

§ 1300.67.2.2. Timely Access to Non-Emergency Health Care Services

(a) Application

1. All health care service plans that provide or arrange for the provision of hospital or physician services, including specialized mental health plans that provide physician or hospital services, or that provide mental health services pursuant to a contract with a full service plan, shall comply with the requirements of this section.

2. Dental, vision, chiropractic, and acupuncture plans shall comply with subsections (c)(1), (3), (4), (7), (9) and (10), and subsections (d)(1) and (g)(1). Dental plans shall also comply with subsection (c)(6).

3. The obligation of a plan to comply with this section shall not be waived when the plan delegates to its medical groups, independent practice associations, or other contracting entities any services or activities that the plan is required to perform. A plan's implementation of this section shall be consistent with the requirements of the Health Care Providers' Bill of Rights, and a material change in the obligations of a plan's contracting providers shall be considered a material change to the provider contract, within the meaning of subsections (b) and (g)(2) of Section 1375.7 of the Act.

4. This section confirms requirements for plans to provide or arrange for the provision of access to health care services in a timely manner, and establishes additional metrics for measuring and monitoring the adequacy of a plan's contracted provider network to provide enrollees with timely access to needed health care services. This section does not:

(A) Establish professional standards of practice for health care providers;

(B) Establish requirements for the provision of emergency services; or

(C) Create a new cause of action or a new defense to liability for any person.

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

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

2. "Appointment waiting time" means the time from the initial request for health care services by an enrollee or the enrollee's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its contracting providers.

3. "Preventive care" means health care provided for prevention and early detection of disease, illness, injury or other health condition and, in the case of a full service plan includes but is not limited to all of the basic health care services required by subsection (b)(5) of Section 1345 of the Act, and Section 1300.67(f) of Title 28.

4. "Provider group" has the meaning set forth in subsection (g) of Section 1373.65 of the Act.

5. "Triage" or "screening" means the assessment of an enrollee's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care, for the purpose of determining the urgency of the enrollee's need for care.

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

7. "Urgent care" means health care for a condition which requires prompt attention, consistent with subsection (h)(2) of Section 1367.01 of the Act.

(c) Standards for Timely Access to Care.

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

(2) Plans shall ensure that all plan and provider processes necessary to obtain covered health care services, including but not limited to prior authorization processes, are completed in a manner that assures the provision of covered health care services to enrollees in a timely manner appropriate for the enrollee's condition and in compliance with the requirements of this section.

(3) When it is necessary for a provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice, and consistent with the objectives of Section 1367.03 of the Act and the requirements of this section.

(4) Interpreter services required by Section 1367.04 of the Act and Section 1300.67.04 of Title 28 shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. This subsection does not modify the requirements established in Section 1300.67.04, or approved by the Department pursuant to Section 1300.67.04 for a plan's language assistance program.

(5) In addition to ensuring compliance with the clinical appropriateness standard set forth at subsection (c)(1), each plan shall ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the following timeframes:

(A) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in (G);

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

(C) Non-urgent appointments for primary care: within ten business days of the request for appointment, except as provided in (G) and (H);

(D) Non-urgent appointments with specialist physicians: within fifteen business days of the request for appointment, except as provided in (G) and (H);

(E) Non-urgent appointments with a non-physician mental health care provider: within ten business days of the request for appointment, except as provided in (G) and (H);

(F) Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within fifteen business days of the request for appointment, except as provided in (G) and (H);

(G) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee;

(H) Preventive care services, as defined at subsection (b)(3), and periodic follow up care, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice; and

(I) A plan may demonstrate compliance with the primary care time-elapsed standards established by this subsection through implementation of standards, processes and systems providing advanced access to primary care appointments, as defined at subsection (b)(1).

(6) In addition to ensuring compliance with the clinical appropriateness standard set forth at subsection (c)(1), each dental plan, and each full service plan offering coverage for dental services, shall ensure that contracted dental provider networks have adequate capacity and availability of licensed health care providers to offer enrollees appointments for covered dental services in accordance with the following requirements:

(A) Urgent appointments within the dental plan network shall be offered within 72 hours of the time of request for appointment, when consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice;

(B) Non-urgent appointments shall be offered within 36 business days of the request for appointment, except as provided in subsection (c)(6)(C); and

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

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

(A) This section does not modify the requirements regarding provider-to-enrollee ratio or geographic accessibility established by Sections 1300.51, 1300.67.2 or 1300.67.2.1 of Title 28.

(B) A plan operating in a service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring enrollees to, or, in the case of a preferred provider network, by assisting enrollees to locate, available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs.

Plans shall arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network, when medically necessary for the enrollee's condition. Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

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

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

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

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

a. Regarding the length of wait for a return call from the provider; and

b. How the caller may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

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

3. Unlicensed staff persons handling enrollee calls may ask questions on behalf of a licensed staff person in order to help ascertain the condition of an enrollee so that the enrollee can be referred to licensed staff. However, under no circumstances shall unlicensed staff persons use the answers to those questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of an enrollee or determine when an enrollee needs to be seen by a licensed medical professional.

(9) Dental, vision, chiropractic, and acupuncture plans shall ensure that contracted providers employ an answering service or a telephone answering machine during non-business hours, which provide instructions regarding how enrollees may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

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

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

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

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

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

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

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

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

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

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

(3) A plan shall implement prompt investigation and corrective action when compliance monitoring discloses that the plan's provider network is not sufficient to ensure timely access as required by this section, including but not limited to taking all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance. Plans shall give advance written notice to all contracted providers affected by a corrective action, and shall include: a description of the identified deficiencies, the rationale for the corrective action, and the name and telephone number of the person authorized to respond to provider concerns regarding the plan's corrective action.

(e) Enrollee Disclosure and Education

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

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

(f) Plans may file, by notice of material modification, a request for the Department's approval of alternative time-elapsed standards or alternatives to time-elapsed standards. A request for an alternative standard shall include:

(1) An explanation of the plan's clinical and operational reasons for requesting the alternative standard, together with information and documentation, including scientifically valid evidence (based on reliable and verifiable data), demonstrating that the proposed alternative standard is consistent with professionally recognized standards of practice and a description of the expected impact of the alternative standard on clinical outcomes, on access for enrollees, and on contracted health care providers;

(2) The burden shall be on the plan to demonstrate and substantiate why a proposed alternative standard is more appropriate than time elapsed standards. Plans that have received approval for an alternative standard shall file, on an annual basis, an amendment requesting approval for continued use of the alternative standard, and providing updated information and documentation to substantiate the continued need for the alternative standard; and

(3) In approving or disapproving a plan's proposed alternative standards the Department may consider all relevant factors, including but not limited to the factors set forth in subsections (d) and (e) of Section 1367.03 of the Act and subsection (c) of Section 1300.67.2.1 of Title 28.

(g) Filing, Implementation and Reporting Requirements.

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

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

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

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

processes, or through provider reporting required pursuant to subsection (f)(2) of Section 1367.03 of the Act;

(C) Whether the plan identified, during the reporting period,

(1) any incidents of noncompliance resulting in substantial harm to an enrollee or

(2) any patterns of non-compliance and, if so, a description of the identified non-compliance and the plan's responsive investigation, determination and corrective action;

(D) A list of all provider groups and individual providers utilizing advanced access appointment scheduling;

(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;

(F) The results of the most recent annual enrollee and provider surveys and a comparison with the results of the prior year's survey, including a discussion of the relative change in survey results; and

(G) Information confirming the status of the plan's provider network and enrollment at the time of the report, which shall include, on a county-by-county basis, in a format approved by the Department:

1. The plan's enrollment in each product line; and

2. A complete list of the plan's contracted physicians, hospitals, and other contracted providers, including location, specialty and subspecialty qualifications, California license number and National Provider Identification Number, as applicable. Physician specialty designation shall specify board certification or eligibility consistent with the specialty designations recognized by the American Board of Medical Specialties.

3. The information required by paragraphs (g)(2)(G)(1) and (2) shall be included with the annual report until the Department implements a web-based application that provides for electronic submission via a web portal designated for the collection of plan network data. Upon the Department's implementation of the designated network data collection web portal, the information required by paragraphs (G) (1) and (2), shall be submitted directly to the web portal.

(3) In determining a plan's compliance or non-compliance with the requirements of this section, the Department will focus more upon patterns of non-compliance than isolated episodes of non-compliance and may consider all relevant factors, including but not limited to:

(A) The efforts by a plan to evade the standards, such as referring enrollees to providers who are not appropriate for an enrollee's condition;

(B) The nature and extent of a plan's efforts to avoid or correct non-compliance, including whether a plan has taken all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance;

(C) The nature of physician practices, including group and individual practices, the nature of a plan's network, and the nature of the health care services offered;

(D) The nature and extent to which a single instance of non-compliance results in, or contributes to, serious injury or damages to an enrollee; and

(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.