • <u>Section 1300.67.2.2(d)(2)(A)</u>: Given Brown & Toland’s proposed changes to the definition of “Appointment waiting time” and the additional definition for the term “Appointment time,” please consider the following proposed changes: <ul style="list-style-type: none"> ○ Appointment times and Appointment waiting times, which shall be assessed for appropriateness tracked separately for each of the following categories of providers: (i) primary care physicians; (ii) non-hospital based 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; 	<p>Decline: Please see response to Comment No. 12-30.</p>
<p>12-35</p>	<ul style="list-style-type: none"> • <u>Section 1300.67.2.2(d)(2)(C)</u>: Given that Brown & Toland argues that the definition of “Telephone waiting time” be deleted in its entirety, as the requirement to track Telephone waiting times is unenforceable and would require prohibitively expensive systems and resources, I therefore request that this section be deleted in its entirety as well. 	<p>Decline: Please see response to Comment No. 12-32.</p>

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12-36	<ul style="list-style-type: none"> Section 1300.67.2.2(d)(5)(C): Given that Brown & Toland argues that the definition of "Telephone waiting time" be deleted in its entirety, as the requirement to track Telephone waiting times is unenforceable and would require prohibitively expensive systems and resources, we request that this section be deleted in its entirety as well. 	Decline: Please see response to Comment No. 12-32.
12-37	<ul style="list-style-type: none"> Section 1300.67.2.2(e)(1)(D): The concept of plan monitoring of its contracted provider network for patterns on non-compliance with the plan's timely access standards is in opposition to the appropriate premise in Section 1300.67.2.2(a)(1) and (2) that makes it explicitly clear that a plan cannot waive its compliance obligations to these regulations to delegated provider groups. To rectify this conceptual disconnect, we request that this section be deleted in its entirety as well. 	Decline: Please see response to Comment No. 12-33.
12-38	<ul style="list-style-type: none"> Section 1300.67.2.2(e)(2)(B): The concept of plan monitoring of its contracted provider network for patterns on non-compliance with the plan's timely access standards is in opposition to the appropriate premise in Section 1300.67.2.2(a)(1) and (2) that makes it explicitly clear that a plan cannot waive its compliance obligations to these regulations to delegated provider groups. To rectify this conceptual disconnect <u>and</u> to enable a plan to monitor <u>its</u> own compliance with these regulations, we ask the Department to consider the following changes: <ul style="list-style-type: none"> The rate of the plan's compliance, during the reporting period, with each of the plan's timely access standards, in accordance with Section 1300.67.2.2(d)(2), separately reported for each of the plan's contracted provider groups located in each county of the plan's service area. 	Decline: Please see response to Comment No. 12-33.
12-39	<ul style="list-style-type: none"> Section 1300.67.2.2(e)(2)(D): The concept of plan monitoring of its contracted provider network for patterns on non-compliance with the plan's timely access standards is in opposition to the appropriate premise in Section 1300.67.2.2(a)(1) and (2) that makes it explicitly clear that a plan cannot waive its compliance obligations to these regulations to delegated provider groups. To rectify this conceptual disconnect <u>and</u> to enable a plan to monitor <u>its</u> own compliance with these regulations, we ask the Department to consider the following changes: <ul style="list-style-type: none"> Whether the plan identified, during the reporting period, any patterns of its own 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. 	Decline: Please see response to Comment No. 12-33.

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<p>12-40</p>	<ul style="list-style-type: none"> • <u>Section 1300.67.2.2(e)(4)(E)</u>: Please note a typographical error, corrected as follows: <ul style="list-style-type: none"> ○ 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 	<p>Accept: The suggested non-substantive revision to correct the typographical error has been made.</p>
<p>13-41</p>	<p>Thank you for the opportunity to comment on the Department's proposed regulations adopting Section 1300.67.2.2 that would establish requirements for plans to ensure timely access to care. Ensuring access to care is a very important issue, and Blue Cross of California (Blue Cross) appreciates the Department's efforts to provide a workable framework for complying with AB 2179 (Cohn, 2002).</p> <p>While it is important to ensure timely access to care, it is important to consider plan costs and all situations a plan may face it complying with the regulations. Blue Cross has the following comments on the proposed regulations:</p> <p><u>The Regulations Must Provide for Explicit Accommodation for Rural Areas</u></p> <p>While the Department primarily regulates HMO products that are provided almost exclusively in urban areas, some carriers also have PPO products regulated by the Department with members in areas of the state that are very rural. In some areas in the state, there literally are no providers with which to contract. With no explicit accommodation in the regulation for such a circumstance, plans face uncertainty with how they will comply with the regulations.</p> <p>We strongly request that the Department provide for explicit accommodation in cases where plans can demonstrate that there are no providers to contract with in certain areas that would bring the plan into compliance with the regulations. Without such accommodation, a plan would have no reasonable ability to comply with the regulations while continuing to service rural areas. A plan that is willing to provide much needed coverage to its members in such outlying areas should not be penalized for offering such coverage.</p>	<p>Decline: this comment reflects a misunderstanding as to the difference between timely access, which relates to a provider's availability, e.g., to schedule appointments, and geographic access, which relates to the distance a provider is from where an enrollee lives or works.</p> <p>The specific exception suggested in this comment is not necessary and is not consistent with the Department's intended approach for this regulation. In addition, geographic access standards, including those applicable to rural areas, are outside the intended scope of this rulemaking action, and are addressed through other regulations, e.g., Rules 1300.51(d)(Ex. H) and 1300.67.2.1</p> <p>This regulation is not intended to, and does not, create a lesser standard, or otherwise provide any degree of automatic exception, for providing timely access to persons residing in rural service areas or areas that have a shortage of one or more types of health care provider(s). The discussion below is intended to illustrate the difference and the interaction between timely access and geographic access requirements, and does not reflect any particular outcome that may result from a plan's particular proposed timely access standards.</p> <p>Plans operating in service areas in which the Knox-Keene geographic access standards cannot be met with respect to one or more particular types of health care providers, have been required to document, during the licensing process and in accordance with the requirements of Section 1367(d) and (e) of the Act, and Rules 1300.51(d)(Ex. H), 1300.67.1, 1300.67.2 and 1300.67.2.1, how they will ensure continuity of care and access to covered health care services in a timely manner appropriate</p>

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		<p>for the enrollee's condition and health care needs consistent with professionally recognized standards of practice.</p> <p>One or more conditions may have been imposed upon a particular plan's Knox-Keene license to ensure timely access to covered services for enrollees in provider shortage areas, including but not limited to rural areas. For example, a plan may be subject to the condition to refer enrollees to available contracted providers in neighboring service areas. This regulation does not relieve or otherwise alter a plan's obligation to comply with any such conditions previously imposed on the plan's license.</p> <p>The factors the Department considers in approving alternative geographic access standards are reflected in Rule 1300.67.2.1, which includes consideration of the patterns of practice in the service area for seeking health care services. For example, it is a common pattern of practice in a rural area for people to travel longer distances, including to urban service areas, to obtain timely services, as opposed to allowing their condition to deteriorate while they wait for an appointment with a provider in their rural area. In addition, providers in rural areas often have processes for rescheduling appointments or working additional hours to enable them to see patients with urgent conditions, to accommodate and address changes in utilization patterns among their patient population.</p> <p>Accordingly, where there are no providers in a service area, then it would be the pattern of practice for residents of that service area to travel to the nearest service area where such providers do practice. So, to follow that example through, a plan that operates statewide in rural and urban service areas, will be expected where possible to maintain an adequate network in its urban service areas to meet the timely access needs of its enrollees in neighboring rural area that lacks providers, because the plan should be referring those enrollees, in accordance with patterns of practice, to the neighboring urban area, to ensure compliance with the requirements of Section 1367(d) and (e) and Section 1367.03. Of course, if there is a statewide</p>
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		<p>shortage of a particular specialty or subspecialty, that factor will be relevant to the Department's review of the plan's proposed timely access standards with respect to that specialty or subspecialty.</p> <p>The performance standards established by this regulation provide for appropriate flexibility to accommodate variations in plan operations and networks, including variations between HMO and PPO networks. Plans filings should describe the referral patterns they will implement to meet the approved timely access standards and, when requesting approval for a longer time-elapsd standard in a rural area, should include information substantiating why it is not feasible to meet a lesser time-elapsd standard through referral to contracted providers in neighboring urban areas.</p>
13-42	<p><u>Regulations Do Not Envision Self-Referral</u></p> <p>The proposed regulations are written with a focus on a model that requires pre-authorization or provider referrals. With some plans providing for self-referral, particularly for mental health and state programs, we request that the regulations provide a clear exemption in cases where a member is seeing providers without interacting with the plan.</p>	<p>Decline: This rulemaking action is not intended to except or exempt any full service plans from the timely access requirements. Plans that do not require prior authorization, or that permit enrollees to self refer to specialists or other providers, must still meet the performance standards established by this regulation. The performance standards provide for appropriate flexibility to account for variations in plan operations and networks, including the variations referenced in this comment.</p>
13-43	<p><u>Five-Day Requirement for Specialists</u></p> <p>The proposed regulations require plans to demonstrate access to specialists within five business days. This timeframe is too tight to be workable for several classes of specialists. We strongly request that the Department move back to a 10 business day requirement.</p>	<p>Decline: Please see the response to Comment No. 12-29.</p>
13-44	<p><u>Provider Satisfaction Surveys</u></p> <p>The proposed regulations require plans to issue a provider satisfaction survey to ascertain patterns of non-compliance. This is a costly component that is not required by AB 2179. Additionally, the regulations would need to be clarified to state that the percentage of providers surveyed refers to the number of</p>	<p>Decline: The suggested revision is not necessary to clarify the application of the referenced provision. This comment does not provide any information to support the assertion regarding anticipated costs to implement the provider survey requirement. The performance standard established in the regulation provides appropriate flexibility to account for variations in plan operations</p>

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	<p>surveys that need to be sent, as opposed to the number of surveys that need to be received back by the plan.</p>	<p>and networks, and plans may develop cost effective methods for surveying providers, for example distributing the survey with other routine mailings, and incorporating review of the returned surveys into existing quality assurance processes. The regulation does not impose performance requirements on individual providers.</p>
<p>13-45</p>	<p><u>Monthly Requirement for Reviewing Access and Taking Corrective Action</u></p> <p>The proposed regulations require plans to review information related to access and launch corrective action on a monthly basis. Because measuring access consistent with this regulatory package will require new cost-intensive administrative processes, we strongly request that the Department move to a semi-annual requirement. A semi-annual requirement is more reasonable, and will offer a similar level of consumer protection for a significantly smaller administrative burden.</p>	<p>Decline: Existing requirements in the Act and regulations “require plans to continuously review the quality of care provided.” Timely access to covered services is a critical service element of quality of care. Reference Section 1370 of the Act, and Rule 1300.70. Further, the August 26, 2002 amendments to AB 2179 included the addition of the following underlined text to the declaration of legislative intent at Section 1342: “It is the intent of the legislature to promote the delivery <u>and the quality</u> of health and medical care to the people of the Stet of California...”</p> <p>The suggested semi-annual review of information received on a daily basis regarding timely access concerns and deficiencies, including but not limited to information received through the plan’s grievance processes and triage/screening/appointment facilitation processes, is not sufficient to meet the existing continuous review requirements of the Act and regulations. The monthly review required by the regulation is necessary and appropriate to ensure: prompt identification of patterns of non-compliance and instances of substantial harm to an individual enrollee; prompt follow up investigation to determine the root cause of the deficiency; and prompt corrective action appropriate to the identified root cause.</p>
<p>13-46</p>	<p><u>Requirement for Telephone Screening and Triage by “Qualified Health Care Professional”</u></p> <p>The proposed regulations require plans to make available a “qualified health care professional” to do telephone screening and triage. Requiring such a process is over-prescriptive and would increase plan administrative costs significantly. Plans can take other action to make sure that members are informed about arranging for appointments in a timely manner. Establishing such requirements in regulation could stifle innovative solutions to achieving the same objective at a lower cost. Additionally, “qualified health care</p>	<p>Decline: Existing requirements in the Act and regulations require plans to deliver care consistent with professionally recognized standards of practice. The Act requires plans to provide or arrange for the provision of health care in a timely manner for the enrollee’s condition consistent with good professional practice and professionally recognized standards of practice. Reference for example Sections 1367(d) and (e), 1367.01 and 1370 of the Act, and Rule 1300.70.</p>

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	<p>professional” would need to be defined.</p>	<p>The public comments received by the Department in the course of this rulemaking action reflect that merely “informing enrollees about arranging for appointments in a timely manner” as suggested in this comment is not sufficient to ensure that the plan will provide or arrange for the provision of needed services in a timely manner appropriate for the enrollee’s condition or health care needs consistent with professionally recognized standards of practice.</p> <p>The public comments reflect that the insufficiency of the suggested approach is due to various reasons, including but not limited to enrollees lacking clinical knowledge necessary to determine whether a particular appointment waiting time is appropriate for their condition and health care needs, and enrollees lack the ability or authority to require a plan or provider to provide an earlier appointment if the plan’s network is inadequate. Accordingly, the regulation establishes the performance standard that requires health plans to provide or arrange for the provision of a telephone screening and triage services to assist enrollees and providers to determine and facilitate timely appointments. The regulation also establishes and clarifies performance standards for delivering, monitoring and reporting regarding timely access to covered health care services.</p> <p>The meaning of “qualified health professional” is already clear from the definition at subsection (b)(7) for telephone waiting time and from the context of subsection (d)(5).</p>
<p>13-47</p>	<p><u>Compliance Reporting for Each County</u></p> <p>The proposed regulations require plans to report compliance on a county-by-county basis, which will add to the administrative burden of complying with the regulations. We request that the Department allow for more flexibility by deleting this requirement and allowing plans to report the data on a more aggregated basis that makes sense consistent with other DMHC reporting requirements.</p>	<p>Decline: Plans and providers have submitted comments asserting that some counties are rural service areas with provider shortages, and have requested variations from time elapsed standards previously proposed for urban areas that do not have provider shortages. The county by county reporting is necessary and appropriate to address variations for those counties with demonstrated shortages of particular providers. This comment does not explain why reporting on a county by county basis will be costly, inasmuch as plans are already required to file network information on a county-by-county basis</p>

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		<p>when requesting approval for a service area expansion or to implement a new product in an existing service area, or to request approval for alternative geographical access standards. For example, Rule 130.51(d)(Ex. I) states: under the heading "Description of Health Care Arrangements" the following clarifying note: "Providers of Health Care Services. The information in this item is for the purpose of assessing the adequacy of the applicant's health care provider arrangements. If the service area of the plan and the distribution of its enrollees is so geographically limited that all plan health care providers are readily available and accessible to all enrollees, no geographic division of the provider information required in this part need be made. However, if applicant's service area is divided into separate provider networks for regions within the service area, the information required in this Item-1 must be furnished separately for each such region and provider network." Please also reference, for example, Rules 1300.67.1, 1300.67.2 and 1300.67.2.1.</p>
<p>13-48</p>	<p><u>Telephone Wait Times</u></p> <p>The proposed regulations require telephone wait times not to exceed five minutes. Due to the volatility of call volume, we request that the Department add some flexibility to this requirement, such as making the five minutes an "average" requirement. Additionally, the definition of "telephone wait time" should be clarified to capture only plan call centers and not provider offices.</p>	<p>Decline: Please see the response to Comment No. 12-32.</p>
<p>13-49</p>	<p><u>Regulations Do Not Envision Knox-Keene Licensed Subcontractors</u></p> <p>The proposed regulations do not provide for the ability for plans to appropriately delegate the responsibility for complying with these regulations to subcontractors that also have a limited Knox-Keene license. As these subcontractors have a Knox-Keene license, we request that the Department add the ability for plans to delegate the responsibility to a subcontractor if that subcontractor has a Knox-Keene license.</p>	<p>Decline: This regulation does not create any exception or exemption for plans that contract with provider groups that are "limited licensees." Plans retain the ultimate obligation to ensure full performance of Knox-Keene responsibilities, including responsibilities delegated to contracting providers or other contracting entity. Please see the last sentence in Section 1367 of the Act, which was added to Section 1367 with the August 26, 2002 amendments to AB 2179. Plans are prohibited from delegating the plan's Knox-Keene obligations to contracted providers who are unable to perform the delegated obligations in accordance with the Knox-Keene standards. Please reference Section 1370 of the Act and Rule 1300.70. This regulation does</p>

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		<p>not prohibit appropriate delegation by plans to contracted provider groups, including contracted provider groups that have obtained a limited license as referenced in this comment, when done in compliance with the requirements of the Act and regulations, including the requirements of this regulation. The plan retains the ultimate responsibility for ensuring timely access to the services covered under the plan's subscriber contracts.</p>
<p>13-50</p>	<p><u>Implementation Date</u></p> <p>The proposed regulations require policies and procedures to be in place by the end of 2008. Because of the potential administrative complexity that would be involved in complying with these regulations, we request that the implementation date be moved to June 30, 2009.</p>	<p>Decline: The stated concerns regarding “administrative complexities” have already been addressed with the revisions that establish performance standards, which provide appropriate flexibility to account for and accommodate variations in plan operations and networks.</p>
<p>14-51</p>	<p>On behalf of Molina Healthcare of California, I am providing the California Department of Managed Health Care with our comments regarding the proposed regulation referenced above concerning timely access to health care services. Molina Healthcare has served the Medi-Cal program for more than 25 years, with the specific mission of caring for those patients traditionally facing barriers to health care. We also offer a significant added value to local communities we serve by operating 19 primary care clinics in predominately economically disadvantaged and underserved areas. Our clinics treat not only Molina Healthcare members, but the uninsured as well. In addition to Medi-Cal, Molina Healthcare also participates in the Healthy Families and Access for Infants and Mothers Programs.</p> <p>Molina Healthcare appreciates that the Department made several revisions to the proposed regulation. We do, however, have some continuing concerns that the proposed regulation exceeds statutory authority and is unnecessarily prescriptive. In addition to the comments below, Molina Healthcare reiterates and joins with those comments submitted by the California Association of Health Plans and California Association of Physician Groups.</p>	<p>No change requested. Please see the responses to Comment Nos. 23-146 through 23-176 by the California Association of Health Plans.</p>
<p>14-52</p>	<p><i>The Notice Period Fails to Comply with the Administrative Procedure Act</i></p> <p>The Department issued the revised proposed timely access regulation on December 10, 2007, with a comment closing date of December 26, 2007, for a total of 16 days. However, under the California Administrative Procedure Act, the Department is required to provide a 45-day notice period when major changes are made to a proposed regulation. Government Code Sec. 11346.8(c). The Department should remedy its failure to comply with the APA and re-notice the regulation for the required 45-day period.</p>	<p>Decline: The comment does not accurately describe the APA requirements. Please see the response to Comment No. 17-104.</p>

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<p>14-53</p>	<p><i>The Proposed Regulation Burdens Plans in Government Programs</i></p> <p>Managed care plans that contract to provide services to Medi-Cal, Healthy Families and AIM members are already more than adequately regulated under the jurisdiction of the Department of Health Care Services and the Managed Risk Medical Insurance Board. The regulation takes the form of not only statutory and regulatory requirements, but also contractual requirements. Plans and providers providing services to those enrolled in Medi-Cal are inadequately reimbursed. Adding the unnecessary costs associated with implementing the requirements of the proposed regulation would exacerbate the already existing challenges of maintaining provider networks that serve the traditionally underserved. The Department should defer regulation of timely access to those agencies operating government sponsored programs.</p>	<p>Decline: The comment is unclear and does not specify or describe the regulation text that is objectionable or suggest any text revisions that could be helpful to clarify the commenter's concerns. The apparent concerns regarding reimbursement of providers by Medi-Cal are outside the intended scope of this rulemaking action. Revisions are not necessary to address the apparent concerns regarding shared jurisdiction with DHS and MRMIB. DHS already has policies and contractual requirements establishing timely access requirements for their programs, and MRBIB generally tracks the Knox-Keene standards. The Department and sister agencies have existing processes for resolving any issues that may arise with respect to overlapping regulatory jurisdiction. This comment does not provide any information or data in support of its assertions regarding excessive costs for plans that participate in government subsidized coverage programs. Nonetheless, any such concerns are already addressed because the revised regulation establishes performance standards rather than prescriptive requirements, thereby providing appropriate flexibility to account for and accommodate variations in plan operations and provider networks.</p>
<p>14-54</p>	<p><i>Specific Section Comments</i></p> <p>In addition to the preceding general comments, Molina Healthcare provides the following comments pertaining to specific sections within the revised proposed regulation:</p> <p><u>1300.67.2.2(b)(2)</u>: Appointment waiting times should not include the time required to authorize a service if authorization is required.</p>	<p>Decline: The suggested revision is not consistent with the intended application of the regulation. Section 1367.03(b)(4) requires the Department to consider the "requirements of other provisions of law, including Section 1367.01 governing utilization review that may affect timeliness of access." A plan must ensure that plan processes, including utilization review processes, do not generate barriers to timely access to needed health care services. This comment highlights the necessity for the clarification provided at subsection (b)(2) of the regulation.</p>
<p>14-55</p>	<p><u>1300.67.2.2(d)(5)(C)</u>: The proposed regulation attempts to establish standards for timely telephone access. Specifically, this section would require that the telephone wait time during office hours not exceed five minutes. Establishing such a standard is beyond the scope of the statutory authority granted to the Department. The five-minute standard should be removed.</p>	<p>Decline: This comment reflects a misunderstanding regarding application of Subsection (d)(5). One of the access indicators enumerated at Section 1367.03(a) is waiting time to speak with a person trained to screen or triage, and directs the Department to establish standards to ensure timely access to needed services. The regulation establishes a performance standard for plans to provide or arrange for the provision of telephone screening and</p>

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		<p>triage by persons qualified and trained to screen and triage. The referenced standard is squarely within the Department's statutory authority. See also Comment No. 12-32 and 15-66.</p>
<p>14-56</p>	<p><u>1300.67.2.2(e)(4)</u>: This provision of the proposed regulation would require a plan to file a material modification seeking approval for standards other than time-elapased standards. This proposed requirement should be deleted. The rulemaking file on record with the Department more than adequately demonstrates that time-elapased standards are not the appropriate measure of timely access to care.</p>	<p>Decline: The suggested revision is not consistent with the requirements of Section 1367.03 or the Department's intended approach and application of this regulation. The public comments by plans opposed to time elapsed standards are not the only comments the Department is required to consider. Consumer advocates and other interested persons have submitted voluminous comments providing facts and arguments in support of time-elapased standards. The weight of the legislative intent reflected in Section 1367.03 also significantly favors time-elapased standards. To date, the Department has not determined that there are better methods for measuring timely access than time-elapased standards. Accordingly, the regulation retains the requirement for time-elapased standards, to be proposed by the plans and subject to Department approval.</p>
<p>14-57</p>	<p><u>1300.67.2.2(c)(2)(A) and (B)</u>: The proposed regulation would require that plans survey provider and enrollee satisfaction regarding timely access to health care services. First, the Department should delete the requirement for a provider satisfaction survey. A provider satisfaction survey is beyond the scope of the statute. Second, the Department overreaches in this provision by requiring plans to file a material modification and obtain prior approval regarding the survey questions. This requirement should also be deleted.</p>	<p>Decline: The Department's statutory authority for establishing requirements for plans to maintain a robust and meaningful quality assurance program is found throughout the Act, including Sections 1367 and 1370. Many of the public comments submitted during this rulemaking process have been by and on behalf of health care providers who contract with health plans, demonstrating that providers are interested and willing to provide feedback when feedback is solicited. Further, this comment does not dispute that information from contracting providers regarding barriers and deficiencies in timely access is important for plans to monitor and understand access problems within the provider network. Section 1367.03 gives broad authority to the Department to "develop and adopt regulations to ensure that enrollees have access to needed health care services in a timely manner." There is nothing in Section 1367.03 that prohibits the Department from requiring plans to survey their providers to ensure collection of information necessary for adequate quality assurance monitoring. The Department has determined that a provider survey is necessary and appropriate, and within the Department's statutory authority. Please see also the response</p>

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14-58	<p><u>1300.67.2.2(c)(3)</u>: This provision of the revised proposed regulation would direct plans to correct timely access deficiencies by contracting with additional providers. This requirement exceeds the statutory scope of authority, undermines the delegated model and significantly disrupts negotiating leverage in favor of providers. This disruption of negotiating power will lead to unnecessary increased costs without any enhancement of the quality of care provided to patients. In addition, contracting with additional providers is not the only way to remedy such a deficiency. The Department should delete this requirement.</p>	<p>to Comment No. 15-63.</p> <p>Decline: The regulation does not establish specific prescribed corrective actions, rather it establishes performance standards, including that plans shall investigate timely access deficiencies to determine the root cause, and shall take corrective action appropriate to the root cause of the timely access deficiency. Contracting with additional providers may be an appropriate corrective action to address an identified root cause of a timely access deficiency, e.g., insufficient contracted providers. Regarding the objections to the requirements for obtaining the Department's approval of survey questions, the subsection referenced in this comment does not establish a requirement for a notice of material modification.</p>
15-59	<p>The following are the comments of Blue Shield of California regarding the revised text of the proposed regulations referenced above. In addition to these comments, we fully endorse and support the written comments submitted by the California Association of Health Plans.</p> <p>First, we want to acknowledge the significant modifications that have been made to the proposed regulations since the previous draft. It is clear that the Department very carefully considered the comments from the large number of stakeholders (the vast majority of which were very consistent) and has prepared this new third draft to attempt to address and resolve many of the concerns raised. We very much appreciate that hard work and trust that, by continuing to work in such a cooperative fashion, we will be able to develop a final version of the regulation that is more acceptable and reasonable.</p>	<p>No change requested.</p>
15-60	<p>However, notwithstanding the significant changes made, we continue to have some very serious concerns with the regulation – some of which are variations on concerns previously raised and some of which are new, based on new provisions in this latest draft. We have enclosed proposed red-line changes to the most recent version of the regulations and offer the following comments to explain those proposed changes:</p> <p><u>PCP v. Specialist Access</u>: Our clinical staff has suggested that it really makes sense to approach primary care and specialty care differently under these regulations for a number of reasons:</p>	<p>Decline: The suggested revisions are not necessary to address the concerns stated in this comment, and are not consistent with the Department's intended approach pursuant to the performance standards established in the regulation. The public comments from plans, providers and consumers raise serious concerns regarding specialist shortages in certain areas, and referral processes that fail to provide appointments in a timely manner as appropriate for the enrollee's condition and health care needs. The comments also reflect that if a plan's network of specialists is inadequate, PCPs are unable to assist enrollees to obtain an appointment for a specialist and if a plan's ancillary</p>

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	<ul style="list-style-type: none"> • Once a patient is being seen by their PCP, the PCP is really in the best position to drive timely access to necessary specialists. In reality, PCPs (and, when arranging further referrals, specialists) are and can be very effective in working to ensure that a specialist referral appointment is, in fact, made available when clinically necessary. They frequently deal with urgent and emergent situations where they need to contact the specialist for accommodation – and it works. • Advanced access is used primarily for primary care. The plan is not aware of any groups or physicians that use advanced access techniques for specialty services; it simply is not appropriate or necessary. • Geographic variations in physician availability exist almost exclusively with specialists, not PCPs. But, as noted elsewhere, PCPs and groups are effective in dealing with those variations and challenges and ensuring that care is made available in a clinically appropriate way. • Plans and provider groups can develop reasonable and workable methods by which to monitor PCP appointment access much more easily than for specialists. 	<p>services network is inadequate PCPs are unable to assist their patients to obtain diagnostic laboratory or imaging services necessary to assess the next steps and relative urgency for referring the enrollee for further care in a course of illness or injury.</p> <p>The performance standards established by the regulation do not interfere with the judgment of qualified health care providers for determining the time in which an appointment for health care services is clinically necessary and appropriate. Please note that the performance standards at subsection (d)(1) requires plans to “provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee’s condition consistent with good professional practice.” Plans are not obligated to comply with the permissive “safe harbor” provision established at subsection (d)(5) and pursuant to the definition of advanced access established at subsection (b)(1), but to the extent they do not provide or arrange for the provision of care within the time elapsed standards established as a “safe harbor” for time-elapsed standards, plans must provide or arrange for the provision of triage and screening services as described at subsection (d)(5) of the regulation.</p> <p>The term advanced access is defined for purposes of its application as a safe harbor provision for purposes of deeming adequate time-elapsed standards, so it is unlikely to generate confusion.</p>
15-61	<p><u>Encourage Best Practices:</u> Our clinical staff has also suggested that, through these regulations, the Department can actually encourage provider groups to implement more efficient and better practices for specialty access. As with advanced access for primary care, many groups (especially larger groups) follow a process of “open access” to certain categories of specialty services. In those groups PCPs are free to directly refer patients to those specialists without having to get an authorization approval from the group. This empowers PCPs and reduces potential wasteful administrative time in the UM process. We believe that the regulations should acknowledge and encourage groups to use open access. Note, however, open access is</p>	<p><u>Decline:</u> This comment highlights the numerous and complex variations within the health care delivery system with respect to scheduling appointments. The Department has determined that the regulation text is not the appropriate location in which to specify all of the time-elapsed standards and variations as prescriptive requirements. Instead, the regulation has established:</p> <p>1. The ultimate performance standard for providing timely access to care, which is based on clinical appropriateness, and specifically for providing timely access to care based on the</p>

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	<p>commonly and appropriately limited to common categories of high volume specialties (e.g., ENT, dermatology, cardiology, orthopedics, etc.) and not to more unique and tertiary specialties where clinical monitoring of referrals is more appropriate. We have proposed changes in the regulations to accommodate these recommendations.</p>	<p>enrollees condition; 2. A requirement that plans develop and obtain department approval for different time elapsed standards; 3. A single clear and definitive “safe harbor” standard for time elapse standards, which is not mandatory; and 4. A requirement for plans to provide, or arrange for the provision of, telephone triage and screening services to assist enrollees and providers to determine the time frame in which an appointment is needed.</p>
<p>15-62</p>	<p><u>Facilitate PCP Decisions:</u> As noted above, PCPs are in the best position to determine if their patients are not getting clinically appropriate access to specialty services. We recommend that the plans establish a process whereby PCPs who are encountering problems in getting a timely specialty referral from a provider group can contact the plan for assistance. That procedure would result in prompt intervention by the plan by the appropriate clinical staff to review and assist the PCP in arranging the appropriate referral in a timely manner. This would have a number of positive benefits: (1) it empowers the PCP who is coordinating the patient’s care, (2) it gives the PCP a vehicle to address a problem not being address by a provider group, and, (3) it provides the plan with information/evidence to investigate to see if a particular provider group is experiencing patterns of noncompliance with access standards. We have drafted provisions to implement this.</p>	<p>No change requested in this comment. Please see the response to Comment No. 15-81.</p>
<p>15-63</p>	<p><u>Provider Satisfaction Surveys:</u> We continue to believe that provider satisfaction surveys are both beyond the scope of the applicable statute and inappropriate in these regulations. Provider satisfaction is not a factor in nor does it influence access. Thus, we believe these references should all be deleted.</p>	<p>Decline: The Department considers a contracted provider’s concerns regarding the accessibility of other contracted providers, including but not limited to availability of PCPs, specialists and ancillary services, to be very relevant. A provider’s education, expertise and clinical experience enable the provider to assess whether access is available within the plan’s network consistent with professionally recognized standards of practice. Please also see Rule 1300.70 which requires a plan’s quality assurance program to “ensure that ... physicians...who provide care to the plan’s enrollees are an integral part of the QA program.” Please see also the response to Comment No. 14-57.</p>
<p>15-64</p>	<p>We believe the additional/new requirement to track “referral time” in addition to appointment wait time is unworkable and unnecessary. Thus, are proposing</p>	<p>Decline: The access indicator to which this comment objects is expressly enumerated in Section 1367.03(a)(2). Please see</p>

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	that these references be deleted.	also the response to Comment No. 3-5 and 12-31. Please also reference Rule 1300.67.1 regarding requirements for plans to ensure continuity of care.
15-65	We believe that the various references to “urgent care” are unnecessary as presented in these regulations. Urgent care, in the context of urgent referrals in Section 1367.01(h)(2), does not require unique procedures; there is sufficient time for the patient to contact their PCP the next business day and obtain a timely appointment for care, within the context of clinical appropriate standards adopted by the plan. And, as noted above, when referral to a specialist is needed on a more urgent basis, PCPs and groups are very effective in working with their network providers to accommodate those needs.	Decline: Section 1367.03(b)(3) expressly requires the Department to consider urgency of care in developing these regulations. The regulation does not impose performance standards on individual providers. Rather these are performance standards applicable to plan compliance with monitor and ensure the adequacy of contracted provider networks. Reference subsection (a)(2) of the regulation.
15-66	The new provisions on telephone screening and triage are troublesome to us. Not all calls to a physician’s office require triage regarding care – enrollees call all the time seeking information, etc., and not seeking an appointment. The proposal of 5 minutes for return of all calls solely to triage is misguided. The only way a physician’s office could practically comply with the requirement as stated would be to have trained clinical staff answer all calls – a process which would be unworkable and prohibitive from a cost standpoint. It should be sufficient that the provider respond to calls as clinically appropriate.	Decline: The requirement to provide screening and triage is not imposed on providers. The regulation clarifies at subsection (a)(2) that it does not impose performance requirements on individual providers. The requirement to provide or arrange for the provision of screening and triage by telephone is imposed on the plans. Please reference subsection (d)(5). This provision is intended to address exactly the concerns stated in this comment regarding those provider offices that lack capacity to provide screening and triage to enrollees who need “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,” as described in the mandatory access indicator established at Section 1367.03(a)(3) of the Act.

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<p>15-67</p>	<p>Finally, the required new reporting of specific “incidents” that result in “substantial harm” to the enrollee are very troublesome (subsection (e)(2)(c)). First, since the regulations are focused on patterns of non-compliance rather than specific providers/incidents, we believe this provision should be deleted. Second, information on these matters would be confidential peer review and quality assurance information, the disclosure of which could be VERY damaging to providers and plans in litigation, etc. At a minimum, if the requirement is not deleted, it should be absolutely clear that the report will be treated by the Department as confidential and will not be disclosed.</p> <p>In summary, we are <u>very</u> encouraged by the new approach now being taking by the Department for these regulations. We believe substantial progress has been made. While some problems remain, we believe that our comments herein offer acceptable means by which to resolve those concerns fully consistent with the intent of the statute.</p>	<p>Decline: Section 1367.03(g)(1) does not prohibit the Department from taking action in connection with isolated episodes of noncompliance. To the contrary, Section 1367.03(g)(2) expressly authorizes the Department to investigate and take enforcement action against plans for non-compliance, including when substantial harm has occurred as a result of plan non-compliance, which may occur in an isolated episode of non-compliance. Accordingly, it is necessary for plan quality assurance programs to also monitor for incidents of non-compliance resulting in substantial harm to an enrollee, and to require plans to take appropriate corrective action when such situations are identified.</p> <p>The stated concerns regarding maintaining the confidentiality of information within the scope of medical peer review processes is already adequately addressed by the availability of requesting confidential treatment pursuant to Rule 1007. A plan asserting that a report required under this regulation contains information that should be given confidential treatment because it contains privileged peer review information may request confidential treatment for the portion of the report that constitutes privileged content, as provided in Rule 1007, which also describes the burden of proof a plan must meet in requesting confidential treatment.</p>
<p>15-68</p>	<p>(2) This section clarifies requirements for plans<u>This section requires a plan</u> 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.</p>	<p>Decline: The suggested revision is not necessary to clarify the regulation, and could be mistakenly read as meaning this regulation contains all applicable requirements for ensuring and monitoring for access to services. This is not the Department’s intent, and this regulation does not have that effect. Rather, there are additional requirements in existing sections of the Act and Rules that also apply and which are not modified or affected by the adoption of this regulation, including but not limited to Sections 1367, and 1370, and Rules 1300.67.1, 1300.67.2, 12300.67.2.1, and 1300.70.</p>

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15-69	(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).	Decline: The suggested revisions are not consistent with the Department's intended definition and scope of this provision. See also the response to Comment No. 15-60.
15-70	(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.	Decline: The suggested revisions are not consistent with the Department's intended definition and scope of this provision. See also the response to Comment Nos. 3-4 and 14-54.
15-71	<u>(3)</u> "Open access" means a process whereby a plan or provider group permits a primary care physician to directly refer patients to high volume specialists without having to first seek referral authorization or approval. High volume specialists are those top XX specialty areas as determined by the plan based on patient encounters.	Decline: The suggested revision is not consistent with the Department's intent to include a single definitive "safe harbor" provision that will be applied to deem compliance with requirements to develop time-elapsd standards. Please see also the response to Comment Nos. 15-60 and 15-61.
15-72	<u>(3)(4)</u> "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.	No change requested.
15-73	<u>(4)(5)</u> "Provider group" has the meaning set forth in Section 1373.65(g) of the Act.	No change requested.
15-74	<u>(5)</u> "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.	Decline: The suggested revisions are not consistent with the Department's intended definition and scope of this provision. See also the response to Comment Nos. 3-5; 12-31; and 15-64.
15-75	(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, when such screening or triage is necessary.	Decline: The suggested revisions are not consistent with the Department's intended definition and scope of this provision. See also the response to Comment No. 12-32.
15-76	<u>(8)</u> "Urgent care" means health care for a condition which requires prompt attention, consistent with section 1367.01(h)(2).	Decline: The suggested revisions are not consistent with the Department's intended definition and scope of this provision. See also the response to comment No. 15-65.
15-77	(A) An annual, statistically valid, enrollee satisfaction survey. The survey shall be conducted in accordance with valid and reliable survey methodology, and designed	Decline: The suggested revisions are not consistent with the Department's intended performance standard for enrollee satisfaction survey. The suggested revisions are not necessary to clarify the requirements of the enrollee survey or the meaning of NCQA certification in the context of this regulation.

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	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 accreditation 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.	
15-78	(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.	Decline: The provider survey is necessary to adequate QA monitoring. See also the response to Comment Nos. 3-8; 14-57; and 15-63.
15-79	(C)(B) Review, on not less than a monthly <u>quarterly</u> 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, <u>and</u> plan monitoring of provider performance, and screening and triage activities pursuant to subsection (d)(5).	Decline: Please see the response to Comment No. 13-45.
15-80	(D)(C) 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).	No change requested.
15-81	(3) An established procedure whereby an enrollee's primary care physician can contact the plan directly for assistance if the primary care physician concludes that he or she is unable to get timely access to a specialist through a physician group as the physicians has determined is medically necessary for the particular enrollee. The plan's procedure shall provide for prompt intervention by the plan to arrange for timely access to the necessary specialty service either through the physician group or, if necessary, by direct referral authorization by the plan, and investigation of the alleged delay by the physician group.	Decline: The suggested revision is not necessary to accomplish the objective recommended in this comment. Under existing requirements of the Act and regulations plans are free to implement this suggested approach to enhance the communication pathways between plans and providers. Similarly, after adoption of this regulation, plans will be able to implement this and similar enhancements to plan and provider communication pathways. However, the suggested revision will not accomplish the intended objective underlying subsection (c)(2)(B) of the regulation regarding additional performance standards applicable to plan monitoring of network adequacy, which must include a survey soliciting provider input regarding those aspects of the plan network.

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15-82	<p>(3)(4) A plan shall implement prompt investigation and corrective action when compliance monitoring identifies <u>a pattern of</u> 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 <u>and open access</u> 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.</p>	<p>Decline: The suggested revision is not consistent with the intended scope of monitoring, because it would limit required plan compliance monitoring to only patterns of non-compliance. The regulation is intended to include monitoring for isolated episodes of non-compliance, which is consistent with the required scope of enforcement set forth in Section 1367.03. See also the response to Comment No. 15-67.</p>
15-83	<p>(4)(5) 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 <u>as appropriate for the nature of the medical condition of the patient</u>. 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.</p>	<p>Decline: The revision is not necessary to clarify the applicable performance standard established by the regulation.</p>
15-84	<p>(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): (A) Appointment waiting times, which shall be tracked separately for each of the following categories of providers: (i) for 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;</p>	<p>Decline: The suggested revision is not consistent with the intended scope of access indicators to be established in this regulation pursuant to the requirements of Section 1367.03(a). Section 1367.03(a) reflects that "the timeliness of care in an episode of illness, including the timeliness of... obtaining other services," includes the timeliness of coordinating and providing access to medically necessary ancillary services for diagnosis and treatment, including but not limited to diagnostic laboratory and radiological imaging services, radiological treatment therapies, and physical, speech and occupational therapies. Please reference Section 1345(b) and Rule 1300.67, which clarifies the basic health care services for which a plan must maintain an adequate network.</p>
15-85	<p>(B) Timeliness of care in an episode of illness, including timeliness of referrals <u>Referral times in an episode of illness, injury or other health condition;</u> and</p>	<p>Decline; The suggested revision does not provide the intended specificity for the intended access indicator of "referral times" as defined at subsection (b)(5). Please also see the response to Comment Nos. 3-5; 12-31; and 15-84.</p>
15-86	<p>(4) A plan may demonstrate compliance with the requirements of this section through implementation <u>by provider groups</u> of standards, processes and systems providing advanced access <u>to primary care services</u>, as defined at subsection (b)(1), <u>or open access to high volume specialist services, defined at subsection (b)(3)</u>, to appointments for health care services.</p>	<p>Decline: The suggested revision is not necessary to clarify how the regulation will be applied, and is not consistent with the last sentence of Section 1367 of the Act, which was added with the August 26, 2002 amendments to AB 2179. The revision suggested by this comment would likely be read as meaning that a plan does not retain the ultimate responsibility for ensuring</p>

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		performance of delegated obligations. This is not consistent with the requirements of Sections 1367 and 1367.03, or the intended objective of this rulemaking action.
15-87	(5) A plan or delegated provider group that does not provide advanced access <u>or open access</u> to appointments shall have systems and personnel sufficient to ensure that:	Decline: The regulation is intended to include only one safe harbor provision, that is “advanced access” as defined at subsection (b)(1). As the regulation is implemented, the Department will continue to evaluate, and will welcome information and data from interested persons bearing on the effectiveness of this provision. See also the responses to Comment Nos. 15-60 and 15-61.
15-88	(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 <u>when necessary</u> 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.	Decline: The suggested revision is not consistent with the regulatory intent to have the referenced qualified person readily available by telephone during normal business hours. The suggested revision appears to reflect that a plan can predict when during business hours it would be necessary to staff the triage line to receive a call from an enrollee needing assistance in determining the need for an appointment.
15-89	(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.	Decline: The information regarding access problems that is obtained during this process, which is a performance standard established by the regulation at subsection (d)(5), is necessary to a plan’s QA monitoring of compliance with timely access requirements.
15-90	(B) 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 <u>is reasonable shall not exceed five minutes</u> . After hours and weekends, plan and provider medical advice and triage lines shall provide clear recorded instructions regarding how to obtain <u>urgent</u> or emergency care.	Decline: The suggested revisions lack the scope and specificity intended by the Department. The term “reasonable” does not provide the intended specific time-elapsed standard.
15-91	(D)(C) 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 <u>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.</u>	Decline: The suggested revision would eliminate an important performance standard based on clinical appropriateness for the enrollee’s condition and health care needs and, therefore, is not consistent with the Department’s regulatory intent. The suggested revision is not consistent with Section 1367.03 or the objectives of this rulemaking action. Please see also the response to Comment Nos. 12-32 and 15-66.

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15-92	(A) 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.	Decline: The suggested revision is not consistent with the regulatory intent that a plan substantiates its request for the Department's approval of proposed variations to timely access standards.
15-93	(B) 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.	Decline: Please see the response to Comment Nos. 3-8; 14-57; and 15-63.
15-94	(C) The disclosures, <u>if any, the plan proposes to include</u> 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.	Decline: EOC disclosures and enrollee educational materials are intended performance standards. Knox Keene requirements regarding full and fair enrollee disclosures, and requirements to provide enrollee education regarding how to obtain covered services, can be found at Section 1351, 1363, and Rules 1300.63, 1300.63.1, 1300.63.1.2, and 1300.67(f)(8). Accordingly, these materials must be updated consistent with the requirements of this regulation.
15-95	(B) The rate of compliance, during the reporting period, with each of the plan's timely access standards, <u>as identified through the compliance monitoring required by 130.67.2.2(c)(2) separately reported for each of the plan's contracted provider groups located in each county of the plan's service area.</u>	Decline: The suggested revision would eliminate the information necessary to enable consumers to compare performance of a plan's various medical groups, as required by Section 1367.03(f)(2). See also the response to Comment No. 13-47.
15-96	(C) 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. <u>Any such reports will be treated by the Department as strictly confidential and privileged peer review and quality assurance information and shall not be further disclosed, including, but not limited to, requests under the Public Records Act.</u>	Decline: The suggested revision is not necessary to address the stated concerns because Rule 1007 is available for plans to request confidential treatment of submitted materials. Please see section 1007 of title 28. See also the response to Comment No. 15-67.
15-97	(E) A list of all provider groups and individual providers utilizing advanced access appointment scheduling. <u>[Recommend delete or modify to read: "A list of all providers groups which utilize advanced access appointment scheduling for primary care and open access to high volume specialty services.]</u>	Decline: The suggested revision would not accomplish disclosure of the individual physicians, not associated with a medical group, that provide advanced access to appointment scheduling. The suggested addition of reference to "open access" is not consistent with the Department's intended approach to provide for a single "safe harbor" for deemed compliance with of this regulation. In addition, the reference to "open access" which as defined by this commenter at comment No. 15-71, is not consistent with the objectives of Section 1367.03 and this rulemaking action because it does not establish time-elapsd standards, but instead, is based on a process for obtaining specialist appointments without a referral from a PCP

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		acting as a managed care “gatekeeper.” Further, a plan permitting appointments with a specialist without requiring a referral from a gatekeeper PCP does not ensure timely access to the specialist. For example, a lack of time elapsed standards for appointments with a “high volume” specialist scheduled without a referral from a PCP could result in less access for those enrollees if the specialists give priority to PCP referrals based on an expectation that the PCP has determined the appointment is medically necessary.
15-98	(F) 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.	Decline: Please see response to Comment No. 3-9.
15-99	(G) The results of the most recent annual enrollee and provider satisfaction surveys and a comparison with the results of the prior year’s survey, including a discussion of the relative change in satisfaction.	Decline: Please see response to Comment Nos.3-8; 14-57; and 15-63.
15-100	(B) The adequacy of a plan’s mechanisms to make alternative arrangements for enrollees <u>specialty care</u> when <u>a primary care physician notifies the plan that contracting providers are unable to meet the standards to provide timely access to necessary specialty services for a patient;</u>	Decline: The suggested revision reflects a much narrower factor for Department consideration than intended by this rulemaking action and so would not accurately reflect the scope, breadth and depth of factors the Department considers relevant to its review of a plan’s proposed standards pursuant to subsection (e)(3).
15-101	<p>(A) The efforts by a plan to evade the standards, such as referring enrollees to providers who are not appropriate for an enrollee’s condition;</p> <p>(B)(A) The nature and extent of a plan’s efforts to avoid or identify and to correct <u>patterns of non-compliance;</u></p> <p>(C)(B) The nature and extent to which <u>plan’s response to a single</u> instances of non-compliance results in, or contributes to, serious injury or damages to an enrollee;</p> <p>(D)(C) The extent to which non-compliance is the result of an urgency or emergency affecting a provider or provider group;</p> <p>(E)(D) 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</p> <p>(F)(E) 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.</p>	Decline: The suggested deletion of (e)(3)(A) would not accurately reflect the scope, breadth and depth of factors the Department considers relevant to its review of a plan’s compliance or non-compliance with the requirements of the regulation. The additional suggested revisions are not necessary to clarify the referenced provisions, and would not accomplish the objective of this rulemaking action.

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<p>15-102</p>	<p>(5) 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.</p>	<p>Decline: The suggested revision is not consistent with the Department's intended rulemaking objectives, that is, to provide a mechanism by which plans may propose alternatives to time-elapsed standards, but only if they meet the requisite burden established in Section 1367.03(c).</p>
<p>16-103</p>	<p>In response to the most recent iteration of the department's proposed regulations to assure patients timely access to care through their health plans, we note that the department addressed some of the specific provisions that the California Dental Association had expressed concerns about at the department's previous hearings. More specifically, we also note that the department has removed specialty health care plans, namely dental, vision, and chiropractic health plans, from the scope of the proposed rule's authority. We want to acknowledge this, and to thank the department for its receptivity to the points raised by CDA.</p> <p>As we expressed in our communications to the department during this rulemaking, CDA supports the enhancement of patient access to care. Should the department consider future rulemakings to address improved access, CDA will look forward to working with the department to develop workable and meaningful requirements.</p>	<p>No change requested.</p>
<p>17-104</p>	<p><u>Timeliness Standards</u></p> <p>As consumer advocates we are dismayed by the radical departure the latest proposed regulations take from earlier approaches. The Department has gone from thorough regulations which would have given clear guidance to consumers and providers alike regarding what timely access to care is in different arenas and required statistically significant compliance monitoring and replaced them with an approach which leaves it up to individual health plans to decide what timely means.</p> <p>The current proposed regulations do not fulfill the statutory requirements of AB 2179 (Health & Safety Code § 1367.03). AB 2179 requires the Department to "adopt regulations to ensure that enrollees have access to needed health care services in a timely manner [and] develop indicators of timeliness of access to care." Rather than providing clear standards as required, these proposed regulations are a shadow of their former self and leave it up to the various health plans to decide what is timely for a given type of care. We have gone, for example, from a standard of 24 hours for an urgent primary care appointment to each plan being able to set its own standard "consistent with professionally recognized standards of practice." It is baffling indeed that the Department would abandon the previously proposed clear standards while still</p>	<p>Decline: Although the final revised version of the regulation text is different in structure and content from the initial text, the Department has met the APA procedural standards for rulemaking actions.</p> <p>The final revised regulation text remains true to the legislative intent and directives of Section 1367.03, while accomplishing the difficult task delegated to the Department by the Legislature, that is, to balance the competing concerns among affected persons, to accomplish sensible, workable and meaningful regulations designed to ensure timely access to care for enrollees. The revisions to the final regulation text reflect primarily a simplification, restatement and relocation of most of the standards and requirements reflected in the initial text. The necessity for the provisions in the final revised text and for the changes made to the text that was initially published, are explained in the Final Statement of Reasons under the heading "Specific Purpose of the Regulation."</p> <p>Section 1367.03 required the Department to consider multiple factors to ensure the new regulations account for variations in</p>

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<p>conceding that there are professionally recognized standards. We cannot see this as anything but an abdication of the Legislature's charge to develop indicators of timely care.</p> <p>We are aware that many of the health plans, medical groups and provider groups that testified on the regulations argued that the number of timeliness indicators in the last version was unduly onerous. However, the current regulations would still require a full-service plan to set standards for primary care, specialty care, mental health, and ancillary care in the categories of routine, preventive and urgent care. So, the main difference is not that the plan no longer has many standards to adhere to and track but rather that plans can diverge drastically from one another in determining what is appropriate. The result is that consumers will not have a common benchmark for knowing that they should be able to get a particular type of care within a set amount of time. This undermines the fundamental goal of the authorizing statute.</p> <p>We strenuously urge the Department to return to the previous approach of laying out specific time-elapsed standards applicable to all health plans. How can it be timely for one health plan to provide urgent care within 24 hours and another within a week? If this is not possible, but rather, as we believe, it is "consistent with professionally recognized standards of practice" that all health plans offer an urgent primary care appointment within 24 hours, this suggests a consistent standard should be applied to all plans. Consumers should have a common understanding of what to expect in getting a timely appointment for a given type of care.</p>	<p>plan operations and networks. The prior versions of the regulations included many exceptions and mechanisms for plan to request additional exceptions to the time elapsed standards set forth in the regulation as well as alternatives to time-elapsed standards. The final revised regulation text accomplishes the objectives of Section 1367.03 and the Department's rulemaking intent through a simplified approach that includes additional performance standards not in the two prior versions of regulation text.</p> <p>The regulation retains requirements for time elapsed standards for the categories of health care and the access indicators enumerated at Section 1367.03(a) and (b), and establishes performance standards for their development by the plans and clarifies the criteria and factors for the Department's review and approval.</p> <p>The Department has complied with the requirements of the Administrative Procedures Act, and specifically with the requirements of Government Code section 11346.8(c). Please see also the clarification provided at sections 40 and 42 of title 1, California Code of Regulations (CCR) regarding the meaning of "substantial changes" and "sufficiently related" as those terms are used in Government Code section 11346.8.</p> <p>The final revised regulation text reflects changes that are sufficiently related to the original text and within the scope of the Notice of Rulemaking Action (Notice). A reasonable member of the directly affected public could have determined from the explanation provided in the Notice that these changes to the regulation could have resulted.</p> <p>The Notice explains that "...the regulation establishes standards and requirements related to: timely access to primary care physicians, specialty physicians, hospital care, and other health care; health plan monitoring of health care provider compliance with the standards; corrective action by health plans upon identifying deficiencies in compliance; and the statutory requirement of filing an annual report of compliance." The final</p>
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		<p>revised regulation text fulfills this objective because it establishes standards and requirements related to: timely access to the referenced health care services; health plan monitoring of compliance; corrective action by health plans upon identifying compliance deficiencies; and reporting requirements.</p> <p>The Notice also states that, “Proposed section 1300.67.2.2 adopts time-elapsd standards and proposes a ‘same-day access’ standard which is demonstrated to be ‘more appropriate’ than time-elapsd standards because timeliness of access under the same-day access standard exceeds timeliness of access under all of the time-elapsd standards of the proposed regulation.”</p> <p>The final revised text of the regulation fulfills this stated objective by retaining requirements for time-elapsd standards for waiting time, and providing for the referenced “safe harbor” provision, which is called “advanced access” in the final regulation text, rather than same-day access.</p> <p>Accordingly, consistent with the explanation announced in the Notice, the final revised regulation text establishes indicators of timely access related to: appointment waiting times, telephone waiting time and office waiting time. The regulation also establishes standards and requirements related to: timely access to primary care physicians, specialty physicians, hospital care, and other health care; educating enrollees about timely access; health plan monitoring of health care provider compliance with the standards; corrective action by health plans upon identifying deficiencies in compliance; and the statutory requirement of filing an annual report of compliance.</p>
17-105	<p><u>Dental, Vision, Acupuncture and Chiropractic Care</u></p> <p>Also deeply troubling is the Department’s abandonment of standards for dental, vision, acupuncture and chiropractic care. While the previous regulations had clear timeliness standards for these types of care they are nowhere in the new regimen. Full-service plans are no longer required to set standards in these areas even if they provide these types of care and specialty</p>	<p>Decline: The Department has determined that it is not necessary for this regulation to apply to the referenced specialized plans in order to accurately implement Section 1367.03. Other provisions regarding timely access are applicable to these specialized plans, including but not limited to Section 1367 and Rules 1300.51(d)(H), 1300.67.2 and 1300.67.2.1.</p>

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	<p>plans such as dental and vision plans are no longer subject to any timeliness standards. Our work with consumers has shown us what has been well documented – the link between dental health and overall health. Take the case of “James” who was served by one of our Health Consumer Centers. When he called the Center he was suffering from gastrointestinal and heart ailments related to his inability to eat because he only had five teeth and could not eat food to get the nourishment he needed. The fact that he could not get medically necessary dental care directly impacted James’ health. We implore the Department to include timeliness standards for dental care. Similarly, the regulations should include standards for vision, acupuncture and chiropractic care.</p>	
<p>17-106</p>	<p><u>Telephone Triage Access</u></p> <p>The telephone waiting times are a critical component of timely access and we agree that a consumer must be able to receive telephone triage within five minutes during office hours. However, we are very concerned with the vague requirement during non-office hours. Subsection (d)(5)(D) simply requires a triage line to “provide clear recorded instructions regarding how to obtain urgent or emergency care.” It is unacceptable for a consumer not to be able to reach a triage doctor or nurse for guidance on whether to seek urgent or emergency care. We continue to request that providers be required to advise patients how to reach a qualified professional who is trained to screen and triage.</p>	<p>Decline: The suggested revisions are not necessary to ensure timely access. The regulation does not require an enrollee to obtain telephone triage or screening before seeking emergency services. Enrollees are encouraged to use the 911 emergency response system and go to the nearest emergency room if they reasonably believe they have a medical emergency, and plans are required to provide coverage for emergency services if the enrollee reasonably believed that an emergency condition existed. Please see Health and Safety Code sections 1317.1, 1371.4, 1371.5 and 1363.2, and Rule 1300.71.4. The regulation requires plans to inform and educate patients about how to access services, which includes how to access the telephone triage and screening services to obtain assistance in obtaining timely appointments.</p>
<p>17-107</p>	<p><u>Compliance Monitoring</u></p> <p>Monitoring compliance with the timely access standards is required by the statute and critical to ensuring that these standards are meaningful. As with the departure from time-elapsed standards, in the area of compliance monitoring the Department has taken a troubling about-face. Until this point the Department’s proposed regulations laid out progressively more effective and clear methods of compliance monitoring. The July 2007 proposed regulations set forth a carefully developed and statistically valid survey method. The latest version scraps that careful work based on academic standards. Under the current proposal plans would monitor their own set timeliness standards through:</p>	<p>Decline: The regulation does not reflect a departure from time-elapsed standards. The requirement for developing time-elapsed standards for the indicators set forth at subsection (d)(2) in accordance with the definitions set forth at (b)(2), (5) and (7). It is not necessary for the regulation to specify the details of a statistically valid survey methodology. Subsection (c)(2)(A) establishes the performance standard of a statistically valid survey, and plans may differ in the manner in which they achieve that performance standard.</p>

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	<p>(A) An annual, statistically valid enrollee satisfaction survey; (B) An annual provider satisfaction survey of at least 5% of the contracted providers; and (C) Monthly review of information from enrollee complaints and grievances, monitoring of provider performance and screening and triage.</p> <p>Our letters on previous versions of the regulations have pointed to problems relying on consumer surveys, non-anonymous surveys and grievances, so we will not reiterate those though we continue to have these concerns. Further, we urge the Department to return to the statistically valid survey method.</p>	
<p>17-108</p>	<p><u>Network Providers</u></p> <p>Subsection (c)(4) would require plans to have systems in place to ensure that if there is no available provider within the enrollee's medical group, the plan offer her a provider within the plan's network. However, it would not require similar systems to provide an appointment with an out-of-network provider. If a consumer cannot get medically necessary care covered by her health plan in a timely manner, the plan should be required to find an appointment with an out-of-plan provider.</p>	<p>Decline: It is not necessary to include the suggested requirement in the regulation. The performance standard requires timely access appropriate for the enrollee's condition, and provides for appropriate flexibility for plans to develop and implement the necessary processes, including referral processes, to accomplish that. After this regulation is adopted, the Department will continue to assess, and will welcome information and data submitted by interested persons, regarding timely access deficiencies that reflect a need for changes to this regulation. Please reference Section 1367.03(j).</p>

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17-109	<p><u>Language Access</u></p> <p>In previous letters we have submitted regarding these regulations and in our testimony at the hearings we have laid out in detail the need for these regulations to reference the Language Assistance Plan regulations. We are deeply disappointed that the Department did not accept our recommendation to coordinate the two sets of regulations as you lead advocates to believe you would do. The weakening of these regulations will impact all managed care enrollees and will have particular ramifications for Limited English Proficient (LEP) enrollees who will be the most likely to experience delays in care because of the vague definition of "timely access" in the Language Assistance Plan regulations and the exclusion of any application of the new timely access regulation to the LEP population. Once again, we urge the Department to follow through on your representations and coordinate these two critical sets of regulations as we outlined in detail.</p> <p>We strongly urge the Department to rethink its current approach and return to specific time-elased standards to effectuate the requirements of AB 2179.</p>	Decline: The suggested revision is not necessary because the concerns are already addressed by the requirements set forth in Rule 1300.67.04(c)(2)(G)(v).
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<p>18-110</p>	<p>While the revised regulation is an improvement from the previous version, CMA continues to have concerns. In particular, CMA believes that the proposed regulation is deficient because it does not contain sufficient provisions to ensure that plans have an adequate number of providers in their networks. CMA is equally concerned with the DMHC's decision to allow plans to develop their own standards for timely access to care. We discuss these concerns below and raise other issues that we believe are lacking statutory authority, are unclear, or are inconsistent with the enabling legislation on timely access to care, AB 2179. (Health & Saf. Code, § 1367.03.)</p> <p>I. The DMHC is obligated to develop specific regulatory provisions to ensure that plans have an adequate number of providers in their networks as required under AB 2179.</p> <p>As mentioned above, in our view the revised regulation is deficient because it does not contain sufficient provisions to ensure that plans have an adequate number of providers in their networks. Under AB 2179, the DMHC is clearly required to ensure enrollees have timely access to care and to ensure that plans have an adequate number of providers in their networks. To support CMA's position, we cite AB 2179's legislative intent and specific provisions below:</p> <p>The Legislature finds and declares that timely access to health care is essential to safe and appropriate health care and that lack of timely access to health care may be an indicator of other systemic problems such as lack of adequate provider panels....</p> <p>(a) Not later than January 1, 2004, the department shall develop and adopt regulations to ensure that enrollees have access to needed health care services in a timely manner (Health & Saf. Code § 1367.03 (a).)</p> <p>(d) The department shall review and <i>adopt standards, as needed, concerning the availability of primary care physicians, specialty physicians, hospital care, and other health care, so that consumers have timely access to care. In so doing, the department shall consider the nature of physician practices, including individual and group practices as well as the nature of the plan network.</i> (Health & Saf. Code § 1367.03 (d).)</p>	<p>Decline: Section 1367.03 contains no language referencing or otherwise requiring the Department to adopt specific provider-to-enrollee ratios or other specific requirements or formulas for establishing specific numbers of providers in a plan network. There are existing regulations that address this topic, for example, Rule 1300.51(d)(H) and (I) and Rules 1300.67.2, and 1300.67.2.1. In addition, the regulation already establishes performance standards by which plans must investigate identified access deficiencies to determine the root cause of the deficiency and to take corrective action directed to the root cause of the deficiency. Accordingly, if an inadequate number of providers is the root cause of an identified access deficiency, the plan could correct the deficiency by increasing the number of providers. However, other approaches may also be appropriate to correct the deficiency if the root cause is, for example, an inadequate number of providers in a particular service area. The regulation is intended to permit appropriate flexibility to accommodate a plan's use of innovative methods to ensure timely access. For example, a plan may develop innovative uses of available and emerging technology to enhance timely access in an area where there is a provider shortage. Accordingly, the regulation is not intended to impose the prescriptive requirements suggested in this comment.</p> <p>The concerns regarding a need for ongoing tracking of access are already addressed by the regulations provisions that require consistent ongoing monitoring and reporting of compliance with the time-elapsd standards for the access indicators enumerated in the regulation. Upon adoption and implementation of these regulations, the standards will be considered and applied in the context of the Department's Licensing, Medical Survey, and Enforcement processes.</p>
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<p>Here, the regulation proposes to establish standards to ensure enrollees have timely access to care, but it does not propose to establish standards to ensure plans have an adequate number of providers in their network. In truth, an enrollee's timely access to care goes hand in hand with the availability of physicians in a plan's network; to simply address one without the other is unreasonable and unworkable. Therefore, CMA respectfully requests that the DMHC exercises its authority under AB 2179 and develop specific regulatory provisions to ensure that plans have an adequate number of providers in their networks</p> <p>In addition to AB 2179's requirements on network adequacy, CMA further submits that there is a need for the DMHC to adopt a network adequacy regulation because existing access regulations are insufficient to ensure that plans have an adequate number of providers in their networks. Existing access regulations require one full time equivalent physician to each 1,200 enrollees and one primary care physician to each 2,000 enrollees (28 C.C.R. § 1300.67.2 (d) and § 1300.51(c)(H)(i)), but the DMHC appears to consider these regulations as mere guidelines. Furthermore, the DMHC applies these regulations only during the initial licensing of a plan, which means that there is no consistent, on-going, or systematic tracking of whether plans have an adequate number of providers in their networks.</p> <p>To further highlight the need for a network adequacy regulation, CMA cites a 2005 DMHC Routine Medical Survey of PacifiCare, which suggests that existing access regulations are not necessarily complied with by plans. Specifically, the survey concluded that PacifiCare failed to provide evidence that it had an appropriate ratio of at least one full-time physician to each 1,200 enrollees, and that it had no alternative mechanism to demonstrate an adequate ratio of physicians to enrollees. The same report further indicated that some specialist ratios were also well beyond acceptable access standards as shown below:</p> <table data-bbox="378 1282 945 1396"><tr><td>High Volume Specialists (HVS)</td><td>1:20,000</td></tr><tr><td>OB/GYNs</td><td>1:10,000</td></tr></table> <p>It is important to note that a DMHC Routine Medical Survey is insufficient to</p>	High Volume Specialists (HVS)	1:20,000	OB/GYNs	1:10,000	
High Volume Specialists (HVS)	1:20,000				
OB/GYNs	1:10,000				

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	<p>determine whether a plan complies with access standards because it is conducted once every three years, and the DMHC is not always required to look into access issues under current law.</p> <p>In sum, CMA believes that not only is the DMHC required to address network adequacy under AB 2179, but there is also a need for the department to do so in light of the insufficient existing access regulations and the PacifiCare survey discussed above.</p>	
<p>18-111</p>	<p>II. The DMHC’s decision to allow health plans to develop time elapsed standards exceeds statutory authority and it is inconsistent with AB 2179.</p> <p>It is CMA’s position that the DMHC has exceeded its statutory authority by allowing health plans to essentially develop time elapsed standards as drafted in §1300.67.2.2 (d) and as stated in the DMHC’s “Responses to Comments” on page 121 below:</p> <p>The Department [DMHC] has decided that it is not a workable approach to include in the regulation text every specific time elapsed standard for each of the access indicators set forth in Section 1367.03 that could apply in the multitude of geographic circumstances, operational variations, and health care conditions affecting plans, providers, and enrollees. <i>Instead, the Department</i></p>	<p>Decline: There is no language in Section 1367.03 expressly directing the Department to include, <u>in the regulation text</u>, the numerous prescriptive time elapsed standards for the access indicators and the numerous variations in time elapsed standards necessary to account for variations in plan business operations, service areas and provider networks.</p> <p>The regulation requires time elapsed standards, and the development of those standards is not left to the discretion of the plans. To the contrary. Plans must develop time-elapsed standards in accordance with performance standards in the regulation and subject to the Department review and approval. The regulation also establishes performance standards requiring that time elapsed standards be documented in the plan’s QA policies and procedures and applied in the plans QA monitoring</p>

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	<p><i>has determined that the appropriate place for the specific time elapsed standards to be established and documented is in each plan's internal written policies and procedures</i></p> <p>As mentioned above, AB 2179 clearly requires the DMHC to develop timely access regulations, and it further states that "the department may adopt standards other than the time elapsed [standards]" but it must demonstrate why that standard is more appropriate. (Health & Saf. Code § 1367.03 (a), (c).)</p> <p>There is nothing in AB 2179 that allows for health plans to develop specific time elapsed standards; to do so would be allowing health plans to essentially regulate themselves. We respectfully requests that DMHC redraft all of 1300.67.2.2 (d), so that it develops the appropriate time elapsed standards, and not the plans.</p>	<p>for regulatory compliance. Please see subsections (d) and (e) of the regulation. Please see also the response to Comment Nos. 8-20; 10-26; and 17-104.</p>
<p>18-112</p>	<p>III. Below are other issues that CMA believes are lacking in statutory authority, are unclear, or are inconsistent with AB 2179. (Health & Saf. Code, § 1367.03.)</p> <p><u>§ 1300.67.2.2 (a) Timely Access to Health Care Services</u></p> <p>(a)(2) As drafted, this subdivision clarifies requirements for plans to monitor and ensure adequacy of contracted provider networks, but there is no specific provisions stipulating how this will be done. As mentioned in Section I above, the DMHC needs to exercise its authority and draft specific provisions ensuring that plans have an adequate number of providers in their networks.</p>	<p>Decline: The referenced provision is intended to clarify that the regulation is directed to plan compliance with the requirement to ensure timely access to covered services and that the regulation does not establish performance requirements for individual providers. The manner in which plans will demonstrate adequacy of their respective provider networks is through the provision of timely access to covered services, consistent with the requirements set forth in the regulation, and with the time elapsed and other timely access standards approved by the Department.</p>
<p>18-113</p>	<p><u>§ 1300.67.2.2 (c) Quality Assurance Processes</u></p> <p>(c) As drafted, this subdivision requires all plans to have written quality assurance processes, which could confuse providers because each plan is likely to develop different quality assurance processes. CMA believes that the DMHC should develop quality assurance processes for plans, so that the regulation is uniform and consistent with AB 2179.</p>	<p>Decline: The regulation is consistent with Government Code section 11340.1(a), which requires "It is the intent of the Legislature that agencies shall actively seek to reduce the unnecessary regulatory burden on private individuals and entities by substituting performance standards for prescriptive standards wherever performance standards can be reasonably expected to be as effective and less burdensome, and that this substitution shall be considered during the course of the agency rulemaking process." Accordingly the regulation establishes performance standards amenable to documentation, monitoring, oversight, and enforcement, by plans and their delegated medical groups, and the Department.</p>

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		<p>Section 1367.03 requires the Department to consider variations in plan operations and networks. Accordingly, the regulation focuses on meaningful performance standards that provide appropriate flexibility for plans to achieve the performance standards in a manner that is cost-effective and workable for a plan's particular business operations and provider network.</p> <p>The revisions suggested by this comment would be unworkable prescriptive requirements, which are disfavored by the Administrative Procedures Act. The suggested prescriptive approach was attempted in the prior two versions of regulation text, but proved unworkable in the context of the complex, and highly variable health care delivery systems in California. The regulation does not prohibit plans and providers from collaborating to develop uniform processes and criteria, subject to the Department's approval, e.g. though the Industry Collaboration Effort (ICE).</p> <p>This rulemaking action is not intended to specify all of the detailed day-to-day operations of a plan's quality assurance processes, which are matters addressed by other provisions of the Act and regulations, see for example, Section 1370 and Rule 1300.70.</p>
18-114	<p>(c)(1) As drafted, this subdivision states that “[s]tandards for the provision of covered services in a timely manner consistent with professionally recognized standards of practice....” CMA believes that “consistent with professionally recognized standards of practice” is unclear, and therefore the DMHC must define it.</p>	<p>Decline: The referenced term “consistent with professionally recognized standards of practice” has been long established and applied in existing regulations, such as section 1300.70 of title 28, and definition is not necessary to clarify this term, which is also often used interchangeably with the term “good professional practice” as set forth at Section 1367(d) and (e).</p>
18-115	<p>(c)(2) As drafted, this subdivision suggests that enforcement action can be taken against providers for non-compliance rather than health plans. CMA believes non-compliance with timely access regulation is actionable only against the health plans as required under AB 2179 (Health & Saf. Code, § 1367. 03 (h)(2)(3); therefore, the italicized sentence below must be added to subdivision (c)(2) so that it is clear and consistent with existing law:</p> <p>[A] plan shall monitor its contracted provider network for patterns of non-</p>	<p>Decline: Subsection (a)(1) and (2) already address the stated concerns, e.g., by clarifying that the regulation does not establish performance requirements for individual physicians, and that a plan retains the ultimate responsibility for performance of delegated obligations. However, a plan is obligated to maintain oversight of obligations delegated to providers, and plan-provider delegation contracts must contain</p>

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	compliance and for incidents of non-compliance resulting in substantial harm to an enrollee. <i>The director may investigate and take enforcement action against plans regarding non-compliance with the requirements of this section. Where substantial harm to enrollee has occurred as a result of plan non-compliance, the director may, by order, assess administrative penalties in accordance with Health & Saf. Code, § 1397.</i>	terms sufficient to ensure that the delegated obligations will be performed in compliance with applicable Knox-Keene standards and requirements, and that the plan will ensure oversight and enforcement of delegated obligations.
18-116	(c)(2)(B) As noted in CMA's previous comment letter, a provider survey is time consuming and takes physician and staff time away from patient care. CMA requests that the DMHC move away from the provider survey concept and develop a more acceptable alternative.	Decline: Comments from providers and consumers have raised serious concerns regarding barriers to delivering good quality health care when there is delayed access to diagnostic and treatment services necessary for referral and continuity of care consistent with good professional practice, during a course of illness or injury. Please see the requirements of Section 1367(d) and (e), and 1367.03(a)(2). The public comments reflect that plans and health care providers will be pleased to have this mechanism for communicating concerns for review in the context of the plan's quality assurance processes. Please see also the responses to Comment Nos. 3-8; 14-57 and 15-63.
18-117	(c)(2)(D) CMA notes that the appropriate citation in this section is Health & Saf. Code, § 1367. 03 (g)(1), and not (f)(1).	Decline: Subsection (c)(2)(D) of the regulation text is accurate in referencing subsection (f)(1) of section 1367.03, the second sentence of which provides, "These contracts shall require <u>reporting by health care providers to health care service plans and by health care service plans to the department to ensure compliance with the standards.</u> " (Underline added.)
18-118	(c)(3) As drafted, health plans have the authority to define "timely access deficiencies," which could confuse providers because each plan is likely to define the term differently. CMA believes that the DMHC should define "timely access deficiencies," so that the regulation is uniform and consistent with AB 2179.	Decline: The regulation is clear regarding the meaning and application of the term "timely access deficiencies." See subsection (c)(2). The suggested definition is not necessary to clarify the regulation or to avoid confusion among providers. The concerns stated in this comment are also unlikely to materialize because this regulation permits plans and providers to collaborate to develop uniform time elapsed standards, subject to the Department's approval.
18-119	(c)(4) As drafted, this subdivision allows health plans or delegated groups to search for a qualified and geographically accessible provider in the event that it is unable to secure timely access pursuant to this section. CMA believes that the italicized sentence below should be added to ensure delivery of timely	Decline: The regulation is not intended to impose the suggested requirement. Please see the response to Comment No.17-108.

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	<p>access to care is consistent with AB 2179:</p> <p>Standards, procedures and systems to ensure that, if a contracted provider or provider group is unable to deliver timely access ..., 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, <i>and if there are none, then the plan shall arrange for the provision of timely appointment with an appropriately qualified and geographically accessible non-contracting provider.</i></p>	
18-120	<p><u>§ 1300.67.2.2 (d) Plan Standards for Access to Care</u></p> <p>(d)(2)(A) As drafted, this subdivision requires plans to determine timely access to care based on appointment waiting times. CMA believes that this subdivision needs to clearly state that it is the plan's responsibility to track waiting times and not the provider; therefore, CMA requests the italicized words and sentence below be included so that it is consistent with AB 2179.</p> <p>(d)(2)(A) Appointment waiting times, <i>which the plan shall tracked separately for each of the following categories of providers: (i) primary care physicians No plan shall require a contracting health care provider or provider group to maintain log books, or any other recording mechanism, that records appointment waiting times, office waiting times, referral times, and telephone waiting times for all enrollees served by the provider or provider group.</i></p>	<p>Decline: The suggested revision is not necessary and not consistent with the intent to avoid prescriptive requirements, but instead to establish meaningful performance standards that provide appropriate flexibility for plans to develop mechanisms and processes sufficient to achieve the performance standards within the context of a plan's particular operations and provider network.</p>
18-121	<p>(d)(5)(A)&(C) As drafted, both subdivisions refer to a "qualified health care professional." CMA believes this term is unclear and that the DMHC should define it.</p>	<p>Decline: The meaning of the term is clear in the context of both of these subsections and a definition is not necessary. Please see also the response to Comment No. 13-46.</p>
18-122	<p><u>§ 1300.67.2.2 (e) Filing, Implementation and Reporting Requirements</u></p> <p>(e)(1)(B) As raised in (c)(2)(B) above, CMA requests that provider surveys be removed from the regulation.</p>	<p>Decline: Please see response to Comment Nos. 3-8; 14-57; and 15-63.</p>
18-123	<p>(e)(1)(D) CMA notes that the appropriate citation in this section is Health & Saf. Code, § 1367.03 (g)(1), and not (f)(1). Furthermore, to ensure that plan amendments to provider contracts and other contracts are conducted in compliance with existing law and consistent with the intent of AB 2179, CMA requests the addition of the Health Care Provider's Bill of Rights, see italicized section below:</p>	<p>Decline: The referenced citation is accurate. Please see also the response to Comment No. 18-117. The Provider Bill of Rights is already referenced in subsection (a)(2).</p>

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	Amendments to provider and other contracts as necessary for compliance with Section 1367.03 (f)(g)(1) of the Act, with subsection (a), <i>and Health and Saf. Code § 1375.7.</i>	
18-124	(e)(2) CMA notes that the appropriate citation in this section is Health & Saf. Code, § 1367. 03 (g)(2), and not (f)(2).	Decline: The referenced citation is accurate. Please see also the response to Comment No. 18-117.
18-125	(e)(2)(D) Similar to (c)(2), this subdivision suggests that enforcement action can be taken against providers for non-compliance rather than health plans. CMA believes non-compliance with timely access regulation is actionable only against the health plans as required under AB 2179 (Health & Saf. Code, § 1367. 03 (h)(2)(3); therefore, the italicized sentence below must be added to subdivision (e)(2)(D) so that it is clear and consistent with existing law: 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 non compliance <i>The director may investigate and take enforcement action against plans regarding non-compliance with the requirements of this section. Where substantial harm to enrollee has occurred as a result of plan non-compliance, the director may, by order, assess administrative penalties in accordance with Health & Saf. Code, § 1397.</i>	Decline: Please see response to Comment No. 12-33.
18-126	(e)(2)(G) As raised in (c)(2)(B) and (e)(1)(B)above, CMA requests that provider surveys be removed from the regulation.	Decline: Please see the responses to Comment Nos. 3-8; 14-57; and 15-63.
18-127	(e)(3)(A) If the DMHC decides not to draft specific regulatory provisions to ensure that plans have adequate providers in their networks, then CMA believes that the DMHC should, at a minimum, require plans to comply with the existing physician and enrollee access ratio prior to approval or disapproval of a plan's proposed standards for timely access. Specifically, the DMHC should consistently require plans to prove that their networks have one full time equivalent physician to each 1,200 enrollees and one primary care physician to each 2,000 enrollees. Accordingly, CMA strongly requests that deleted words and italicized sentence below are adopted so that the regulation is fairly consistent with AB 2179. (A) The availability and distribution of primary care physicians, specialty physicians and other types of providers within a service area, <i>is consistent with the requirements under 28 C.C.R. § 1300.67.2 (d) and § 1300.51(c)(H)(i).</i>	Decline: Outside the scope of this regulation. The referenced topic is already addressed by other regulations, including but not limited to Rules 1300.67.2 and 1300.67.2.1.
18-	(e)(3)(F) Inevitably, plans are probably going to incorporate requirements of	Decline: It is not necessary to reference the Provider bill of

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128	<p>the timely access regulations by way of plan and provider contract. To ensure that providers are afforded their contractual rights, CMA suggests incorporating a new subdivision requiring plans to abide by their existing, statutory contractual obligations to providers prior to approval of their timely access standards, see the italicized sentence below.</p> <p><i>(e)(3)(F) The plan's compliance with the Health Care Provider's Bill of Rights in the Knox-Keene Act (Health and Saf. Code § 1375.7.)</i></p>	<p>Rights in order to require compliance with at provision as to all provider contracts. Nonetheless, subsection (a)(2) already references the Provider Bill of Rights.</p>
18-129	<p>As mentioned in our introductory comments above, CMA believes that for an enrollee to have timely access to care plans must have an adequate number of providers in their networks. Also, CMA urges the DMHC to exercise its authority to develop the timely access regulation themselves, as opposed to the plans, so that enrollees and providers are afforded a more fair and balance regulation.</p>	<p>Decline: The prior two versions of regulation text attempted a prescriptive approach to establish, in the regulation text, the numerous specific time-elapsd standards for the several access indicators for each of the enumerated categories of physicians and health care services, and numerous exceptions for each to account for the variations in networks etc., but that approach has been determined to be unworkable. Accordingly, the regulation establishes performance standards applicable to the plans development of the required time elapsed standards, and the specific time elapsed standards, to be developed by the plans in accordance with the performance standards and subject to Department approval, must be documented in the plans' respective written QA policies and procedures.</p>
19-130	<p>NCQA supports the current proposed draft of the Timely Access to Health Care Services regulations. It is a realistic approach to setting standards for plans and their contracted providers which clearly outlines the state's expectations for access while allowing for much needed flexibility. We commend the Department for its efforts on the newest draft.</p>	<p>No change requested.</p>
20-131	<p>(b) <u>Definitions.</u> (1) "Advanced access"</p> <p>There are three problems with this definition that we suggest be revised or else it will not be reflective of current leading-edge industry standards of care, and cannot be complied with. If the current definition is not revised, it is unlikely that any health plan will be able to file for the alternative monitoring standard in the regulation, since provider groups are not capable of meeting the definition, and it's inclusion in the regulation as an alternative standard will be moot.</p> <p>Primary Care Physicians: Advanced access appointments can be provided by someone other than a primary care physician. The definition is too limited. The Administration has recognized the important contribution of mid-level practitioners to the provision of greater access to care in the Governor's healthcare reform proposal. For example, a retail clinic staffed by a nurse practitioner would not fit this current definition as an advanced access program. We believe that is contrary to the Administration's intent. We have suggested alternative language below that rephrases the concept to avoid this limitation.</p>	<p>Decline: Please see response to Comment Nos. 12-29; 15-60; and 15-61.</p>

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	<p>Same Day Appointments: Current industry standards for “advanced access” programs go beyond same day appointments, and thus the definition is too limiting. For example, a patient may call in at 4:00, and cannot be seen by their doctor that day, but could obtain an appointment the very next day, within 24 hours of the request. The current definition would not allow for that circumstance, and thus would not recognize the delivery of timely access.¹ We suggest the phrase “same day” be changed and the sentence rephrased to allow for the provision of appointments within 24 hours of the enrollee’s request.</p> <p>¹ “Many primary care physicians do not work every day. A patient calling to request an appointment with a physician not present should be given the choice of seeing another physician or waiting to schedule an appointment with his physician later in the week.” Murray, M and Berwick, DM “Advanced Access Reducing Waiting Delays and in Primary Care” JAMA 2003;239:1035-1040</p>	
	<p>Specialist Appointments Within 5 Days: The requirement in this definition that a specialty appointment be provided within 5 days is not a part of any current “advanced access” program in California, or to our knowledge, anywhere in the United States. We have raised this issue with the Department in prior comments. Advanced access programs have only been successfully implemented in primary care settings. Referrals to all specialties should be timely, but it cannot and should not be proscribed within a set time-elapse standard.² The DMHC may just as well strike this definition in its current form and remove the alternative filing option under Subsection (e) (5) for “Advanced Access.” No one can meet this standard and it is doubtful that the industry will ever be able to do so.</p> <p>Our suggested revision of this definition is as follows:</p> <p>“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 primary care appointments within 24 hours of the enrollee’s request; and advanced scheduling of appointments at a later date if the enrollee prefers not to accept the appointment offered, with timely referral to an appropriate specialist according to sound clinical practice.</p> <p>² For example, the VA reported the successful use of reduction of appointment types, reduction of demand, development of service agreement with primary care, and standardized documentation using templates in the Urology department reduced waiting times to 14.2 days. Hankinson MT, Faraone D, Blumenfrucht M. Sustained improvement for specialty clinic access Jt Comm J Qual Patient Saf. 2006 Mar;32(3):142-51</p>	
<p>20-132</p>	<p>(b) Definitions. (5) “Referral time”</p> <p>The current definition is limited to “written” requests, which does not take into account current practice methods that also include electronic and telephonic. We suggest that the Department add to last line “written, <u>electronic, or telephone request</u> for additional health care services.” Alternatively, the Department may wish to avoid the regulation becoming dated as communications technology advances, and we suggest the removal of the word “written” from the sentence, so that all future means of communication are then recognized.</p>	<p>Decline: Please see response to Comment Nos. 3-5 and 12-31. Please also reference Rule 1300.67.1 regarding requirements for plans to ensure continuity of care, including but not limited to required documentation and QA monitoring of referrals.</p>

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<p>20-133</p>	<p>(c) <u>Quality Assurance Processes</u>. (2) Requirements for Plan monitoring (A) An annual statistically valid survey</p> <p>The regulation does not recognize the complete current industry standard of patient survey tools. The Patient Assessment Survey measures patient experience at the physician group level. The publicly-reported results are used by physician groups for quality improvement, by consumers for physician group selection, and by health plans for determining quality-based payments through the Integrated Healthcare Association (IHA) Pay for Performance initiative. Any California provider group that serves adult commercial HMO and POS enrollees is eligible to participate in PAS.³ The metrics that have been developed in the PAS program have been tested and modified through experience and represent the most advanced patient survey tools in the nation. For more information on this system, see http://www.cchri.org/programs/mg_cas.asp.</p> <p>We suggest that the section be amended to include the PAS program, as follows:</p> <p>(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), <u>or the Patient Assessment Survey (PAS)</u> may meet the requirements of this subsection by including appropriate supplemental questions, as approved by the Department, with the NCQA survey.</p>	<p>Decline: The suggested revision would not achieve the directive of Section 1367.03 or meet the objectives of this rulemaking action for consistent monitoring and reporting of performance, to enable consumers to compare among plans and their contracting medical groups. Reference Section 1367.03(f)(2) and subsection (e)(2) of the regulation. Please also see the response to Comment No. 3-7.</p>
<p>20-134</p>	<p>(c) <u>Quality Assurance Processes</u>. (2) Requirements for Plan monitoring (D) Contracts with Providers</p> <p>While a Plan’s quality assurance program may be reasonable, as approved by the Department, the downstream requirements associated with compliance by providers may not be reasonable. Under the current language, Plans will have unbridled discretion to require providers to implement procedures that may be overly burdensome, unreasonable or impossible. CAPG suggests that a reasonableness standard be inserted into the requirement.</p> <p>We suggest the following amendment to this sub-section:</p> <p>(D) Contracts between a plan and a provider group shall <u>reasonably</u> 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).</p>	<p>Decline: The regulation does not grant “unbridled discretion” to the plans as referenced in this comment. To the contrary, the regulation establishes meaningful performance standards amenable to documentation, monitoring and enforcement by providers, plans and the Department. Please see also the response to Comment Nos. 9-24 and 13-49.</p>
<p>20-135</p>	<p>(d) <u>Plan Standards for Access to Care</u> (5) Plan or provider groups that do not provide Advanced access (C) and (D)</p> <p>Please refer to our prior comments concerning the definition of “Advanced access.” CAPG respectfully suggests that both sub-sections (C) and (D) be amended as follows in this regulation.</p> <p>Section (C) indicates the telephone waiting time shall not exceed 5 minutes, but almost all physicians’ offices have no mechanism to measure or track on-hold waiting times. Sub-sections A and B indicate that a qualified health care professional must be readily available for prompt screening and triage. The after-hours recorded instructions are already required by the health plans in their provider group audits.</p>	<p>Decline: This comment illustrates and highlights the necessity for the performance standard requiring plans to provide or arrange for the provision of telephone screening and triage services, and the need to specify a consistent, definitive time-elapased standard for this access indicator for this category of required health care service. As this and other comment notes, individual providers lack the staffing and other administrative capacity to provide timely assessment of an enrollee’s clinical need for a timely appointment, and enrollees lack the clinical education and expertise to determine the time in which an appointment is</p>

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	<p>We suggest the following amendment to sub-section (C):</p> <p>(A) 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 <u>not be excessive</u>. 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.</p>	<p>needed. Section 1367.03 expressly requires the regulation to include an access indicator for waiting time to speak with a qualified person trained in screening and triage. Accordingly, the regulation clarifies the requirement by confirming the performance standard requiring that <u>plans</u> provide or arrange for the provision of these services, in order to <u>assist enrollees and providers</u>. As reflected by the enumerated access indicators in Section 1367.03(a), the lack of access to a qualified clinician to determine the appropriate time for an appointment may itself be a barrier to access to an appointment in a timely manner appropriate for the nature of the enrollee's condition and health care needs consistent with professionally recognized standards of practice. Please see also the response to Comment Nos. 13-46 and 15-66.</p>
<p>20-136</p>	<p>Section (D) is vague and ambiguous regarding what constitutes "multiple provider cancellations" and this is not a standard that anyone will be able to either define or comply with.</p> <p>We suggest the following amendments to the current language:</p> <p>... and is not subjected to multiple provider cancellations that may disrupt continuity of care or otherwise delay timely access contrary to <u>in accordance with</u> the requirements of Section 1367.03 of the Act and this section.</p>	<p>Decline: The referenced provision is clear in the context of this regulation, and is necessary to clarify the expectation that plans and their contracting providers must be alert to situations in which an enrollee has experienced multiple provider cancellations of scheduled appointments. The regulation is not overly prescriptive so as to provide for appropriate flexibility for plans to implement policies and procedures necessary and appropriate to ensure that multiple provider cancellations do not occur or, if they occur, then other arrangements are made to provide timely access and continuity of care.</p>
<p>21-137</p>	<p>We serve these consumers in a variety of ways including assisting them in receiving timely appointments and referrals. From this experience we know that relying on a health plan to come up with their own timely standards, adhere to them, and reveal them to clients is not reasonable.</p> <p>Currently Health and Safety Code § 1383.15(c) requires that plans have timelines filed with the Department detailing how they process requests for second opinions. "Sarah", a current Hotline client, has been attempting to get a surgery performed by her Medi-Cal HMO for well over a year. The plan keeps denying her for different medical reasons and Sarah requested a second opinion. This second opinion is still pending even though during the past few weeks the Hotline has repeatedly contacted the plan to request a speedy resolution. The Hotline contacted the Department to find out what the HMO's timeline for second opinions is; the Department said the Hotline would have to</p>	<p>Decline: Individual enrollee complaints are outside the intended scope of this rulemaking action. However, the information provided in this comment raises concerns regarding an apparent delay, denial or modification of health care services that may trigger certain requirements in the Knox-Keene Act and/or requirements applicable to Medi-Cal coverage.</p> <p>Health plan decisions which constitute a delay, denial or modification of a requested health care service, including delay, denial or modification of a request for a second opinion, trigger the requirements of Section 1368 (complaints and grievances) and/or Section 1374.30 (independent medical review).</p> <p>Enrollee complaints regarding plans regulated by the</p>

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	<p>contact the plan for that information. The Hotline contacted the plan who said they did not have that information on hand and suggested that the Hotline ask Sarah as it might be in her evidence of coverage. Sarah does not know the timeline and is still awaiting the result of her request for a second opinion. Sarah's situation illustrates that even when plans are required to have public timelines they do not routinely share them with beneficiaries. The Department's new proposed timely access regulations would keep things just as they are currently, with the health plans in control of when beneficiaries get care and beneficiaries suffering the consequences.</p>	<p>Department of Managed Health Care may be submitted to the DMHC Help Center. The Help Center may be contacted toll free by telephone at 888-466-2219 or on line at www.dmhc.ca.gov.</p> <p>Medi-Cal beneficiaries may obtain assistance from the Office of the Medi-Cal Ombudsman by contacting that office toll free by telephone at 888-452-8609.</p>
<p>21-138</p>	<p>Timeliness Standards</p> <p>The Department had proposed detailed timeliness standards in the past two rounds of proposed regulations. While the Hotline did not fully support each and every time standard, overall we were very pleased with the proposed regulations as they would have brought clarity and rapidity to beneficiaries' pursuit of needed health care. The new regulations do not provide this. They keep things as they are now. The Department has taken §1367.03, which requires them to adopt regulations "to ensure that enrollees have access to needed health care services in a timely manner" and passed that responsibility on to the plans.</p> <p>The Department's actions do not fulfill the requirements of §1367.03. They have only placed the onus of the regulations on the plans. The proposed regulations do not ensure that enrollees will receive timely access to health care; they simply require the plans to create their own standards based on vague professional standards which do not currently provide timely access. On top of that the Department has so weakened their proposed monitoring of compliance of these self-made regulations that there will be no valid way to show if the plans are adhering to their own standards.</p> <p>The statute clearly placed the responsibility of developing timely access standards upon the Department. The Department cannot pass that responsibility on to the health plans. Furthermore, the Department is much better situated to create these standards than the health plans. The Department has done years of research on what these standards should be. The Department should take that knowledge and add to it the "professionally recognized standards of practice" and the "involvement from actively practicing health care providers," that they suggest plans use. Using all three resources the Department should create the comprehensive timely access standards that</p>	<p>Decline: The regulation retains requirements for time-elapased standards. Please see subsections (d)(2) and (3) and (b)(2), (5) and (7). The specific detailed time elapsed standards are to be developed by the plans in accordance with the performance standards established by the regulation. See subsections (d)(3) and subject to the Department's review and approval. In addition to the performance standards set forth at subsection (d)(3), the Department may, in reviewing and approving a plan's proposed timely access standards, all relevant factors as outlined at subsection (e)(3).</p> <p>During the course of this rulemaking action, it became clear that an approach involving specifying in the regulation text the numerous detailed prescriptive time elapsed standards, and exceptions attempting to address variations in plan operations, service areas and provider networks, was unworkable. The second version of regulation text was more complicated, cumbersome and unworkable than the first version, and rather than lessening concerns about unintended consequences, clarity and consistency, the second version generated additional concerns.</p> <p>The regulation meets the statutory objective by establishing performance standards to ensure access to needed health care services in a timely manner for enrollees. The Department has established definitive performance standards, amenable to documentation and reporting, by which plans will develop time-elapased standards and propose them for the Department's</p>

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	<p>§1367.03 requires. This will yield stronger, less biased and more consistent standards than what the plans will have the resources or desire to create. Moreover, any standards the Department implements will have the added benefit of being vetted in the public comments process.</p> <p>The result of health plan authorized standards will have a number of negative consequences. Beneficiaries who switch from one plan to another will encounter differing standards of care along the way. Beneficiaries who switch plans may not remember if they can get urgent care from their new plan in 24 or 48 hours, and when they are experiencing a need for urgent care they will not have the luxury of looking it up in their evidence of coverage. We urge the Department to go back to a system of specific timely access standards based on urgency and specialty, as well as to return to an effective version of compliance monitoring, so the regulations are in compliance with §1367.03 and so consumers actually receive timely access to care.</p>	<p>approval. The time-elapsd standards approved by the Department will also be amenable to documentation and reporting. Because the performance standards established in the regulation and the time-elapsd standards approved by the Department are amenable to documentation and reporting, they will be amenable to compliance oversight monitoring and enforcement by the plans, their delegated provider groups and the Department.</p>
<p>21-139</p>	<p>Statutory Requirements</p> <p>The proposed regulations are drastically changed from the last two rounds. No person could logically have expected this iteration to arise from the previous versions of timely access regulations. This can be seen in the fact that nearly all 20 pages of the second round were cut out and the 7 pages of this new regulation are almost entirely brand new. These major and significant changes were not “sufficiently related to the original text so that the public was adequately placed on notice that the changes could result from the originally proposed regulatory action” as the notice of the third comment period claims, and as Gov. Code § 11346.8 (c) requires. The department must publish a new notice with a 45 day comment period.</p>	<p>Decline: Please see response to Comment Nos. 8-20 and 10-26.</p>
<p>21-140</p>	<p>Specialty Plans</p> <p>The proposed regulations do not apply to dental, vision, chiropractic, acupuncture, or EAP plans. While the Hotline recognizes that the care these specific medical plans offer differs from the care full service health plans provide, we also know that when this specific medical care is needed, it is required in as timely a manner as any other health care service. Prompt dental attention is just as important as prompt medical attention. A child with an infected tooth needs timely care as much as a child with any other kind of infection. Under this proposed system, where only plans that use hospitals are covered, the beneficiary’s right to timely care only arises once dental health</p>	<p>Decline: The Department has determined that it is not necessary for this regulation to apply to the referenced specialized plans in order to implement, clarify, make specific and otherwise accomplish the objectives of Section 1367.03. Other provisions regarding timely access are applicable to these specialized plans, including but not limited to Section 1367 and Rules 1300.51(d)(H), 1300.67.2 and 1300.67.2.1.</p>

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	<p>becomes problematic enough to require a hospital setting. This is not only physically harmful to the beneficiary, it is fiscally irresponsible. We urge the department to apply the regulations to dental, vision, chiropractic, acupuncture, and EAP plans and services.</p>	
21-141	<p>Office Waiting Times</p> <p>There should be guidelines for office waiting times. We often speak with clients who have waited hours in offices for care even when they had made appointments in advance. For many people long office wait times mean not getting care at all because they must return to work or caregivers for their children. LEP beneficiaries often have to wait long times in waiting rooms while interpreters are acquired. These regulations should specify that LEP beneficiaries cannot be provided a different standard of care than people who are English proficient. The Department should include office waiting times as an indicator of timeliness.</p>	<p>Decline: Office waiting time is not included among the access indicators enumerated at Section 1367.03(a), and it is not necessary to include it in the regulation to achieve the objectives of Section 1367.03 and this rulemaking action. After this regulation is adopted, the Department will continue to assess, and will welcome information and data submitted by interested persons, regarding timely access deficiencies that reflect a need for changes to this regulation. Please reference Section 1367.03(j).</p>
21-142	<p>Interpretation</p> <p>There is no mention in these regulations of time guideline for acquiring an interpreter. The Department should expressly state that time to acquire interpreters, or serve LEP beneficiaries equally in any way must be included in the plans' time standards. Not including this would discriminate against LEP beneficiaries, and violate §1367.04.</p>	<p>Decline: Please see response to Comment No. 8-22.</p>
21-143	<p>Out-of-Network Providers</p> <p>Currently the proposed regulations state in §(c)(4) that when a medical group cannot provide timely access, the beneficiary will be referred to another in-network provider. To ensure that beneficiaries always have access to timely care, even when their plans provider network is insufficient, the section should state that if another in-network provider is not available in a timely manner, the beneficiary will be referred to an out-of-network provider and the plan will pay for the treatment from that out-of-network provider.</p>	<p>Decline: Please see the response to Comment No. 17-108.</p>
22-144	<p>We support strong regulations to require health plans to fulfill their duty to provide timely access to health care services. We are disappointed that DMHC has removed time elapsed standards from the proposed regulations. The appropriate place to debate and determine standards is the regulatory process. The current proposed language does not provide health plans or consumers with sufficient information to develop standards. The wide discretion DMHC is claiming in approving standards does not allow</p>	<p>Decline: Please see the responses to Comment Nos. 8-20; 10-26; and 17-104.</p>

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	<p>stakeholders sufficient input into this process. The difficult give and take with stakeholders over the past few years will not vanish without specific standards, but will move underground, into backdoor conversations without public oversight.</p>	
<p>22-145</p>	<p>We strongly disagree that access for interpreters was addressed in (c)(2)(G)(v) in Rule 1300.67.04. The wording in the language access regulation is vague and does provide plans with a clear time elapsed standard for the provision of interpreters.</p> <p>In CPEHN's previous comments we urged DMHC to ensure that enforcement of these timely access regulations must include assessing how these requirements impact communities of color and limited English proficient communities, which are subject to vast health disparities. We strongly support the requirement that plans conduct satisfaction surveys of their enrollees to determine compliance with the regulations. However, there is no requirement that plans translate surveys into other languages, or ensure adequate sample sizes of communities of color. These two issues are not addressed anywhere in the language access regulations. A response to these points was not made in the comments chart DMHC provided us, and we are eager to see this important issue addressed. Plans must not only ensure overall compliance but also ensure that specific communities are not bearing the brunt of excessive wait times.</p>	<p>Decline: Please see response to Comment No. 8-22.</p>
<p>23-146</p>	<p>The revised text of the proposed regulation addressed many of the concerns CAHP expressed in prior comment letters. We appreciate the Department's efforts to work with plans and providers to develop a framework that will achieve the goals of the statute without burdening the system. While we appreciate the Department's revisions, there are several provisions that continue to be problematic and unworkable for CAHP's member plans. I have attached a redlined version of the draft regulation with our suggested changes, and have highlighted our primary concerns below.</p> <p>1) Appointment Waiting Time Should Not Include Time to Authorize Services – Proposed Rule 1300.67.2.2 (b)(2).</p> <p>The proposed regulation defines "appointment waiting time" to include the time for obtaining authorizations. This requirement does not reflect the process of authorizing services and setting appointments. In most instances the plan or provider group authorizing the service is not the same as the provider that sets</p>	<p>Decline: Please see the responses to Comment Nos. 3-4 and 14-54.</p>

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	<p>the appointment. Additionally, Health and Safety Code Section 1367.01 already requires authorizations to be made promptly given the circumstances of the enrollee's condition. Because it is neither the standard of practice nor appropriate for an appointment to be set before an authorization is granted, appointment waiting time should begin once an authorization to obtain the service is provided.</p>	
23-147	<p>2) Provider Satisfaction Survey is not Related to Ensuring Timely Access of Care and Should be Deleted – Proposed Rule 1300.67.2.2 (c)(2)(B).</p> <p>The requirement for a provider satisfaction survey goes beyond the intent of the law. There is no requirement to assess provider satisfaction, but rather to ensure timely access to care for enrollees. A survey of this magnitude will be costly and time consuming for plans to perform, and will not be meaningful in determining timely access to care. Provider satisfaction surveys measure a provider's satisfaction, not whether an enrollee is obtaining timely access to care. Providers will be the ones setting appointments, speaking to enrollees on the phone and providing services – how does their satisfaction determine whether enrollees receive timely care? Plans should use their resources on tools that will assist them in evaluating access, not simply measuring provider satisfaction with plans.</p>	<p>Decline: Please see the responses to Comment Nos. 3-8; 14-57; and 15-63.</p>
23-148	<p>3) Review of Information Regarding Accessibility Should be Performed Quarterly- Proposed Rule 1300.67.2.2 (c)(2)(C).</p> <p>The proposed regulation would require plans to monitor access data on a monthly basis for compliance purposes. CAHP requests that this requirement be changed to quarterly. Quarterly review is more conducive to gathering the data from which patterns of non-compliance can be identified. A quarterly process is also more consistent with quality management processes pursuant to the Knox-Keene Act.</p>	<p>Decline: Please see the responses to Comment Nos. 13-45 and 15-81.</p>
23-149	<p>4) The Additional Requirements for Providers without Advanced Access Should be Eliminated - Proposed Rule 1300.67.2.2(d)(5).</p> <p>The proposed regulation would place additional requirements on plans and providers that do not offer advanced access. While CAHP supports promoting advanced access, Proposed Rule 1300.67.2.2(d)(5) is seriously flawed in several respects, is not needed to promote timely access to care, and should be removed in its entirety.</p>	<p>Decline: The "advanced access" provision in this regulation is not an "extra" requirement. It provides a "safe harbor" within which a plan will be deemed to be in compliance with the requirement to establish time-elapsed standards for appointment waiting times, and will be excepted from the requirement to provide or arrange for the provision of telephone screening and triage services. The "deeming" of adequate time-elapsed standards and the "exception" from telephone screening and triage requirements</p>

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<p>First, it is unclear why the Department has included the telephone and triage standards for providers that do not offer advanced access. Advanced access would have no bearing on a patient's need for timely telephone access as a patient would need to speak to someone in order to set a same day appointment and may need triage and screening services. Telephone waiting time standards will already be placed on providers pursuant to Proposed Rule 1300.67.2.2(d)(1)-(3), and the addition of this section will create confusion.</p> <p>Second, the Department has added the concept that plans should perform or should be responsible for ensuring that certain screening and triage activities take place (Proposed Rule 1300.67.2.2(d)(5)(B)). This addition is extremely problematic for plans. Plans do not practice medicine. It is unclear how a plan would document, monitor and evaluate the screening and triage that providers provide to their patients. This requirement is clearly beyond the scope of the statute and is intrusive into providers' practices. In effect, the Department is creating an additional role for health plans. Any such expansion should be crafted in legislation.</p> <p>Finally, the proposed regulation would require plans to ensure that enrollees speak to a qualified health professional within 5 minutes (Proposed Rule 1300.67.2.2(d)(5)(C)). The Department has otherwise eliminated all rigid timeframes from the proposed regulations. This five minute standard should also be eliminated as it is excessive, intrusive and unnecessary to carry out the purpose of the statute. The monitoring that would be required to determine compliance would intrude into a provider's practice, putting more strains on providers and potentially taking time away from patients. Most providers do not have any means of tracking telephone wait time. Many small provider offices do not have separate lines for triage versus general questions, and other than tracking by hand in log books, which the Department has previously rejected, so accurate monitoring would be impossible.</p> <p>CAHP urges the Department to delete Proposed Rule 1300.67.2.2(d)(5) in its entirety. Alternatively, CAHP requests that Proposed Rule 1300.67.2.2(d)(5)(B) and the five minute requirement in Proposed Rule 1300.67.2.2(d)(5)(C) be deleted.</p>	<p>will only be applicable to the portion of the plan's provider network that provides advanced access to appointment scheduling. For portions of the plan network that do not provide advanced access to appointment scheduling, the plan will be required to provide telephone screening and triage services and apply time-elapsed standards for appointment waiting times.</p> <p>Overarching the advanced access and time-elapsed standards, is the ultimate performance standard for ensuring timely access, established at subsection (d)(1) and based on clinical appropriateness.</p> <p>The performance standard clarifying the obligation for plans to provide or arrange for the provision of telephone screening and triage services is soundly based in the Department's statutory authority and obligation pursuant to Sections 1342, 1344 and 1346 to implement, clarify and make specific the requirements of Sections 1367 and 1367.03.</p> <p>Please refer also to Section 1367.03(a)(3) which enumerates as an access indicator "the 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." Section 1367(d) requires, "The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice." Section 1367(e)(1) requires, "All services shall be readily available at reasonable times to each enrollee consistent with good professional practice. To the extent feasible, the plan shall make all services readily accessible to all enrollees consistent with Section 1367.03."</p> <p>The last sentence of Section 1367, added with the August 226, 2002 amendments to AB 2179 confirms that, "The obligation of the plan to comply with this section shall not be waived when the plan delegates any services that it is required to perform to its medical groups, independent practice associations, or other contracting entities."</p>
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		<p>Rule 1300.67.1 clarifies that, "Within each service area of a plan, basic health care services shall be provided in a manner, which provides continuity of care, including but not limited to... (d)The maintenance of staff, including health professionals, administrative and other supporting staff, directly or through an adequate referral system, sufficient to assure that health care services will be provided on a timely and appropriate basis to enrollees; (e) An adequate system of documentation of referrals to physicians or other health professionals. The monitoring of the follow up of enrollees' health care documentation shall be the responsibility of the health care service plan and associated health professionals."</p> <p>It is clearly the legislative expectation that plans will establish processes for ensuring that enrollees have timely access to medical advice from qualified clinicians for the purpose of determining and facilitating timely appointments.</p> <p>Many plans and contracted medical groups already provide telephone medical advice. See also Section 1348.8.</p> <p>The requirement for providing telephone screening and triage services is an obligation of the health plans, and does not intrude into the practices of providers. Plans and their contracting medical groups may choose to collaborate and negotiate for the contractual delegation of this obligation, in accordance with applicable standards and requirements in the Act for such delegated obligations.</p> <p>The assertion that plans do not practice medicine therefore it is unclear how they would document, monitor and evaluate delegated screening and triage services, raises serious concerns regarding a lack of basic understanding regarding Knox-Keene licensure and the requirements of the Knox Keene Act with respect to delegation of the plan's obligations under the Knox-Keene Act. A plan that lacks adequate contractual authority and adequate QA standards, policies and procedures for ensuring performance of delegated obligations in accordance</p>
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		<p>with the requirements of the Knox-Keene Act is not in compliance with the Knox-Keene Act. Please reference, for example, Sections 1342, 1348.8, 1351, 1367 and 1370, and Rules 1300.51(d)(Exhibits O, K, N) and 1300.70.</p> <p>With respect to the performance standard requiring a waiting time of not more than 5 minutes, please see the responses to Comment Nos. 12-32 and 15-66.</p>
23-150	<p>6) Time-Elapsed Standards are Not Necessary – Proposed Rule 1300.67.2.2 (e)(5)</p> <p>The public record supports the conclusion that time-elapsed standards are neither clinically appropriate nor evidence based, and that they will interfere with the providers’ ability to utilize sound judgment for each individual patient’s circumstances. Based on overwhelming evidence that time-elapsed standards are not considered clinically appropriate by the provider community, the Department should reject them, as expressly permitted by the Legislature in Section 1367.03(c). The Department should permit plans to file standards that are appropriate. It is not necessary to require plans to file a material modification and demonstrate more appropriate standards; the Department already has the power to review and approve the plan’s proposed standards.</p>	<p>Decline: The comments submitted by health plans are not the only comments the Department is required to consider pursuant to the Administrative Procedures Act. The Department has not determined that there are any standards more appropriate than time-elapsed standards. Accordingly, the regulation requires time elapsed standards. Please see the responses to Comment Nos. 8-20 and 10-26.</p>
23-151	<p>(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. <u>[[This appears to be a restatement of current law and does not need to be in the regulation.]]</u></p>	<p>Decline: The comments from health plans and providers, including Comment No 23-149, highlight the necessity for this provision to clarify that the obligations of this regulation are obligations of the health plans and may only be delegated in accordance with the requirements of the Knox Keene Act applicable to delegation contracts. Please see also the responses to Comment No. 23-149.</p>
23-152	<p>(3)(2) This section does not create a new cause of action or a new defense to liability for any person.</p>	<p>No change requested.</p>
23-153	<p>(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 <u>510</u> 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 <u>510</u> days (for specialist physicians).</p>	<p>Decline: Please see the responses to Comment Nos. 12-29; 15-60; and 15-61.</p>
23-	<p>(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</p>	<p>Decline: Please see the responses to Comment Nos.3-4 and 14-</p>

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23-155	(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.	Decline: Please see the responses to Comment Nos. 3-5; 13-31; and 15-64.
23-156	(6)(5) "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.	No change requested.
23-157	(7)(6) "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, when such screening or triage is necessary.	Decline: Please see the responses to Comment Nos. 13-46 and 15-66.
23-158	(8)(7) "Urgent care" means health care for a condition which requires prompt attention, consistent with section 1367.01(h)(2).	No change requested.
23-159	(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 accreditation 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.	Decline: Please see the responses to Comment Nos. 3-7 and 15-77.
23-160	(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.	Decline: Please see the responses to Comment Nos. 3-8; 14-57; and 15-63.
23-161	(C)(B) Review, on not less than a monthly <u>quarterly</u> 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, and plan monitoring of provider performance, and screening and triage activities pursuant to subsection (d)(5).	Decline: Please see response to Comment No. 13-45.
23-162	(D)(C) 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).	No change requested.

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23-163	(3) A plan shall implement prompt investigation and corrective action when compliance monitoring identifies <u>a pattern of</u> 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.	Decline: Please see the responses to Comment No. 15-67 and 15-82.
23-164	(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 <u>as appropriate for the nature of the medical condition of the patient</u> . 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.	Decline: Please see the response to Comment No. 15-83.
23-165	(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 <u>through the process set forth in subsection (e)(3)</u> : (A) Appointment waiting times, which shall be tracked separately for each of the following categories of providers: (i) primary care physicians; (ii) specialty care physicians; <u>and</u> (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, <u>as appropriate for the type of provider</u> .	Decline: Please see the responses to Comment Nos. 3-10 and 15-84.
23-166	(B) <u>Timeliness of care in an episode of illness, including timeliness of referrals</u> Referral times in an episode of illness, injury or other health condition ; and	Decline: Please see the responses to Comment Nos. 3-5; 12-31; and 15-85.
23-167	(4) A plan may demonstrate compliance with the requirements of this section through implementation <u>by provider groups</u> of standards, processes and systems providing advanced access, as defined at subsection (b)(1), to appointments for health care services.	Decline: Please see the responses to Comment No. 15-86.

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23-168	<p>(S)A plan or delegated provider group that does not provide advanced access to appointments shall have systems and personnel sufficient to ensure that:</p> <p>(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.</p> <p>(B)The screening and triage activities conducted pursuant to subsection (d)(S)(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.</p> <p>(B)The telephone wait time for an enrollee or to speak with a qualified health care professional pursuant to subsection (d)(S)(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.</p>	Decline: Please see the responses to Comment Nos. 13-46; 15-66; and 23-149.
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	<p>(A) 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.</p> <p>—[[CAHP highly recommends removing the entire section 1300.67.2.2(d)(5), however, we submit the following as an alternative:</p> <p>(5) A plan or delegated provider group that does not provide advanced access to appointments shall have systems and personnel sufficient to ensure that:</p> <p>(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 when necessary to provide prompt screening and triage, and to advise enrollees and providers regarding the time in which an enrollee should see a physician, and to facilitate arranging for appointments in a timely manner as appropriate for the enrollee's condition and health care needs.</p> <p>(B) 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 is reasonable. After hours and weekends, plan and provider medical advice and triage lines shall provide clear recorded instructions regarding how to obtain or emergency care.</p> <p>(C) 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.</p>	<p>Decline: Please see the responses to Comment Nos. 13-46; 15-66; 23-149.</p>
23-169	<p>(B) 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.</p>	<p>Decline: Please see the responses to Comment Nos.3-8; 14-57; 15-63.</p>
23-170	<p>(C) 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, if any.</p>	<p>Decline: Please see the responses to Comment Nos. 13-12 and 15-94.</p>
23-171	<p>(E) 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. [[Moved from 1300.67.2.2(e)(2)(E)]]</p>	<p>Decline: The suggested revisions are not consistent with the objective of this rulemaking action, that is, to require this information to be reported annually.</p>
23-172	<p>(B) The rate of compliance, during the reporting period, with each of the plan's timely access standards, as identified through the compliance monitoring required by 1300.67.2.2 (c)(2), separately reported for each of the plan's contracted provider groups located in each county of the plan's service area.</p>	<p>Decline: Please see the responses to Comment Nos. 13-47 and 15-95.</p>

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23-173	(C) 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. <u>Any such reports shall be deemed confidential information that shall not be divulged by the Director.</u>	Decline: Please see the responses to Comment Nos. 15-67 and 15-96.
23-174	<p>(E) A list of all provider groups and individual providers utilizing advanced access appointment scheduling.</p> <p>(E) 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.</p> <p>(G)(E) The results of the most recent annual enrollee and provider satisfaction surveys and a comparison with the results of the prior year's survey, <u>if applicable</u>, including a discussion of the relative change in satisfaction.</p>	Decline: The suggested revisions will not achieve the objective of this rulemaking action with respect to the intended performance standards for robust quality assurance monitoring and prompt correction of timely access problems.
23-175	<p>(A) The efforts by a plan to evade the standards, such as referring enrollees to providers who are not appropriate for an enrollee's condition;</p> <p>(B)(A) The nature and extent of a plan's efforts to <u>avoid identify and to</u> or correct <u>patterns of</u> non-compliance;</p> <p>(C)(B) The <u>plan's response to nature and extent to which</u> a single instance of non-compliance <u>that</u> results in, or contributes to, serious injury or damages to an enrollee;</p> <p>(D)(C) The extent to which non-compliance is the result of an urgency or emergency affecting a provider or provider group;</p> <p>(E)(D) 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 though referrals to other providers; and</p> <p>(F)(E) 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.</p>	Decline: The suggested deletion of (e)(3)(A) would not accurately reflect the scope, breadth and depth of factors the Department considers relevant to its review of a plan's compliance or non-compliance with the requirements of the regulation. The additional suggested revisions are not necessary to clarify the referenced provisions, and would not accomplish the objective of this rulemaking action.
23-176	(5) 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.	Decline: Please see the response to Comment No. 15-102.

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24-177	We support the California Association of Health Plans (CAHP) comments to the Department in response to these regulations on behalf of its member plans, which includes PacifiCare.	No change requested.
24-178	<p>(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).</p> <p><u>General comment:</u> (a)(2) indicates that this section does not establish performance requirements for individual health care providers. However the this definition appears to regulate the individual practice and its scheduling which appears to be inconsistent with (a)(2).</p>	<p>Decline: The "advanced access" provision is not a requirement and is not imposed on providers. It provides a "safe harbor" within which a plan will be deemed to be in compliance with the requirement to establish time-elapsd standards for appointment waiting times, and will be excepted from the requirement to provide or arrange for the provision of telephone screening and triage services. The "deeming" and "exception" to triage will only be applicable to the portion of the plan's provider network that provides advanced access to appointment scheduling. For portions of the plan network that does not provide advanced access to appointment scheduling, the plan will be required to provide telephone screening and triage services and apply time-elapsd standards for appointment waiting times.</p> <p>Overarching the advanced access and time-elapsd standards, is the ultimate performance standard for ensuring timely access, established at subsection (d)(1), which is based on clinical appropriateness.</p> <p>Please see also the response to Comment Nos. 12-29; 15-60; and 23-149.</p>
24-179	<p>(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.</p> <p>It is not feasible that an urgent appointment could be offered within 72 hours if authorization is required and the plan or provider is allowed 72 hours to make the decision after receipt of the request. Utilization decision/notification timeframes and appointment wait times are distinct standards and should be measured separately.</p> <p><u>We suggest the following revised language for your consideration:</u> "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</p>	<p>Decline: This comment highlights the necessity of this provision. Plans are obligated to ensure timely access to covered services. A plan may not allow its utilization review processes to be barriers to timely access to covered services. Section 1367.01 expressly prohibits this by its requirement, for both urgent and non urgent services, that plan utilization review decisions "shall be made in a timely fashion appropriate for the nature of the enrollee's condition..." Accordingly, a plan's utilization review processes must be completed within a time frame that ensures timely access to the appointment. Accordingly, the waiting time for appointment includes the time consumed by any utilization review or other plan process.</p>

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	date offered for the appointment for services.	
24-180	<p>(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.</p> <p><u>General comment:</u> (a)(2) indicates that this section does not establish performance requirements for individual health care providers. However this requirement appears to regulate the individual practice which appears to be inconsistent with (a)(2).</p> <p>This is a critical component of the health care delivery mechanism which may include ineffective processes and communication pathways; however this would also require plans to micromanage individual provider referral processes to identify variation. We are not aware of an evidence-based guideline for "referral time" and having plans establish arbitrary referral timeframes would be inappropriate and would not add value or improve access to care. We are not sure how a plan would identify if a provider determined within an appropriate timeframe whether to refer an enrollee to another provider.</p> <p>We believe the language goes beyond the requirements of the statute and request that it be deleted.</p>	Decline: Please see response to Comment Nos. 3-5; 12-31; and 15-64.
24-181	<p>(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.</p> <p>We are not clear as to how a plan would evaluate the time an enrollee waited for a return call from a physician, except through reliance on the enrollee's experience (satisfaction survey).</p> <p>We believe the language requiring wait time for a return call, goes beyond the requirements of the statute and request that it be deleted.</p>	Decline: Please see the responses to Comment Nos. 12-32; 13-46; and 15-66.
24-182	(A) An annual, statistically valid, enrollee satisfaction survey. The survey shall be conducted in accordance with valid and reliable survey methodology,	Decline: Please see response to Comment No. 3-7.

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	<p>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.</p> <p>There has been significant industry research by the Agency for Healthcare Research and Quality in developing the CAHPS...particularly efforts to develop Ambulatory CAHPS and Hospital CAHPS. We recommend the DMHC leverage this methodology rather than regulate a measurement system that is non-standard by requiring supplemental questions and approval by the Department.</p>	
24-183	<p>(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.</p> <p>Conducting a provider satisfaction survey specifically to gather data on access issues would be an administrative burden and increase administrative cost. Plans have mechanisms in place for providers to report issues or concerns.</p> <p>We believe requiring a provider satisfaction survey goes beyond the requirements of the statute and we request that it be deleted.</p>	Decline: Please see the responses to Comment Nos. 3-8; 14-57; and 15-63.
24-184	<p>(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).</p> <p>Individual access issues are dealt with on a real time basis. Monthly review of plan information will not add value or allow for appropriate evaluation of</p>	Decline: Please see the responses to Comment Nos. 13-45 and 15-81.

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	<p>potential systemic issues. A more appropriate timeframe for review would be on a quarterly basis.</p>	
<p>24-185</p>	<p>(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.</p> <p>We are unclear as to what is meant by “prompt” investigation. The timeframe for correcting deficiencies need to be realistic and reasonable. For example if the plan needs to increase the number of plan-contracted providers in an effected services area and needs to complete the credentialing process or there may be a lack of available providers in a particular specialty in a geographic area this will require a reasonable amount of time to correct and complete.</p> <p>In addition a plan’s monitoring system shall focus upon identifying <u>patterns</u> of noncompliance and take appropriate corrective action to address noncompliance.</p> <p><u>We suggest the following revised language for your consideration:</u> A plan shall implement prompt investigation and corrective action when compliance monitoring identifies a <u>pattern</u> of timely access deficiencies.</p>	<p>Decline: The performance standard requiring “prompt” investigation and corrective action is sufficiently clear for its intended application. This performance standard is intended to provide appropriate flexibility for the consideration of relevant facts and circumstances applicable to a particular situation. For example, please see subsection (e)(4) for factors the department may consider in evaluating and determining a plan’s non-compliance. The revision suggested by this comment does not propose any change in the term “prompt,” which the comment states is the basis for the concerns. Further, the suggested revision would not accomplish the objective of this rulemaking action which includes requiring plans to monitor for instances of substantial harm to an enrollee.</p>
<p>24-186</p>	<p>(B) Referral times in an episode of illness, injury or other health condition; and</p> <p><u>General comment:</u> (a)(2) indicates that this section does not establish performance requirements for individual health care providers. However this requirement appears to regulate the individual practice which appears to be inconsistent with (a)(2).</p> <p>This would also require plans to micromanage individual provider referral processes to identify variation. We are not aware of an evidence-based guideline for “referral time” and having plans establish arbitrary referral</p>	<p>Decline: Please see the responses to Comment Nos. 18-115 and 24-180.</p>

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	<p>timeframes would be inappropriate. We are not sure how a plan would identify if a provider made a referral within an appropriate timeframe for a specific condition.</p> <p>We believe the language goes beyond the requirements of the statute and request that it be deleted.</p>	
24-187	<p>(C) Telephone waiting times.</p> <p>Physicians and providers groups will need to have central phone systems or a method for tracking and reporting hold times and returned calls.</p> <p>Mental health provider offices are generally sole practices without front office staff so putting mechanisms in place could dramatically increase telecom costs, both to plan and providers.</p>	Decline: Please see the responses to Comment Nos. 12-32; 12-33; and 15-66.
24-188	<p>(5) A plan or delegated provider group that does not provide advanced access to appointments shall have systems and personnel sufficient to ensure that:</p> <p>Having processes and systems in place to provide advanced access does not eliminate the potential for telephone wait time. Enrollees could still wait on the telephone to schedule an appointment with a physician who provides advanced access.</p>	Decline: The apparent suggestion to eliminate telephone waiting times as an access indicator is not consistent with the requirements of Section 1367.03 and the objectives of this rulemaking action.
24-189	<p>(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.</p> <p>(a)(2) Indicates that this section does not establish performance requirements for individual health care providers. However this requirement appears to regulate the individual practice by requiring plan's have mechanisms to demonstrate that appointments are documented, monitored and evaluated.</p> <p>We believe the language goes beyond the requirements of the statute and request that it be deleted.</p>	Decline: Please see the response to Comment No. 24-186.
24-190	<p>(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.</p>	Decline: The obligation to provide telephone screening and triage and to meet the 5 minute standard for call wait time is an obligation imposed on plans, not on providers. Plans and their

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	<p>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.</p> <p>A telephone wait time that <u>shall not exceed</u> five minute is not feasible or practical at the provider level. It would be more appropriate as a guideline but not a prescriptive requirement. In addition provider offices would need to have a queue that tracks wait time and abandonment rate.</p> <p>This wait time is more appropriate at the Plan level but not at a provider level. We believe the requirement for a telephone wait to not exceed 5 minutes goes beyond the requirements of the statute and request that it be deleted.</p>	<p>contracting medical groups may choose to collaborate and negotiate for the contractual delegation of this obligation, in accordance with applicable standards and requirements in the Act for such delegated obligations. Please also see the responses to Comment Nos. 12-32 and 15-66.</p>
<p>24-191</p>	<p>(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.</p> <p>These types of processes are imbedded in a provider's scheduling processes and enrollees are offered the next available appointment or at a date that the enrollee prefers. The additional language regarding multiple provider cancellations is unnecessary.</p> <p><u>We suggest the following revised language for your consideration:</u> 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.</p>	<p>Decline: The processes described in this comment may be sufficient to meet the objective of this rulemaking action if the alternative appointment is kept and the plan has adequate processes for staff to override other business rules for appointment scheduling, but too often that does occur, and enrollees are inadvertently subjected to rigid scheduling rules, especially for annual exams and preventive screening appointments. The regulation illustrates the situation that raises concerns and provides appropriate flexibility for plans to implement different processes to meet continuity of care requirements.</p>
<p>24-192</p>	<p>(B) 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.</p> <p>We believe requiring a provider satisfaction survey goes beyond the requirements of the statute and we request that it be deleted.</p>	<p>Decline: Please see the responses to Comment No. 3-8; 14-57; and 15-63.</p>
<p>24-193</p>	<p>(C) 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,</p>	<p>Decline: Please see the response to Comment No. 15-67.</p>

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	<p>determination and corrective action taken in response to each incident.</p> <p>Reporting this type of information appears to cross-over into peer review protected information and should not be included within the body of a public report.</p>	
24-194	<p>(G) The results of the most recent annual enrollee and provider satisfaction surveys and a comparison with the results of the prior year's survey, including a discussion of the relative change in satisfaction.</p> <p>We believe requiring a provider satisfaction survey goes beyond the requirements of the statute and we request that it be deleted.</p>	Decline: Please see the responses to Comment Nos. 3-8; 14-57; and 15-63.
24-195	<p>(5) 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.</p> <p>We support the comments made by CAHP.</p>	No change requested. However, please see the responses to the comments submitted by CAHP at 23-146 through 23-176.
25-196	<p>The Department has stated that the objective of these regulations is to develop cost-effective, workable regulations that are consistent with the standards monitored by the National Committee on Quality Assurance. CAFP applauds that goal and wants to work with the Department to achieve it. CAFP would also like to thank the Department for adopting some of what we believe to be necessary improvements to the previously proposed versions of these regulations. However, we believe some remaining aspects may be improved:</p> <p><u>Multiple Plans and Multiple Responsibilities:</u> Under these regulations, a primary care physician who has multiple plan contracts, or who belongs to a physician group that does, may be subject to a plethora of variable and overlapping standards. Compliance with all of these (while remembering which patient falls under each set of standards) would be nearly impossible. Instead, we recommend setting out a unified, non-time-lapse standard of patient satisfaction. The Department could incorporate such</p>	Decline: Please see the response to Comment No. 18-113.

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	<p>a standard into its consumer survey mechanism within the context of quality and cost considerations. We further recommend that the results of the consumer satisfaction survey be used to inform a plan’s corrective action plan, which may include contractual, not just point of service corrective actions.</p>	
<p>25-197</p>	<p><u>Downstream payment for the cost of implementation:</u> While the goals of these regulations are laudable, sustained improvements to the timeliness of care may only come about through fair and equitable increases in payment for services and the necessary growth in provider networks (of primary care physicians and Primary Care Medical Homes, in particular). While language in these regulations governing the contractual obligations of plans is a good start (see (3) (A) under “Delegation and Responsibility”), compliance and adherence to this contractual goal could be strengthened through additional opportunities for the Department to gather useful information not just on compliance, but on the necessary conditions to ensure compliance, such as in contract arrangements between plans and providers that will ensure downstream payment for this higher standard. Regulatory efforts to improve this could include:</p> <ol style="list-style-type: none"> 1) Under “Compliance Monitoring” criteria, we recommend including some form of confidential and/or redacted <u>provider surveys</u> that offer the Department a snapshot of provider and provider-group difficulties (both contractual and workforce) in complying with these standards at various stages of implementation. (For example, although plan contracts may clearly specify the respective obligations of the parties, including the financial risk for additional plan-required services to provide timely access, and the plan’s methods for monitoring the contractually delegated performance, other remuneration to delegated, risk bearing parties may be discounted elsewhere in the plan-provider division of financial responsibility.) For the viability of these regulations, it would be useful for the Department to be at least aware of this de facto forcing of cost and responsibility downstream; 2) We recommend that a <u>working group</u> be established to seek solutions to these and other problems, if and when they arise; 3) In the event that a provider or provider group does not have the capacity to meet these additional standards under an existing contract, providers and provider groups ought to be given the opportunity to build such capacity during a <u>transitional period</u> and/or under a transitional cost-based reimbursement contract that ensures that faster 	<p>Decline: The referenced provider-plan contracting and related provider compensation issues are outside the intended scope of this rulemaking action. Please see the Department’s pending rulemaking action entitled Plan and Provider Claims Settlement, available on line at the Department’s web site at www.dmhc.ca.gov.</p>

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	<p>access for some does not result in no access for others.</p>	
<p>25-198</p>	<p><u>Definitional Concerns:</u> In order for our members to better meet “advanced access” definition of these regulations, we recommend two slight changes to better align the definition with existing and current practice: 1) Family physicians often work in the context of a patient-centered, “Primary Care Medical Home” in which a team of physician and non-physician providers work together to provide the highest quality and most accessible primary care to their patients. We recommend that mid-level providers (who are part of the Medical Home team that is led by the primary care physician) be included among those who can provide advanced access; and, 2) We recommend that you extend the meaning of “same day” (within the context of advanced access) to include “within 24 hours.” We believe this will better provide for end-of-the-day open scheduling requests.</p> <p>The statute pursuant to AB 2179 provides the Department with a great deal of latitude to pursue these regulations in a manner that will improve patient access. CAFP believes our suggestions fall well within that latitude, and would improve implementation by addressing the above features of physician practice and contracting.</p>	<p>Decline: Please see the responses to Comment Nos.12-29 and 15-60.</p>
<p>26-199</p>	<p>As the original sponsors of this legislation, we note our surprise and dismay at the Department’s complete abandonment of the statutory intent of AB2179. The language contained in the third revision of the proposed regulation reflects virtually none of the essential standard-setting, compliance oversight, and enforcement remedies outlined in the law and the first and second versions of the regulation.</p> <p>We believe it is so flawed that the only acceptable course of action would be to withdraw this language, and adopt the second version with the revisions described in our September 21, 2007 letter. The fact that the current version of the regulation consists of seven pages, as opposed to 25 pages in the previous version, we believe it reflects generally less specificity, fewer requirements, and vaguer standards.</p> <p>It is now apparent with this third revision of the regulation that the Department has capitulated to industry pressure. Throughout this regulatory process, we</p>	<p>Decline: The final revised regulation text remains true to the legislative intent and directives of Section 1367.03, while accomplishing the difficult task delegated to the Department by the Legislature, that is, to balance the competing concerns among affected persons, to accomplish sensible, workable and meaningful regulations designed to ensure timely access to care for enrollees. The necessity for the provisions in the final revised text and for the changes made to the text that was initially published, are explained in the Final Statement of Reasons under the heading “Specific Purpose of the Regulation.”</p> <p>Section 1367.03 required the Department to consider multiple factors to ensure the regulations accounted for variations in plan</p>

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<p>witnessed the furious opposition voiced by plans, providers, and associations at the public hearings. We noted the more than 1,000 comments received by the Department describing the dire “unintended consequences” of finalizing the language of the earlier versions of the regulatory process. In fact, in light of such vocal opposition, we can find no rationale for DMHC’s December 2007 version of the regulation that proposes weak standards, multiple exceptions to those standards, and relies heavily upon self-regulation by the plans. The flexibility built into this version of the regulation would make it unlikely that the Department would undertake rigorous enforcement of timely access standards. The force of the industry’s opposition to timely access should dictate the need for the Department to draft the regulation to provide a clearer mandate, establishing an unequivocal standard, undertaking vigorous enforcement, and preserving greater protections for the enrollees as intended by the statute, rather than the reverse.</p>	<p>operations and networks. The prior versions of the regulation text included many exceptions and mechanisms for plan to request additional exceptions to the time elapsed standards set forth in the regulation as well as alternatives to time-elapased standards. The final revised regulation text accomplishes the objectives of Section 1367.03 and the Department’s rulemaking intent through a simplified approach that includes additional performance standards not in the two prior versions of regulation text.</p> <p>The regulation retains requirements for time elapsed standards for the categories of health care and the access indicators enumerated at Section 1367.03(a) and (b), and establishes performance standards for their development by the plans and clarifies the criteria and factors for the Department’s review and approval.</p> <p>The Department has complied with the requirements of the Administrative Procedures Act, and specifically with the requirements of Government Code section 11346.8(c). Please see also the clarification provided at sections 40 and 42 of title 1, California Code of Regulations (CCR) regarding the meaning of “substantial changes” and “sufficiently related” as those terms are used in Government Code section 11346.8.</p> <p>The final revised regulation text reflects substantial changes that are sufficiently related to the original text and within the scope of the Notice of Rulemaking Action (Notice). Accordingly, consistent with the APA, the Department made the revised text available for public comment. A reasonable member of the directly affected public could have determined from the explanation provided in the Notice that these changes to the regulation could have resulted.</p> <p>The Notice explains that “...the regulation establishes standards and requirements related to: timely access to primary care physicians, specialty physicians, hospital care, and other health care; health plan monitoring of health care provider compliance with the standards; corrective action by health plans upon</p>
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		<p>identifying deficiencies in compliance; and the statutory requirement of filing an annual report of compliance.” The final revised regulation text fulfills this objective because it establishes standards and requirements related to: timely access to the referenced health care services; health plan monitoring of compliance; corrective action by health plans upon identifying compliance deficiencies; and reporting requirements.</p> <p>The Notice also states that, “Proposed section 1300.67.2.2 adopts time-elapsd standards and proposes a ‘same-day access’ standard which is demonstrated to be ‘more appropriate’ than time-elapsd standards because timeliness of access under the same-day access standard exceeds timeliness of access under all of the time-elapsd standards of the proposed regulation.”</p> <p>The final revised text of the regulation fulfills this stated objective by retaining requirements for time-elapsd standards for waiting time, and providing for the referenced “safe harbor” provision, which is called “advanced access” in the final regulation text, rather than same-day access.</p> <p>Accordingly, consistent with the explanation announced in the Notice, the final revised regulation text establishes indicators of timely access related to: appointment waiting times, telephone waiting time and office waiting time. The regulation also establishes standards and requirements related to: timely access to primary care physicians, specialty physicians, hospital care, and other health care; educating enrollees about timely access; health plan monitoring of health care provider compliance with the standards; corrective action by health plans upon identifying deficiencies in compliance; and the statutory requirement of filing an annual report of compliance.</p> <p>Although the final revised version of the regulation text is different in structure and content from the initial text, the Department has met the APA procedural standards for rulemaking actions. The specific changes from the initial regulation text are described below, and illustrate the sufficiency</p>
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		<p>of the relationship between the first version of regulation text and the final version. As outlined below, many of the provisions in the initial text have been simplified, relocated and restated in the final text. Although the specific time-elapsd standards for the enumerated access indicators has been deleted from the regulation text, time-elapsd standards are still required by the regulation, to be developed by the plans and subject to the Department's approval. Accordingly, these and other changes reflected in the final regulation text are sufficiently related to the initial text and consistent with the Notice so as to satisfy the APA procedural requirements.</p> <p>After this regulation is adopted, the Department will continue to assess, and will welcome information and date submitted by interested persons, regarding timely access deficiencies that reflect a need for changes to this regulation. Please reference Section 1367.03(j).</p>
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26-200	<p>The proposed regulations violate the statutory authority and specific statutory intent of AB2179, c. 797 of 2002. Specifically, the statute states that</p>	<p>Decline: Please see the responses to Comment Nos. 10-26 and 26-199.</p>
	<p align="center"><i>If the department chooses a standard other than the time elapsed between the time an enrollee first seeks health care and obtains it, the department shall demonstrate why that standard is more appropriate.</i></p> <p>The standards in the Knox-Keene Act are intended to protect consumers, not providers and plans. The Department has failed to demonstrate why the standards proposed in the Dec. 2007 revision are more appropriate for consumers.</p> <p>Also, the Department has failed to demonstrate the manner in which the proposed standards meet the statutory intent. The lack of timely access is an indicator of other serious, systemic problems that affect the delivery of health care in our state and the health outcomes of enrollees. If consumers do not have timely access to care, this often reflects broader problems such as lack of adequate provider panels, fiscal distress of a plan or provider, or shifts in the health care needs of a population. Indeed most of the comments by plans and providers are demonstrations of precisely such systemic failures. These failures should warrant investigation and action by the department for failure to comply with other provisions of the Knox-Keene Act, such as adequacy of networks. These comments also raise questions as to whether plans can actually deliver on the promises they made when offering the coverage to purchasers such as employers, unions, agencies, and individuals.</p>	
26-201	<p>1. Affirmation of Time-Elapsed Standards Set by The Department of Managed Health Care</p> <p>We argue strenuously that the Department reinstate the timely access to care standard as envisioned in the language of the legislation. We believe the timely access to care was a fundamental right outlined in the original Knox-Keene Act in 1975. The legislature reaffirmed that expectation of timely access to care in the language of AB2179, enacted in 2002. Since the enactment of the Knox-Keene Act, health care service plans have been obliged by S. 1367 (e) to assure that "all services shall be readily available at</p>	<p>Decline: Section 1367.03 does not expressly require the referenced time-elapsed standards to be detailed <u>in the regulation text</u>. The regulation retains requirements for time-elapsed standards. These standards are not left to the discretion of the plans. Rather they must be developed and supported in accordance with the standards established in the regulation. See also the responses to Comment Nos. 8-20; 10-26; and 26-199.</p>

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reasonable times to all enrollees". In developing the timely access program requirements, the Department reviewed the standards for timely access that the plans had filed with the Department for *three decades* and which both plans and providers had allegedly complied with for over thirty years (see attachment). The regulations previously proposed by the Department were based on standards for timely access that were substantially consistent with those the plans say they imposed on themselves. If plans have failed to comply with their own standards, and years of complaints by consumers suggest this is the case, that is precisely what AB2179 and these regulations are intended to remedy.

We are therefore surprised at the level of industry opposition in light of the many legislative hearings, the lengthy time since enactment of AB2179, and the recent extensive process of seeking input by the Department. During the development of AB2179, in addition to hearings in the legislative process, the advisory committee to the Department held more than three hearings on timely access to care. Indeed, the law requires the Department to have completed these regulations no later than January 1, 2004, *almost four years ago*. Many plans and providers publicly testified that they were already providing exemplary timely access to care, in which case they should have no problem achieving and even exceeding these standards.

We find the provision in the third version of this regulation allowing each plan to develop their own timely access to care standard constitutes the establishment of **no standard at all**. We think it would be likely that the providers who actually deliver the care under the so-called "delegated model" throughout a large part of California would be very unclear as to which standard they would have to meet. It is typical for a medical practice or medical group to contract with several health service plans, each of whom under this version of the regulation would be free to establish their own individual timely access standards. If the timely access standard were so loosely designed as to be set by individual plans for their contracted providers, some of them would certainly be in conflict with each other. In a contracting environment, it would be very difficult for providers to be sure of what standard they must meet for different patients. It would be virtually impossible for plans to monitor compliance with their own standards by their contracted providers who in all likelihood contract with other health plans as well. It would also result in an administrative nightmare when the Department attempted to monitor compliance with a confusing array of different timely access standards

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	<p>across plans. Based on this confusing patchwork of different standards being applied in any specific practice or medical group, this regulation would result in less timely access to care, rather than more, clearly not meeting any standard of complying with the legislative intent. In addition, we believe this regulation as written would not in any way meet the clarity standard for providers required to comply with it.</p> <p>Therefore, despite the plans' stated opposition, we believe that specific time-elapsd standards issued by the Department would be the only mechanism for the Department to ensure its stated goal of timely access to health care.</p>	
26-202	<p>2. Timely Access Standards Must Apply to All Health Plans</p> <p>AB2179 explicitly states that it applies to health care service plans and specialized healthcare plans. While the March 5, 2007 and July 16, 2007 versions both include that broad applicability, the newest version dated December 10, 2007 restricts the regulation to plans that provide for hospital or physician services or mental health services pursuant to a contract with a full service plan. DMHC has waived applicability for time-elapsd standards to specialized plans including dental, vision, acupuncture, chiropractic or EAP plans. While the Department heard considerable public testimony complaining about the burden imposed on specialized plans, there is no such discretion or exception granted to the Department in the statute. DMHC asserts, without foundation, that application of this regulation to specialized plans is "not necessary to achieve the core objective of AB2179." We can cite no such latitude granted by the legislature in the underlying statute.</p> <p>S.1367.03 (d) gives the Department no statutory authority to exempt plans from standards on timeliness of access. Indeed, S.1367.03 (d) is quite clear that "if the department finds that health care service plans and health care providers are having difficulty in meeting these standards, the department may make recommendations to the Assembly Committee on Health and the Senate Committee on Insurance of the Legislature". By this language, the Legislature made plain that the Department could only return to the Legislature for further action and the Department lacks statutory authority to grant exemptions.</p>	<p>Decline: The Department has determined that it is not necessary for this regulation to apply to the referenced specialized plans in order to implement, clarify, make specific and otherwise accomplish the objectives of Section 1367.03. In addition, other provisions regarding timely access are applicable to these specialized plans, including but not limited to Section 1367 and Rules 1300.51(d)(H), 1300.67.2 and 1300.67.2.1.</p>
26-203	<p>3. Standards Regarding Telephone Triage</p> <p>In 1300.67.2.2 (d) (5) the Department stipulates that any plan that does not provide advanced access to appointments shall have specific systems and</p>	<p>Decline: The suggested revisions are not necessary to ensure timely access. The regulation does not require an enrollee to obtain telephone triage or screening before seeking emergency services. Enrollees are encouraged to use the 911 emergency</p>

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<p>personnel in place. These require a qualified health care professional be available to screen or triage enrollees, advise regarding the time in which an enrollee should see a physician, to receive ancillary care services, or to facilitate arranging for appointments. However, this language states that these services should be available “during normal business hours.” A different, substantially lower level of care is required for “after hours and weekends” which is limited to a requirement for a recorded telephone message.</p> <p>All health plans and all contracting providers should be required to provide prompt telephone service during business hours and telephone triage after hours. The need for health care does not occur only between 9:00 am and 5:00 pm, Monday through Friday. Timely access to care requires that consumers, who are not clinicians, have access to a health care professional who is trained to screen and refer them for emergency or urgent care when appropriate or simply to assure them that they can safely wait until the morning to be seen. A recorded message provides no opportunity to evaluate the medical condition or communicate with the enrollee. A new mother with a baby with a high temperature or vomiting may not know whether her child needs care, a spouse with a partner with shortness of breath may not know what needs to be done, a family friend with an injury may not know whether they need to be seen urgently. These are precisely the kinds of cases AB2179 was intended to address.</p> <p>We also take note that 85% of those who use emergency rooms have coverage of some sort, either Medi-Cal, Medicare or commercial insurance. Directing insured consumers to emergency rooms for triage of non-emergent conditions is wasteful and avoidable. These regulations should assure that consumers can get timely access to triage without being forced to use an emergency room.</p> <p>If an enrollee does not have access at all times to a health professional that is licensed to triage so that an enrollee is forced by the lack of adequate network to be triaged in an emergency room, then the consumer should have no financial barriers to the use of emergency room care. Health plans cannot create financial barriers to the use of emergency room care and at the same time direct consumers to go to the emergency room for basic triage. This is an unacceptable Catch-22 where the consumer always loses, facing a choice between their money and their life.</p>	<p>response system and go to the nearest emergency room if they reasonably believe they have a medical emergency, and plans are required to provide coverage for emergency services if the enrollee reasonably believed that an emergency condition existed. Please see Health and Safety Code sections 1317.1, 1371.4, 1371.5 and 1363.2, and Rule 1300.71.4. The regulation requires plans to inform and educate patients about how to access services, which includes how to access the telephone triage and screening services to obtain assistance in obtaining timely appointments. After this regulation is adopted, the Department will continue to assess, and will welcome information and data submitted by interested persons, regarding timely access deficiencies that reflect a need for changes to this regulation. Please reference Section 1367.03(j).</p>
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	<p>We would prefer that plans and providers provide access to telephone triage 24 hours a day, seven days a week rather than sending consumers to overcrowded emergency rooms. We note that this 24 hour/7 days per week standard is one the Department itself meets at its own HMO Help hotline.</p> <p>Telephone triage is care: it is subject to 1367.01 (c). Indeed telephone triage is by definition the first effort by an enrollee to seek care and thus plainly must be governed by a “standard”, not a “guideline”. The Department must adhere to the provision in the law which states:</p> <p align="center"><i>If the department chooses a standard other than the time elapsed between the time an enrollee first seeks health care and obtains it, the department shall demonstrate why that standard is more appropriate.</i></p> <p>This regulatory language clearly does not comply with the statutory intent.</p>	
<p>26-204</p>	<p>4. No New Cause of Action</p> <p>The third revision of the regulation contains in S 1300.67.2.2 (a) (3) the provision that timely access to health care services “does not create a new cause of action or a new defense to liability for any person.” Indeed, the Legislature in its deliberations could have added such a provision and expressly failed to do so. Instead the Legislature has expressly permitted litigation against health plans (SB 21 Figueroa, c. 536 of 1999) to allow litigation against health care service plans for the failure to exercise ordinary care.</p> <p>There is no statutory basis for this section, it contradicts the legislative history, and it should be stricken in its entirety.</p>	<p>Decline: The requested revision is outside the scope of this regulation. Section 1367.03 directs the Department to adopt regulations to ensure timely access to covered health care services, not to establish a new cause of action for health plan liability. Causes of action against health plans are already established by other provisions of law, for example, California Civil Code section 3428. Enrollees and providers who have complaints regarding their health plans may also file a complaint with the Department pursuant to Section 1368(b) of the Act, and may request independent medical review pursuant to Sections 1370.4 and 1374.30 et seq., of the Act, which are rights established by statute, not by regulation.</p>
<p>26-205</p>	<p>5. Meaningful Standards for Enrollee Satisfaction Survey</p> <p>The Department outlines requirements for quality assurance processes in (c) (2) (A) which include an “annual, statistically valid, enrollee satisfaction survey.” DMHC stipulates that plans that use the CAHPS or ECHO survey instruments in connection with certification by NCQA may meet the requirements of this subsection by including appropriate supplemental questions as approved by the Department.</p>	<p>Decline: The suggested revision is not necessary to address the stated concerns regarding public availability of the supplemental questions. The referenced supplemental questions for the NCQA survey must be filed for Department approval. Unless a plan meets its burden under Rule 1007 for obtaining confidential handling of material submitted in a filing, or the material is granted confidential treatment under other provisions of the Act, e.g., Exhibit K-3 (provider compensation) the materials will be part of the public record and available for public review. Please</p>

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	<p>We would argue that to be a valid assessment, the satisfaction survey, including the questions asked, must be a publicly available document. The CAHPS survey is not a publicly available document; it is instead the creation of a private industry entity, available only at considerable cost, and not subject to either the open meetings law or the public records act.</p>	<p>reference Rule 1006.</p>
<p>26-206</p>	<p>6. Alternative Standards; Material Modification</p> <p>In (e) (5) the Department outlines a method for plans to propose alternatives to the time-elapsd standards as a measurement of quality indicators specified. This provision appears to enable a plan to adopt an alternative, more lenient standard with the Department’s concurrence and to allow that more lenient standard to remain in place for years with no review.</p> <p>The Department states that “the burden shall be on the plan to demonstrate and substantiate why a proposed alternative standard is more appropriate than time elapsed standards.” Since all too often plans and providers translate “more appropriate” as more convenient for the plan or the provider, ignoring the needs of the consumer; this should specify that the proposed alternative is more appropriate <u>for the consumer</u>.</p> <p>In addition, the principal approval mechanism for this deviation from requirements to provide true timely access would be a material modification to the plan’s license. We have serious objections to the process as outlined. The material modification is an internal procedure that is not open to public comment or scrutiny. It would potentially provide plans that will not or cannot meet the timely access standard to evade their responsibility to do so.</p>	<p>Decline: The suggested revision is not necessary to address the stated concerns. The regulation already confirms the performance standards that must apply to the development of a plan’s timely access standards. Please see subsections (d)(2). Please see also the ultimate performance standard at subsection (d)(1). In addition, as noted in the response to Comment No. 205, plan filings are part of the public record and, unless granted confidential treatment, are available for public review. Please reference Rule 1006.</p>
<p>26-207</p>	<p>7. Consideration of Plan Networks</p> <p>Adequacy of network is one of the fundamental principles of the Knox-Keene Act. Plans that are unable to demonstrate adequate networks have been required to withdraw from geographic regions in which they are unable to provide adequate access to care or refused permission to add covered lives.</p> <p>The current regulations in force establish standards based on ratios of enrollees to primary care physicians and all physicians. These have been stricken from the current regulatory language, and replaced with time-elapsd standards. Versions one and two of the Department’s regulations contained specific time-elapsd standards based on type of practitioner, whether routine</p>	<p>Decline: The first two versions contained provisions permitting plans to request variations and alternatives. The final version of this regulation restates and relocates the requirements permitting these same kinds of exceptions. This regulation does not affect any existing regulations establishing provider-enrollee ratios or geographic access standards.</p>

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	<p>or urgent care, and the type of service sought. However in version three, the time-elapsd standards have been significantly weakened while the enrollee to provider ratios have also been eliminated. We believe the proposed regulation no longer can claim to meet the statutory mandate of requiring the Department to “consider the nature of the plan network.”</p>	
<p>26-208</p>	<p>8. Substantial Compliance in Provider Shortage Situations</p> <p>In 1300.67.2.2 (e) (1) invites plans to propose variations for geographic areas in which there are shortages of particular types of providers. Health Access is opposed to the language providing an open-ended exemption from compliance with timely access standards in provider shortage situations. This is an exemption that could make meaningless all of the other requirements of these regulations and other basic provisions of the Knox-Keene Act.</p> <p>This provision requires no explanation of the efforts the plan has undertaken to remedy the shortage of providers. Plans are able to rectify provider shortages by a variety of means including providing increased compensation to recruit and retain an adequate number and mix of providers, enhanced use of technology, utilization of out-of-network specialty consultations, among others. Provider shortages are largely a product of plan failure to compensate providers adequately and to treat them respectfully. It is said there is never a labor shortage, just a wage shortage or a working condition shortage. This section also does nothing to set any limits to an exemption, specify timelines or force other action, such as withdrawal from a geographic region where the plan is unable to provide timely access. If a plan cannot deliver timely access to the care it has promised the enrollee, it should not be permitted to do business in that geographic area.</p> <p>We are particularly unsympathetic to those medical group administrators that have testified again and again over a period of years that they are unable to rectify provider shortages. Their failure to provide timely care and an adequate network merits enforcement action. Consumers should not be put at risk of lack of care because of the incapacity of administrators.</p> <p>Indeed the provision allowing an unlimited exemption from timeliness of access raises in our minds grave concerns as to whether the Department is meeting its statutory obligation to assure adequate networks by plans in their respective service areas.</p>	<p>Decline: The final regulation text contains no reference to substantial compliance and does not provide unlimited or open ended exemption from compliance. The regulation establishes performance standards that meet the requirements of Section 1367.03 that direct the Department to consider variations in plan operations and networks. The referenced provider recruitment activities are outside the intended scope of this rulemaking action. Please also see the response to Comment No.13-41.</p>

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	<p>We further note that California has successfully implemented standards for nursing care in both hospitals and nursing homes. In late 2003, regulations were finalized requiring nursing ratios in hospitals. In 2004, the hospital association attempted various maneuvers to delay or make meaningless these requirements. The various legal battles ended early in 2005. Attached is a chart from a 2007 report by the California HealthCare Foundation that demonstrates that nursing care increased from 7.5 hours per patient day in 2001 to 8.5 hours per patient day in 2005. In 2004, use of registry or temporary nursing staff increased significantly over historic levels but by 2005, use of registry had reverted to the more usual levels. This was done despite a shortage of registered nurses not only in California but across the country. Indeed Kaiser Permanente which implemented nursing ratios in advance of the requirement, increased wages and made other improvements in working conditions (such as allowing meal breaks!) was able to come into compliance even more quickly. If hospitals can obey the law, so can medical groups and health plans.</p>	
<p>26-209</p>	<p>9. “Exemption” to Timely Access for Plans Offering Advanced Access</p> <p>The exemption from adherence to timely access standards granted in (d) (4) and (5) is overly broad. If a plan does not provide advanced access, they must have systems and personnel in place to assure some basic tenets of timely access. If the plan does offer advanced access it is found to “demonstrate compliance” with this provision.</p> <p>Plans, providers, and associations highlighted all of the difficulty they have in recruiting and retaining certain specialists in specific geographic areas. Consequently, we are skeptical that, without oversight, plans would be able to routinely deliver on these open-ended promises of advance access for all enrollees to all providers in all jurisdictions.</p> <p>In addition, the preface to this solicitation of comments, the Department uses the term “safe harbor” for the plans who utilize this exemption. The connotation for this law enforcement term implies little or no oversight. With the difficulty expressed by plans and providers in providing timely access for certain types of care in certain locations, it would certainly be ill-advised to advertise that this provision would have very little review. It is certainly possible for plans to contend they provide advance access, and as a result,</p>	<p>Decline: The regulation establishes at subsection (d)(1) the ultimate performance standard based on clinical appropriateness. This standard is not affected by the advanced access safe harbor provision or the time-elapsd standards that will be established by the plans. (The “safe harbor” provision is a safe harbor deeming compliance with the required development of time-elapsd standards) Similarly, if plan obtains the Department’s approval for an alternative timely access standard, that alternative standard will not affect the ultimate performance standard established at subsection (d)(1). Please see also the response to Comment No. 23-149.</p>

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	evade oversight of that aspect of their operation without penalty.	
26-210	<p>10. Timely Access to Care Should Be Reflected on OPA Report Card</p> <p>AB2179 specifies that “the Department shall work with the patient advocate to assure that the quality of care report card incorporates information . . . regarding the degree to which health care service plans and health care providers comply with the requirements for timely access to care.” There is no discussion of this statutory obligation in the regulatory language. We are skeptical that this requirement can or will be met with the Department’s elimination of any concrete, standardized measurement of timely access performance. We also question how meaningful it would be to highlight plan or provider comparison data when each plan can establish its own, presumably weaker, “standards.”</p>	<p>Decline: The regulation as revised provides for consistent QA monitoring and reporting by plans, so that the comparative information required by Section 1367.03 can be made available to consumers. Prior versions of the regulation text included exceptions to monitoring and reporting requirements, which would not have ensured the consistent monitoring and reporting necessary for the provision of readily comparable information to consumers, which is a requirement established at Section 1367.03(f).</p>
26-211	<p>Timely access to care remains one of the principal complaints from consumers. We are committed to strong consumer protections that closely follow the original statute’s intent and as a result, we recommend that the Department withdraw these proposed regulations, and work to strengthen the regulatory language. Health Access intends to work closely with the Department on the implementation, monitoring, and enforcement of this law, but we need better regulations in order to truly provide consumers the protections that they seek.</p>	<p>Decline: The final regulation text contains standards and requirements that accurately implement the requirements of Section 1367.03, in a manner amenable to documentation, monitoring and enforcement. Following adoption of this regulation, the Department will continue to assess, and will welcome information and data submitted by interested persons, regarding access problems that reflect a need to make further changes to this regulation. Please See section 1367.03(j).</p>