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

TECHNICAL ASSISTANCE GUIDE

ACCESS AND AVAILABILITY OF SERVICES

ROUTINE VISION SURVEY

OF

PLAN NAME

DATE OF SURVEY:

PLAN COPY

Issuance of this June 1, 2020 Technical Assistance Guide renders all other versions obsolete.

VISION TAG

ACCESS AND AVAILABILITY OF SERVICES

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Requirement AA-001: Number and Distribution of Providers

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

Staff responsible for the activities described above, for example:

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

DOCUMENTS TO BE REVIEWED

- Policies and procedures that define the standards for the number and distribution of optometric providers within the service area
- Policies and procedures to periodically update/review the standards for the number and distribution of optometric providers within the service area
- Distribution service area maps indicating location and numbers of enrollees in comparison with optometric providers
- Plan access reports that provide information on provider distributions, closed practices and the like
- Record of periodic review of the standards for the number and distribution of providers within the service area, including minutes of relevant Committee meetings (QM Committee, Public Policy Committee, etc.)
- Documents describing how the Plan monitors and ensures compliance with network standards
- Corrective action plans for areas where access does not meet the standards
- Electronic version of the Plan's provider directory(s) and the link to the Plan's online directory(s).
- Review licensing filing of the Plan's Access standards and confirm submission of appropriate policies and procedures.
- Review procedures for referring enrollee's outside the contracted network, including but not limited to, policies and procedures, criteria for determining out of network referral, policy and procedures regarding applicable co-pays and co-insurance for enrollees accessing care out of network

AA-001 – Key Element1:

1. **The Plan has established a standard for geographic distribution of providers. 28 CCR 1300.51(d)(H); 28 CCR 1300.67.2.(a) and (d); 28 CCR 1300.67.2.1.(b) and (c)(2), (3), (4), and (9).**

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Assessment Question	
1.1	Does the Plan have an established standard on geographic distribution of specialty/vision care providers?

AA-001 – Key Element 2:

2. The Plan can demonstrate that, throughout the geographic regions designated as the Plan's Service Area, a comprehensive range of specialty/optometry services are readily available at reasonable times to all enrollees and, to the extent feasible, that all services are readily accessible to all enrollees.
28 CCR 1300.51(d)(H); 28 CCR 1300.67.2.(a) and (d); 28 CCR 1300.67.2.1.(b) and (c)(2), (3), (4), and (9).

Assessment Questions	
2.1	Does the Plan have an established standard for the numbers of optometric providers which is consistent with the enrollee population?
2.2	Can the Plan demonstrate reasonable accessibility of optometry services within all regions of the Plan's service area?
2.3	Can the Plan demonstrate sufficient numbers of staff, professionals, administrative and support staff that reasonably ensures that all services offered by the Plan will be accessible to enrollees on an appropriate basis without delays?
2.4	Is the Plan's provider network and demonstrated accessibility consistent with documents filed with the Division of Licensing?

AA-001 – Key Element 3:

3. The Plan has established a mechanism that ensures that its health care services are readily available at reasonable times to each enrollee consistent with good professional practice.
CA Health and Safety Code section 1367(e)(1); 28 CCR 1300.67.2.2.(c)(7).

Assessment Questions	
3.1	Does the Plan have mechanisms to ensure that its health care services are readily available at reasonable times to each enrollee consistent with good professional practice?
3.2	Does the Plan have mechanisms to ensure timely access to services in the event there is a shortage of providers in a particular area?
3.3	In the event of a shortage of providers in a particular area, does the Plan assist enrollees in locating contracted providers in neighboring service areas?
3.4	If services are not available in Plan, does the Plan have mechanisms to arrange for referrals outside the Plan's network when medically necessary for the enrollee?

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3.5	Does the Plan ensure that services referred outside the Plan's contracted network do not exceed applicable co-pays, and co-insurance?

End of Requirement AA-001: Number and Distribution of Primary Care Providers

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Requirement AA-002: Hours of Operation and After-Hours Service

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

Staff responsible for the activities described above, for example:

- Optometric Director
- QM Director
- Provider Relations Manager

DOCUMENTS TO BE REVIEWED

- Policies and procedures defining standards for hours of operation
- Policies and procedures for monitoring of the standards for hours of operation
- Policies and procedures defining standards for after-hours coverage requirements
- Policies and procedures for monitoring of the standards for after-hours care
- Plan after-hours coverage and access monitoring reports, after-hours or other types of telephone access studies from the Plan's telephone system or other methodologies (such as random calling at various times and dates)
- Committee meeting minutes (of any/all appropriate committees)
- Provider Manual or other methods to communicate standards to providers
- Corrective action plans
- Review licensing filing of the Plan's access standards and confirm submission of appropriate policies and procedures

AA-002 – Key Element 1:

1. **The Plan has established a standard defining reasonable hours of operation for provider health care facilities that are sufficient to prevent delays detrimental to the health of enrollees.**
   28 CCR 1300.67.2.(b) and (d); 28 CCR 1300.67.2.2.(c)(10).

Assessment Questions	
1.1	Does the Plan have an established standard that defines reasonable hours of operation for provider facilities?
1.2	Does the standard ensure that availability is sufficient to prevent delays detrimental to the health of enrollees?
1.3	Does the Plan 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, does not exceed ten minutes?

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AA-002 – Key Element 2:

**2. The Plan has established standards that ensure that the availability of, and access to, after hours services both at the Plan and provider level are sufficient to prevent delays detrimental to the health of enrollees.
28 CCR 1300.67.2.(b) and (d); 28 CCR 1300.67.2.2.(c)(1), (3), (7), (9), and (10).**

Assessment Questions	
2.1	Does the Plan have established standards on availability of, and access to, after-hours services which address provider message/answering service requirements?
2.2	Does the Plan have established standards on availability of and access to, after-hours services which address availability of providers?
2.3	Does the Plan have established standards on availability of, and access to, after-hours services which address provider response to messages left after-hours?
2.4	Does the Plan have established standards on availability of, and access to, after-hours services which address Plan services? (e.g., customer service)
2.5	Do the standards ensure that availability of, and access to, after-hours services are sufficient to prevent delays detrimental to the health of enrollees?
2.6	Does the Plan ensure that contracted providers employ an answering service or telephone answering machine during non-business hours?
2.7	Does the answering service, or answering machine used during non-business hours provide instructions regarding: (a) How enrollees may obtain urgent or emergency care? (b) 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?

AA-002 – Key Element 3:

**3. The Plan has established and implemented a documented system for monitoring and evaluating providers' adherence to the standards regarding hours of operation and after-hours services.
28 CCR 1300.67.2.(b) and (f); 28 CCR 1300.67.2.2.(d)(1).**

Assessment Questions	
3.1	Has the Plan established standards for the provision of covered services in a timely manner?
3.2	Does the Plan disseminate its standard to providers (e.g., via provider contracts, provider manual, etc.)?
3.3	Does the Plan regularly measure providers' performance against its standard?
3.4	Does the Plan implement corrective action and follow-up review to address any deficiencies?

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3.5	Does the Plan periodically review the appropriateness of its standard and update it when indicated?

End of Requirement AA-002: Hours of Operation and After-Hours Service

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Requirement AA-003: Appointment Availability

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

Staff responsible for the activities described above, for example:

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

DOCUMENTS TO BE REVIEWED

- Policies and procedures that define appointment availability
- Policies and procedures that address re-scheduling of appointments
- Appointment availability studies
- Enrollee and provider satisfaction surveys
- Reports on complaint and grievances
- Telephone access studies from the Plan's telephone system or other methodologies (such as anonymous "mystery shopper" or random calling at various times and dates)
- Committee or applicable subcommittee minutes, prior two years
- Corrective action plans and re-measurement of appointment availability to assure improvements are sustained
- Review licensing filing of the Plan's access standards and confirm submission of appropriate policies and procedures

AA-003 – Key Element 1:

1. **Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments.**
   28 CCR 1300.51(d)(l)(5)(d); 28 CCR 1300.51(d)(H)(iv); 28 CCR 1300.67.1.(d), and (e); 28 CCR 1300.67.2.(e) and (f); 28 CCR 1300.67.2.2.(c)(1), (3), (9), and (10); 28 CCR 1300.67.2.2.(d)(1).

Assessment Questions	
1.1	Does the health Plan have a documented system of monitoring and evaluating access to care, including waiting time and appointments?
1.2	Does the Plan have established standards to ensure ready referral, and provision of covered services in a timely manner appropriate for the nature of the enrollee's condition and in a manner consistent with good professional practice?
1.3	Does the documented system for monitoring and evaluating access to care include urgent appointments?

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1.4	Does the documented system for monitoring and evaluating include rescheduling of appointments to ensure rescheduling is prompt and consistent with health care needs, continuity of care?
1.5	Does the monitoring system include assessment of provider networks throughout the service regions?
1.6	In the event of provider shortages, does the monitoring system identify shortages and take corrective steps to remedy shortages?
1.7	In the event of provider shortages, does the Plan monitor customer service efforts to assist enrollees in locating a contracted provider in neighboring service areas?
1.8	As a way to identify provider shortages or services which may not be available from the Plan's contracted network, does the monitoring system track out of network referrals?
1.9	Does the Plan monitor that contracted providers employ an answering service or telephone answering machine during non-business hours?
1.10	Does the Plan monitor the answering service, or the answering machine used during non-business hours to ensure it provides instructions regarding: (a) How enrollees may obtain urgent or emergency care? (b) 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?
1.11	Does the Plan monitor that telephone service accessibility including that contact with a knowledgeable customer service representative does not exceed ten minutes?
1.12	Does the Plan evaluate network capacity? (This is the percentage of the network accepting referrals / new patients.)
1.13	Does the Plan ensure that there are open practices that are accepting new patients?
1.14	When the Plan identifies problems, does it take action to ensure appointment availability?
1.15	When the Plan identifies problems, does it monitor to assure improvements are maintained?

End of Requirement AA-003: Appointment Availability

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Requirement AA-004: Enrollee Health Education

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

Staff responsible for the activities described above, for example:

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

DOCUMENTS TO BE REVIEWED

- Policies and procedures of the Health Education Program
- Health Education Program description
- Plan and delegate Websites
- Patient education materials regarding the accessibility of service (e.g., certificate of coverage member handbook);
- Plan reviews of delegated entities' Health Education Programs and notification to enrollees of how to access services

AA-004 – Key Element 1:

1. The Plan regularly distributes materials to each enrollee that explain how to obtain services.
28 CCR 1300.67.2.(g).

Assessment Questions	
1.1	Has the Plan developed materials that explain how to obtain optometric services?
1.2	Has the Plan developed materials that explain how to obtain after-hours care?
1.3	Has the Plan developed materials that explain how to obtain urgent care?
1.4	Does the Plan regularly distribute the materials to enrollees?

End of Requirement AA-004: Enrollee Health Education

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Requirement AA-005: Preventative Health Care

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

Staff responsible for the activities described above, for example:

- Optometric Director
- QA Director
- QA Coordinator

DOCUMENTS TO BE REVIEWED

- Policies and procedures ensuring provision of preventive care services
- Preventive care guidelines
- Minutes of QA Committee or subcommittee meetings
- Provider Manual
- Health education literature
- Provider education and informational materials
- Results of measurement of other preventive health guidelines
- List of preventive care objectives with associated tracking reports

AA-005 – Key Element 1:

1. **The Plan has established preventive care guidelines. The Plan has disseminated its guidelines to its providers, regularly monitors performance against the standards and addresses any deficiencies.**
   28 CCR 1300.67(f)(1), (4), and (8); 28 CCR 1300.67.2.(f).

Assessment Questions	
1.1	Does the Plan have established preventive guidelines?
1.2	Does the Plan use appropriate methods in developing or adopting preventive guidelines?
1.3	Are the guidelines comprehensive?
1.4	Does the Plan have an effective mechanism for distributing its guidelines to participating providers?
1.5	Does the Plan monitor the provision of preventive services on an individual and Plan-wide basis?
1.6	Does the Plan regularly measure the level of preventive care provided to enrollees against its established guidelines?
1.7	Does the Plan critically evaluate the results of preventive care monitoring?
1.8	Does the Plan **develop and implement** corrective actions or QM Programs with measurable goals to increase levels of preventive care for enrollees?
1.9	Does the Plan **re-measure and critically evaluate** the results of corrective actions or QM Programs to increase levels of preventive care for enrollees?

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1.10	Does the Plan develop and implement additional corrective actions or QM Programs based on the critical evaluation of its past corrective actions or QM Programs?

AA-005 – Key Element 2:

**2. The Plan has an effective Health Education Program designed to educate enrollees regarding personal health behavior and health care, including recommendations regarding the optimal use of health care services provided by the Plan or health care organizations affiliated with the Plan.
28 CCR 1300.67(f)(8).**

Assessment Question	
2.1	Does the Plan have effective preventive health education services that include information regarding personal health behavior and optimal use of preventive services provided under the Plan?

End of Requirement AA-005: Preventive Health Care

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Requirement AA-006: Provider Directories and 10% Network Change Reporting

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

Staff responsible for the activities described below, for example:

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

DOCUMENTS TO BE REVIEWED

- Electronic version of the Plan's Provider Directory and the Plan's online Provider Directory.
- Plan's Exhibit J-14 and any other policies and procedures relevant to the update of contact information for contracted providers and the Plan's process for updating the Provider Directory.
- Plan's provider notice templates (annual/semi-annual verification notice, notice of pending provider directory removal.)
- Plan's provider notification log or communication timing/tracking history (should include dates notices were sent to providers and if and when responses were received.)
- Evidence the Plan suppressed providers who failed to respond to the required notice in a timely manner.
- Provider Directory Vendor contract (if applicable.)
- Amendment filings reflecting a 10% change in network(s).
- QA/AA program/policies/internal guidance.
- Provider network tracking reports.
- List of grievances handled by the Plan related to Provider Directories.
- Annual report of grievances related to access and availability submitted by the Plan to the Department.
- Consumer complaints filed with the Department related to Provider Directories.
- The Department may request a systems demonstration (onsite or remotely via webinar) for the routine survey.

AA-006 - Key Element 1:

1. **The Plan has adequate processes for provider notice and verification. CA Health and Safety Code section 1367.27(i)(7)-(8), (l)(1)-(4), and (m)(2).**

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Assessment Questions	
1.1	Does the Plan have a process to allow providers to promptly verify or submit changes to its directory information, including an online interface?
1.2	Does the Plan's online interface allow providers to submit verification or changes electronically and generate an acknowledgment of receipt?
1.3	Does the Plan's provider notice template satisfy the content requirements of Section 1367.27(l)(2)(A)-(C)? • The information the plan has in its directory or directories regarding the provider or provider group, including a list of networks and plan products that include the contracted provider or provider group. • A statement that the failure to respond to the notification may result in a delay of payment or reimbursement of a claim pursuant to subdivision (p). • Instructions on how the provider or provider group can update the information in the provider directory or directories using the online interface developed pursuant to subdivision (m).
1.4	Does the Plan notify its contracted providers at least once annually?
1.5	Does the Plan require an affirmative response from providers acknowledging the notification was received?
1.6	Does the Plan require all notified providers to confirm their directory information is current and accurate or otherwise update their directory information?
1.7	If the Plan does not receive an affirmative response and confirmation from the provider within 30 business days, does the Plan have a process to verify the provider's information within 15 business days?
1.8	If the plan is unable to verify whether the provider's information is correct or requires updates, does the plan notify the provider 10 business days in advance of removal that the provider will be removed from the provider directory or directories?
1.9	Does the Plan ensure providers who do not respond are not included in the next required update of the provider directory?
1.10	Does the Plan have a process for handling changes to hospital information?

AA-006 - Key Element 2:

2. The Specialized Health Plan (dental, vision, other) properly maintains its online provider directory.
CA Health and Safety Code section 1367.27(c)(1) and (2), (e)(1)(C), (i).

Assessment Questions	
2.1	Is an online provider directory or directories available on the Plan's Website?
2.2	Is the Plan's online directory or directories available to the public, potential enrollees, enrollees, and providers without any restrictions or limitation?

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2.3	Is the Plan's online directory or directories accessible through an identifiable link or tab and in a manner that is accessible and searchable by enrollees, potential enrollees, the public, and providers?
2.4	Is the Plan's online directory or directories updated at least weekly and when informed of changes/upon confirmation that a provider's practice location or other information required under subdivision (h) or (i) has changed?
2.5	Does the Plan's online directory contain the provider's name, practitioner type, practice location or locations, and contact information?
2.6	Does the Plan's online directory include the National Provider Identifier number, California license number, and type of license, for each listed provider?
2.7	Does the Plan's online directory include the area of specialty, including board certification, if any, as applicable to each listed provider?
2.8	Does the Plan's online directory include the provider's office email address, if available?
2.9	Does the Plan's online directory include the name of each affiliated provider group or specialty plan practice group currently under contract with the plan through which the provider sees enrollees?
2.10	Does the Plan's online directory include the names of each allied health care professional to the extent there is a direct contract for those services covered through a contract with the plan?
2.11	Does the Plan's online directory identify the Non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter, in accordance with Section 1267.04, if any, on the provider's staff?
2.12	Does the Plan's online directory include identification of providers who no longer accept new patients for some or all of the plan's products?

AA-006 - Key Element 3:

3. The Plan has adequate procedures for receiving and investigating reports of provider directory inaccuracy.
CA Health and Safety Code section 1367.27(f), (j)(3), (m)(3), (o)(1) and (o)(2); CA Health and Safety Code section 1368; and 28 CCR 1300.68.

Assessment Questions	
3.1	Does the Plan have a telephone number and dedicated email address to receive reports of a potential directory inaccuracy?
3.2	Does the Plan's provider directory and Website prominently display the Plan's dedicated email address and telephone number to report a potential directory inaccuracy?
3.3	Does the Plan have an electronic form to receive reports of a potential directory inaccuracy?
3.4	Does the Plan's online provider directory and website prominently display the hyperlink to report a potential directory inaccuracy?

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3.5	Can the Plan provide evidence that it promptly investigates each time it receives a report of a potential directory inaccuracy, taking no more than thirty (30) business days to verify the accuracy of the information or update the provider directory or directories?
3.6	Can the Plan provide evidence that its investigation includes contacting the affected provider within five business days?
3.7	Does the Plan document the receipt and outcome of each reported potential directory inaccuracy in accordance with Section 1367.27(o)(2)(B)?
3.8	Can the Plan provide evidence that it makes changes to provider directory information required as a result of any investigation no later than the next scheduled weekly update, or the update immediately following that update?
3.9	For printed provider directories, is the change made no later than the next required update?

AA-006 - Key Element 4:

4. The Plan's provider directory contains the required enrollee disclosures.
CA Health and Safety Code section 1367.27(g)(1) and (2), (n)(2), and (q).

Assessment Questions	
4.1	Does the Plan's provider directory or directories include a statement informing enrollees that they are entitled to language interpreter services at no cost, including information on how to obtain interpretation services?
4.2	Does the Plan's provider directory or directories include a statement informing enrollees that they are entitled to full and equal access to covered services, including enrollees with disabilities as required under the Americans with Disabilities Act of 1990 and Section 404 of the Rehabilitation Act of 1973?
4.3	Has the Plan removed any existing disclosures that are inconsistent with an enrollee's right to reasonably rely on the Plan's provider directory or directories?
4.4	Has the Plan removed any existing disclosures that are inconsistent with the Plan's responsibility to ensure compliance with Section 1367.27, regardless of any delegated responsibilities?

AA-006 - Key Element 5:

5. The Plan properly updates and distributes its printed provider directory to enrollees.
CA Health and Safety Code section 1367.27(d)(1), and (i).

Assessment Questions	
5.1	Can a printed copy of the Plan's directory or directories be requested by enrollees, potential enrollees, providers, and members of the public via the Plan's toll-free telephone number, electronically, or in writing?

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5.2	Does the Plan's printed directory or directories contain the provider information required by Section 1367.27(i)?
5.3	Does the Plan provide a printed copy of the provider directory to the requester by mail postmarked no later than five business days following the date of the request?

AA-006 - Key Element 6:

6. The Plan monitors changes in names to the provider network and file updates with the Department, as required.
CA Health and Safety Code section 1367.27(r); 28 CCR 1300.52(f).

Assessment Questions	
6.1	Does the Plan have a policy or internal guidance that triggers an amendment filing with the Department when there is a 10 percent change to the names contained in the provider list for one of its networks?
6.2	Does the Plan monitor its networks to determine when a 10 percent change occurs?
6.3	If the Plan had a 10 percent change to any of its networks since its last Exhibit I filing for that network, did the Plan file an Amendment with the Department?

End of Requirement AA-006: Provider Directories and 10% Network Change

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Statutory/Regulatory Citations

CA Health and Safety Code section 1367(e)(1)

…
(e)(1) 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.

CA Health and Safety Code section 1367.27

(a) Commencing July 1, 2016, a health care service plan shall publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to the plan's enrollees, including those that accept new patients. A provider directory shall not list or include information on a provider that is not currently under contract with the plan.
(b) A health care service plan shall provide the directory or directories for the specific network offered for each product using a consistent method of network and product naming, numbering, or other classification method that ensures the public, enrollees, potential enrollees, the department, and other state or federal agencies can easily identify the networks and plan products in which a provider participates. By July 31, 2017, or 12 months after the date provider directory standards are developed under subdivision (k), whichever occurs later, a health care service plan shall use the naming, numbering, or classification method developed by the department pursuant to subdivision (k).
(c)(1) An online provider directory or directories shall be available on the plan's Internet Web site to the public, potential enrollees, enrollees, and providers without any restrictions or limitations. The directory or directories shall be accessible without any requirement that an individual seeking the directory information demonstrate coverage with the plan, indicate interest in obtaining coverage with the plan, provide a member identification or policy number, provide any other identifying information, or create or access an account.
(2) The online provider directory or directories shall be accessible on the plan's public Internet Web site through an identifiable link or tab and in a manner that is accessible and searchable by enrollees, potential enrollees, the public, and providers. By July 31, 2017, or 12 months after the date provider directory standards are developed under subdivision (k), whichever occurs later, the plan's public Internet Web site shall allow provider searches by, at a minimum, name, practice address, city, ZIP Code, California license number, National Provider Identifier number, admitting privileges to an identified hospital, product, tier, provider language or languages, provider group, hospital name, facility name, or clinic name, as appropriate.
(d)(1) A health care service plan shall allow enrollees, potential enrollees, providers, and members of the public to request a printed copy of the provider directory or directories by contacting the plan through the plan's toll-free telephone number, electronically, or in writing. A printed copy of the provider directory or directories shall include the information required in subdivisions (h) and (i). The printed copy of the

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provider directory or directories shall be provided to the requester by mail postmarked no later than five business days following the date of the request and may be limited to the geographic region in which the requester resides or works or intends to reside or work.
(2) A health care service plan shall update its printed provider directory or directories at least quarterly, or more frequently, if required by federal law. (e)(1) The plan shall update the online provider directory or directories, at least weekly, or more frequently, if required by federal law, when informed of and upon confirmation by the plan of any of the following:
(A) A contracting provider is no longer accepting new patients for that product, or an individual provider within a provider group is no longer accepting new patients.
(B) A provider is no longer under contract for a particular plan product.
(C) A provider's practice location or other information required under subdivision (h) or (i) has changed.
(D) Upon completion of the investigation described in subdivision (o), a change is necessary based on an enrollee complaint that a provider was not accepting new patients, was otherwise not available, or whose contact information was listed incorrectly.
(E) Any other information that affects the content or accuracy of the provider directory or directories.
(2) Upon confirmation of any of the following, the plan shall delete a provider from the directory or directories when:
(A) A provider has retired or otherwise has ceased to practice.
(B) A provider or provider group is no longer under contract with the plan for any reason.
(C) The contracting provider group has informed the plan that the provider is no longer associated with the provider group and is no longer under contract with the plan.
(f) The provider directory or directories shall include both an email address and a telephone number for members of the public and providers to notify the plan if the provider directory information appears to be inaccurate. This information shall be disclosed prominently in the directory or directories and on the plan's Internet Web site.
(g) The provider directory or directories shall include the following disclosures informing enrollees that they are entitled to both of the following:
(1) Language interpreter services, at no cost to the enrollee, including how to obtain interpretation services in accordance with Section 1367.04.
(2) Full and equal access to covered services, including enrollees with disabilities as required under the federal Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.
(h) A full service health care service plan and a specialized mental health plan shall include all of the following information in the provider directory or directories:
(1) The provider's name, practice location or locations, and contact information.
(2) Type of practitioner.
(3) National Provider Identifier number.
(4) California license number and type of license.

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(5) The area of specialty, including board certification, if any.
(6) The provider's office email address, if available.
(7) The name of each affiliated provider group currently under contract with the plan through which the provider sees enrollees.
(8) A listing for each of the following providers that are under contract with the plan:
(A) For physicians and surgeons, the provider group, and admitting privileges, if any, at hospitals contracted with the plan.
(B) Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers, as defined in Section 1374.73, nurse midwives, and dentists.
(C) For federally qualified health centers or primary care clinics, the name of the federally qualified health center or clinic.
(D) For any provider described in subparagraph (A) or (B) who is employed by a federally qualified health center or primary care clinic, and to the extent their services may be accessed and are covered through the contract with the plan, the name of the provider, and the name of the federally qualified health center or clinic.
(E) Facilities, including, but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, and inpatient rehabilitation facilities.
(F) Pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services.
(9) The provider directory or directories may note that authorization or referral may be required to access some providers.
(10) Non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter, in accordance with Section 1367.04, if any, on the provider's staff.
(11) Identification of providers who no longer accept new patients for some or all of the plan's products.
(12) The network tier to which the provider is assigned, if the provider is not in the lowest tier, as applicable. Nothing in this section shall be construed to require the use of network tiers other than contract and noncontracting tiers.
(13) All other information necessary to conduct a search pursuant to paragraph (2) of subdivision (c).
((i) A vision, dental, or other specialized health care service plan, except for a specialized mental health plan, shall include all of the following information for each provider directory or directories used by the plan for its networks:
(1) The provider's name, practice location or locations, and contact information.
(2) Type of practitioner.
(3)National Provider Identifier number.
(4) California license number and type of license, if applicable.
(5) The area of specialty, including board certification, or other accreditation, if any.
(6) The provider's office email address, if available.

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(7) The name of each affiliated provider group or specialty plan practice group currently under contract with the plan through which the provider sees enrollees.
(8)The names of each allied health care professional to the extent there is a direct contract for those services covered through a contract with the plan.
(9) The non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter, in accordance with Section 1367.04, if any, on the provider's staff.
(10) Identification of providers who no longer accept new patients for some or all of the plan's products.
(11) All other applicable information necessary to conduct a provider search pursuant to paragraph (2) of subdivision (c).
(j)(1) The contract between the plan and a provider shall include a requirement that the provider inform the plan within five business days when either of the following occurs:
(A) The provider is not accepting new patients.
(B) If the provider had previously not accepted new patients, the provider is currently accepting new patients.
(2) If a provider who is not accepting new patients is contacted by an enrollee or potential enrollee seeking to become a new patient, the provider shall direct the enrollee or potential enrollee to both the plan for additional assistance in finding a provider and to the department to report any inaccuracy with the plan's directory or directories.
(3) If an enrollee or potential enrollee informs a plan of a possible inaccuracy in the provider directory or directories, the plan shall promptly investigate, and, if necessary, undertake corrective action within 30 business days to ensure the accuracy of the directory or directories.
(k)(1) On or before December 31, 2016, the department shall develop uniform provider directory standards to permit consistency in accordance with subdivision (b) and paragraph (2) of subdivision (c) and development of a multiplan directory by another entity. Those standards shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), until January 1, 2021. No more than two revisions of those standards shall be exempt from the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) pursuant to this subdivision.
(2) In developing the standards under this subdivision, the department shall seek input from interested parties throughout the process of developing the standards and shall hold at least one public meeting. The department shall take into consideration any requirements for provider directories established by the federal Centers for Medicare and Medicaid Services and the State Department of Health Care Services.
(3) By July 31, 2017, or 12 months after the date provider directory standards are developed under this subdivision, whichever occurs later, a plan shall use the standards developed by the department for each product offered by the plan.
(*l*)(1) A plan shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the plan's provider directory or directories in accordance with this section, and shall, at least annually, review and update the entire

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provider directory or directories for each product offered. Each calendar year the plan shall notify all contracted providers described in subdivisions (h) and (i) as follows:
(A) For individual providers who are not affiliated with a provider group described in subparagraph (A) or (B) of paragraph (8) of subdivision (h) and providers described in subdivision (i), the plan shall notify each provider at least once every six months.
(B) For all other providers described in subdivision (h) who are not subject to the requirements of subparagraph (A), the plan shall notify its contracted providers to ensure that all of the providers are contacted by the plan at least once annually.
(2) The notification shall include all of the following:
(A) The information the plan has in its directory or directories regarding the provider or provider group, including a list of networks and plan products that include the contracted provider or provider group.
(B) A statement that the failure to respond to the notification may result in a delay of payment or reimbursement of a claim pursuant to subdivision (p).
(C) Instructions on how the provider or provider group can update the information in the provider directory or directories using the online interface developed pursuant to subdivision (m).
(3) The plan shall require an affirmative response from the provider or provider group acknowledging that the notification was received. The provider or provider group shall confirm that the information in the provider directory or directories is current and accurate or update the information required to be in the directory or directories pursuant to this section, including whether or not the provider or provider group is accepting new patients for each plan product.
(4) If the plan does not receive an affirmative response and confirmation from the provider that the information is current and accurate or, as an alternative, updates any information required to be in the directory or directories pursuant to this section, within 30 business days, the plan shall take no more than 15 business days to verify whether the provider's information is correct or requires updates. The plan shall document the receipt and outcome of each attempt to verify the information. If the plan is unable to verify whether the provider's information is correct or requires updates, the plan shall notify the provider 10 business days in advance of removal that the provider will be removed from the provider directory or directories. The provider shall be removed from the provider directory or directories at the next required update of the provider directory or directories after the 10-business-day notice period. A provider shall not be removed from the provider directory or directories if he or she responds before the end of the 10-business-day notice period.
(5) General acute care hospitals shall be exempt from the requirements in paragraphs (3) and (4).
(m) A plan shall establish policies and procedures with regard to the regular updating of its provider directory or directories, including the weekly, quarterly, and annual updates required pursuant to this section, or more frequently, if required by federal law or guidance.

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(1) The policies and procedures described under this subdivision shall be submitted by a plan annually to the department for approval and in a format described by the department pursuant to Section 1367.035.
(2) Every health care service plan shall ensure processes are in place to allow providers to promptly verify or submit changes to the information required to be in the directory or directories pursuant to this section. Those processes shall, at a minimum, include an online interface for providers to submit verification or changes electronically and shall generate an acknowledgment of receipt from the health care service plan. Providers shall verify or submit changes to information required to be in the directory or directories pursuant to this section using the process required by the health care service plan.
(3) The plan shall establish and maintain a process for enrollees, potential enrollees, other providers, and the public to identify and report possible inaccurate, incomplete, or misleading information currently listed in the plan's provider directory or directories. This process shall, at a minimum, include a telephone number and a dedicated email address at which the plan will accept these reports, as well as a hyperlink on the plan's provider directory Internet Web site linking to a form where the information can be reported directly to the plan through its Internet Web site. (n)(1) This section does not prohibit a plan from requiring its provider groups or contracting specialized health care service plans to provide information to the plan that is required by the plan to satisfy the requirements of this section for each of the providers that contract with the provider group or contracting specialized health care service plan. This responsibility shall be specifically documented in a written contract between the plan and the provider group or contracting specialized health care service plan.
(2) If a plan requires its contracting provider groups or contracting specialized health care service plans to provide the plan with information described in paragraph (1), the plan shall continue to retain responsibility for ensuring that the requirements of this section are satisfied.
(3) A provider group may terminate a contract with a provider for a pattern or repeated failure of the provider to update the information required to be in the directory or directories pursuant to this section.
(4) A provider group is not subject to the payment delay described in subdivision (p) if all of the following occurs:
(A) A provider does not respond to the provider group's attempt to verify the provider's information. As used in this paragraph, "verify" means to contact the provider in writing, electronically, and by telephone to confirm whether the provider's information is correct or requires updates.
(B) The provider group documents its efforts to verify the provider's information.
(C) The provider group reports to the plan that the provider should be deleted from the provider group in the plan directory or directories.
(5) Section 1375.7, known as the Health Care Providers' Bill of Rights, applies to any material change to a provider contract pursuant to this section.
(o)(1) Whenever a health care service plan receives a report indicating that information listed in its provider directory or directories is inaccurate, the plan shall promptly investigate the reported inaccuracy and, no later than 30 business days following

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receipt of the report, either verify the accuracy of the information or update the information in its provider directory or directories, as applicable.
(2) When investigating a report regarding its provider directory or directories, the plan shall, at a minimum, do the following:
(A) Contact the affected provider no later than five business days following receipt of the report.
(B) Document the receipt and outcome of each report. The documentation shall include the provider's name, location, and a description of the plan's investigation, the outcome of the investigation, and any changes or updates made to its provider directory or directories.
(C) If changes to a plan's provider directory or directories are required as a result of the plan's investigation, the changes to the online provider directory or directories shall be made no later than the next scheduled weekly update, or the update immediately following that update, or sooner if required by federal law or regulations. For printed provider directories, the change shall be made no later than the next required update, or sooner if required by federal law or regulations.
(p)(1) Notwithstanding Sections 1371 and 1371.35, a plan may delay payment or reimbursement owed to a provider or provider group as specified in subparagraph (A) or (B), if the provider or provider group fails to respond to the plan's attempts to verify the provider's or provider group's information as required under subdivision (*l*). The plan shall not delay payment unless it has attempted to verify the provider's or provider group's information. As used in this subdivision, "verify" means to contact the provider or provider group in writing, electronically, and by telephone to confirm whether the provider's or provider group's information is correct or requires updates. A plan may seek to delay payment or reimbursement owed to a provider or provider group only after the 10-business day notice period described in paragraph (4) of subdivision (*l*) has lapsed.
(A) For a provider or provider group that receives compensation on a capitated or prepaid basis, the plan may delay no more than 50 percent of the next scheduled capitation payment for up to one calendar month.
(B) For any claims payment made to a provider or provider group, the plan may delay the claims payment for up to one calendar month
beginning on the first day of the following month. (2) A plan shall notify the provider or provider group 10 business days before it seeks to delay payment or reimbursement to a provider or provider group pursuant to this subdivision. If the plan delays a payment or reimbursement pursuant to this subdivision, the plan shall reimburse the full amount of any payment or reimbursement subject to delay to the provider or provider group according to either of the following timelines, as applicable:
(A) No later than three business days following the date on which the plan receives the information required to be submitted by the provider or provider group pursuant to subdivision (*l*).
(B) At the end of the one-calendar month delay described in subparagraph (A) or (B) of paragraph (1), as applicable, if the provider or provider group fails to provide the information required to be submitted to the plan pursuant to subdivision (*l*).

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(3) A plan may terminate a contract for a pattern or repeated failure of the provider or provider group to alert the plan to a change in the information required to be in the directory or directories pursuant to this section.
(4) A plan that delays payment or reimbursement under this subdivision shall document each instance a payment or reimbursement was delayed and report this information to the department in a format described by the department pursuant to Section 1367.035. This information shall be submitted along with the policies and procedures required to be submitted annually to the department pursuant to paragraph (1) of subdivision (m).
(5) With respect to plans with Medi-Cal managed care contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of the Welfare and Institutions Code, this subdivision shall be implemented only to the extent consistent with federal law and guidance.
(q) In circumstances where the department finds that an enrollee reasonably relied upon materially inaccurate, incomplete, or misleading information contained in a health plan's provider directory or directories, the department may require the health plan to provide coverage for all covered health care services provided to the enrollee and to reimburse the enrollee for any amount beyond what the enrollee would have paid, had the services been delivered by an in-network provider under the enrollee's plan contract. Prior to requiring reimbursement in these circumstances, the department shall conclude that the services received by the enrollee were covered services under the enrollee's plan contract. In those circumstances, the fact that the services were rendered or delivered by a noncontracting or out-of-plan provider shall not be used as a basis to deny reimbursement to the enrollee.
(r) Whenever a plan determines as a result of this section that there has been a 10 percent change in the network for a product in a region, the plan shall file an amendment to the plan application with the department consistent with subdivision (f) of Section 1300.52 of Title 28 of the California Code of Regulations.
(s) This section applies to plans with Medi-Cal managed care contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of the Welfare and Institutions Code to the extent consistent with federal law and guidance and state law guidance issued after January 1, 2016. Notwithstanding any other provision to the contrary in a plan contract with the State Department of Health Care Services, and to the extent consistent with federal law and guidance and state guidance issued after January 1, 2016, a Medi-Cal managed care plan that complies with the requirements of this section shall not be required to distribute a printed provider directory or directories, except as required by paragraph (1) of subdivision (d).
(t) A health plan that contracts with multiple employer welfare agreements regulated pursuant to Article 4.7 (commencing with Section 742.20) of Chapter 1 of Part 2 of Division 1 of the Insurance Code shall meet the requirements of this section.
(u) This section shall not be construed to alter a provider's obligation to provide health care services to an enrollee pursuant to the provider's contract with the plan.

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(v) As part of the department's routine examination of the fiscal and administrative affairs of a health care service plan pursuant to Section 1382, the department shall include a review of the health care service plan's compliance with subdivision (p).
(w) For purposes of this section, "provider group" means a medical group, independent practice association, or other similar group of providers.

CA Health and Safety Code section 1368
(a) Every plan shall do all of the following:
(1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.
(2) Inform its subscribers and enrollees upon enrollment in the plan and annually thereafter of the procedure for processing and resolving grievances. The information shall include the location and telephone number where grievances may be submitted.
(3) Provide forms for grievances to be given to subscribers and enrollees who wish to register written grievances. The forms used by plans licensed pursuant to Section 1353 shall be approved by the director in advance as to format.
(4)(A) Provide for a written acknowledgment within five calendar days of the receipt of a grievance, except as noted in subparagraph (B). The acknowledgment shall advise the complainant of the following:
(i) That the grievance has been received.
(ii) The date of receipt.
(iii) The name of the plan representative and the telephone number and address of the plan representative who may be contacted about the grievance.
(B)(i) Grievances received by telephone, by facsimile, by email, or online through the plan's Internet Web site pursuant to Section 1368.015, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt are exempt from the requirements of subparagraph (A) and paragraph (5). The plan shall maintain a log of all these grievances. The log shall be periodically reviewed by the plan and shall include the following information for each complaint:
(I) The date of the call.
(II) The name of the complainant.
(III) The complainant's member identification number.
(IV) The nature of the grievance.
(V) The nature of the resolution.
(VI) The name of the plan representative who took the call and resolved the grievance.
(ii) For health plan contracts in the individual, small group, or large group markets, a health care service plan's response to grievances subject to Section 1367.24 shall also comply with subdivision (c) of Section 156.122 of Title 45 of the Code of Federal Regulations. This paragraph shall not apply to Medi-Cal managed care health care service plan contracts or any entity that enters into a contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000),

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Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.
(5) Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.
(6) For grievances involving the cancellation, rescission, or nonrenewal of a health care service plan contract, the health care service plan shall continue to provide coverage to the enrollee or subscriber under the terms of the health care service plan contract until a final determination of the enrollee's or subscriber's request for review has been made by the health care service plan or the director pursuant to Section 1365 and this section. This paragraph shall not apply if the health care service plan cancels or fails to renew the enrollee's or subscriber's health care service plan contract for nonpayment of premiums pursuant to paragraph (1) of subdivision (a) of Section 1365.
(7) Keep in its files all copies of grievances, and the responses thereto, for a period of five years.
(b)(1)(A) After either completing the grievance process described in subdivision (a), or participating in the process for at least 30 days, a subscriber or enrollee may submit the grievance to the department for review. In any case determined by the department to be a case involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, cancellations, rescissions, or the nonrenewal of a health care service plan contract, or in any other case where the department determines that an earlier review is warranted, a subscriber or enrollee shall not be required to complete the grievance process or to participate in the process for at least 30 days before submitting a grievance to the department for review.
(B) A grievance may be submitted to the department for review and resolution prior to any arbitration.
(C) Notwithstanding subparagraphs (A) and (B), the department may refer any grievance that does not pertain to compliance with this chapter to the State Department of Public Health, the California Department of Aging, the federal Health Care Financing Administration, or any other appropriate governmental entity for investigation and resolution.
(2) If the subscriber or enrollee is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative, or other designee of the subscriber or enrollee, as appropriate, may submit the grievance to the department as the agent of the subscriber or enrollee. Further, a provider may join with, or otherwise assist, a subscriber or enrollee, or the agent, to submit the grievance to the department. In addition, following submission of the grievance to the department, the subscriber or enrollee, or the agent,

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may authorize the provider to assist, including advocating on behalf of the subscriber or enrollee. For purposes of this section, a “relative” includes the parent, stepparent, spouse, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the subscriber or enrollee.
(3) The department shall review the written documents submitted with the subscriber’s or the enrollee’s request for review, or submitted by the agent on behalf of the subscriber or enrollee. The department may ask for additional information, and may hold an informal meeting with the involved parties, including providers who have joined in submitting the grievance or who are otherwise assisting or advocating on behalf of the subscriber or enrollee. If after reviewing the record, the department concludes that the grievance, in whole or in part, is eligible for review under the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), the department shall immediately notify the subscriber or enrollee, or agent, of that option and shall, if requested orally or in writing, assist the subscriber or enrollee in participating in the independent medical review system.
(4) If after reviewing the record of a grievance, the department concludes that a health care service eligible for coverage and payment under a health care service plan contract has been delayed, denied, or modified by a plan, or by one of its contracting providers, in whole or in part due to a determination that the service is not medically necessary, and that determination was not communicated to the enrollee in writing along with a notice of the enrollee’s potential right to participate in the independent medical review system, as required by this chapter, the director shall, by order, assess administrative penalties. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice of, and the opportunity for, a hearing with regard to the person affected in accordance with Section 1397. The administrative penalties shall not be deemed an exclusive remedy available to the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.
(5) The department shall send a written notice of the final disposition of the grievance, and the reasons therefor, to the subscriber or enrollee, the agent, to any provider that has joined with or is otherwise assisting the subscriber or enrollee, and to the plan, within 30 calendar days of receipt of the request for review unless the director, in his or her discretion, determines that additional time is reasonably necessary to fully and fairly evaluate the relevant grievance. In any case not eligible for the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), the department’s written notice shall include, at a minimum, the following:
(A) A summary of its findings and the reasons why the department found the plan to be, or not to be, in compliance with any applicable laws, regulations, or orders of the director.
(B) A discussion of the department’s contact with any medical provider, or any other independent expert relied on by the department, along with a summary of the views and qualifications of that provider or expert.
(C) If the enrollee’s grievance is sustained in whole or in part, information about any corrective action taken.

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(6) In any department review of a grievance involving a disputed health care service, as defined in subdivision (b) of Section 1374.30, that is not eligible for the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), in which the department finds that the plan has delayed, denied, or modified health care services that are medically necessary, based on the specific medical circumstances of the enrollee, and those services are a covered benefit under the terms and conditions of the health care service plan contract, the department's written notice shall do either of the following:
(A) Order the plan to promptly offer and provide those health care services to the enrollee.
(B) Order the plan to promptly reimburse the enrollee for any reasonable costs associated with urgent care or emergency services, or other extraordinary and compelling health care services, when the department finds that the enrollee's decision to secure those services outside of the plan network was reasonable under the circumstances.
The department's order shall be binding on the plan.
(7) Distribution of the written notice shall not be deemed a waiver of any exemption or privilege under existing law, including, but not limited to, Section 6254.5 of the Government Code, for any information in connection with and including the written notice, nor shall any person employed or in any way retained by the department be required to testify as to that information or notice
(8) The director shall establish and maintain a system of aging of grievances that are pending and unresolved for 30 days or more that shall include a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more.
(9) A subscriber or enrollee, or the agent acting on behalf of a subscriber or enrollee, may also request voluntary mediation with the plan prior to exercising the right to submit a grievance to the department. The use of mediation services shall not preclude the right to submit a grievance to the department upon completion of mediation. In order to initiate mediation, the subscriber or enrollee, or the agent acting on behalf of the subscriber or enrollee, and the plan shall voluntarily agree to mediation. Expenses for mediation shall be borne equally by both sides. The department shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process authorized by this paragraph.
(c) The plan's grievance system shall include a system of aging of grievances that are pending and unresolved for 30 days or more. The plan shall provide a quarterly report to the director of grievances pending and unresolved for 30 or more days with separate categories of grievances for Medicare enrollees and Medi-Cal enrollees. The plan shall include with the report a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more. The plan may include the following statement in the quarterly report that is made available to the public by the director:
"Under Medicare and Medi-Cal law, Medicare enrollees and Medi-Cal enrollees each have separate avenues of appeal that are not available to other enrollees. Therefore, grievances pending and unresolved may reflect enrollees pursuing their Medicare or Medi-Cal appeal rights."

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If requested by a plan, the director shall include this statement in a written report made available to the public and prepared by the director that describes or compares grievances that are pending and unresolved with the plan for 30 days or more. Additionally, the director shall, if requested by a plan, append to that written report a brief explanation, provided in writing by the plan, of the reasons why grievances described in that written report are pending and unresolved for 30 days or more. The director shall not be required to include a statement or append a brief explanation to a written report that the director is required to prepare under this chapter, including Sections 1380 and 1397.5.
(d) Subject to subparagraph (C) of paragraph (1) of subdivision (b), the grievance or resolution procedures authorized by this section shall be in addition to any other procedures that may be available to any person, and failure to pursue, exhaust, or engage in the procedures described in this section shall not preclude the use of any other remedy provided by law.
(e) Nothing in this section shall be construed to allow the submission to the department of any provider grievance under this section. However, as part of a provider's duty to advocate for medically appropriate health care for his or her patients pursuant to Sections 510 and 2056 of the Business and Professions Code, nothing in this subdivision shall be construed to prohibit a provider from contacting and informing the department about any concerns he or she has regarding compliance with or enforcement of this chapter.
(f) To the extent required by Section 2719 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19) and any subsequent rules or regulations, there shall be an independent external review pursuant to the standards required by the United States Secretary of Health and Human Services of a health care service plan's cancellation, rescission, or nonrenewal of an enrollee's or subscriber's coverage.

28 CCR 1300.51(d)(l)(5)(d) and (d)(H)
(d) Exhibits to Plan Application.
…
I. Description of Health Care Arrangements.
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.
…
5. Applicants Standards of Accessibility. Attach as Exhibit I-5 a detailed description of the applicant's standards with respect to the accessibility and its procedures from monitoring the accessibility of services. Standards should be expressed in terms of the

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level of accessibility, which the applicant has as its objective, and minimum level of accessibility below which corrective action will be taken. Cover each of the following:
...
d. the proximity of specialists, hospitals, etc. to sources of primary care, and
...
(H) Geographical Area Served.
Note: The applicant is required to demonstrate that, throughout the geographic regions designated as the plan's Service Area, a comprehensive range of primary, specialty, institutional and ancillary services are readily available at reasonable times to all enrollees and, to the extent feasible, that all services are readily accessible to all enrollees.
For the purpose of evaluating the geographic aspects of availability and accessibility, consideration will be given to the actual and projected enrollment of the plan based on the residence and place of work of enrollees within and, if applicable, outside the service area, including the individual and group enrollment projections furnished in Items CC, DD and EE of this application.
An applicant for plan license must demonstrate compliance with the accessibility requirement in each of the areas specified in paragraphs (i) through (iv) below, either by demonstrating compliance with the guideline specified in such paragraphs or, in the alternative, by presenting other information demonstrating compliance with reasonable accessibility. These guidelines apply only with respect to initial license applications and provide presumptively reasonable standards in the absence of actual operating experience. Such guidelines are not intended to express minimum standards of accessibility either for applicants or for licensees nor to create any inference that a plan which does not meet these guidelines does not meet the requirement of reasonable accessibility.
(i) Primary Care Providers. All enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated primary care provider in such numbers and distribution as to accord to all enrollees a ratio of at least one primary care provider (on a full-time equivalent basis) to each 2,000 enrollees.
(ii) Hospitals. In the case of a full-service plan, all enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated hospital which has a capacity to serve the entire dependent enrollee population based on normal utilization, and, if separate from such hospital, a contracting or plan-operated provider of all emergency health care services.
(iii) Hospital Staff Privileges. In the case of a full-service plan, there is a complete network of contracting or plan-employed primary care physicians and specialists each of whom has admitting staff privileges with at least one contracting or plan-operated hospital equipped to provide the range of basic health care services the plan has contracted to provide.
(iv) Ancillary Services. Ancillary laboratory, pharmacy and similar services and goods dispensed by order or prescription on the primary care provider are available from contracting or plan-operated providers at locations (where enrollees are personally served) within a reasonable distance from the primary care provider.

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1. Description of Service Area. As Exhibit H-1, attach a narrative description of the applicant's service area and the geographic area in which its enrollees (actual and/or projected) live and work and list all U.S. Postal ZIP Code numbers included in the service areas. If the applicant has more than one service area, each service area should be separately described. To the extent possible, service areas should be delineated by political or natural boundaries. (If applicant uses sub-service areas or regions within its service areas for the purpose of allocating the provision of health care services by providers to enrollees, include that information in the description of the considerations which underlie the geographic distribution of the applicant's contracting and plan-operated providers.)
2. Map of Service Area. As Exhibit H-2, attach a map or maps upon which the information specified below is indicated by the specified system of symbols. The map(s) employed should be of convenient size and of the largest scale sufficient to include the applicant's entire service area and the surrounding area in which the actual or projected enrollees live or work. The use of good- quality city street maps or the street and highway maps available for various metropolitan areas, and regions of the state, such as are commonly available from automobile associations or retail service stations is preferred. The map or maps should show the following information:
a. Such geographic detail, including highways and major streets, as is generally portrayed on the kinds of maps referred to above.
b. The boundaries of applicant's service area.
c. The location of any contracting or plan-operated hospital and, if separate, each contracting or plan operated emergency health care facility. Hospitals are to be designated by an "H'' and emergency care facilities by an "E.''
d. The location of primary care providers, designated by a "P.'' For convenience, the primary care providers within any mile-square area may be considered as being at one location within that area.
e. The location of all other contracting or plan-operated health care providers including the following: Dental, designated by a "D.'' Pharmacy, designated by an "Rx.'' Laboratory, designated by an "L.'' Eye Care, designated by an "O.'' Specialists and ancillary health care providers, designated by an "S.''
f. The location of all subscriber groups which have submitted letters of intent or interest to join the applicant's plan designated by a "G.'' (See Item CC-3.)
1. Index to Map. As Exhibit H-3, attach an index to the map or maps furnished as Exhibit H-2 which shows, for each symbol placed on the map for a hospital, emergency care facility, primary care provider or ancillary provider, the following information:
a. For each hospital, its total beds and the number of beds available to enrollees of the plan.
b. For each symbol for primary care providers, the number of full-time equivalent primary care providers represented by that symbol.
c. For each interested subscriber group, the name of the group and the projected number of enrollees from that group.

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28 CCR 1300.52(f)

…

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

28 CCR 1300.67(f)(1), (4), and (8)

…

(f) Preventive health services (including services for the detection of asymptomatic diseases), which shall include, under a physician’s supervision,

(1) Reasonable health appraisal examinations on a periodic basis;

…

(4) Vision and hearing testing for persons through age 16;

…

(8) Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan.

28 CCR 1300.67.1.(d) and (e)

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.

28 CCR 1300.67.2.(a) (b), (d)-(f)

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

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

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

…

(d) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably

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assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. There shall be at least one full-time equivalent physician to each one thousand two hundred (1,200) enrollees and there shall be approximately one full-time equivalent primary care physician for each two thousand (2,000) enrollees, or an alternative mechanism shall be provided by the plan to demonstrate an adequate ratio of physicians to enrollees;
(e) A plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral;
(f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments;

28 CCR 1300.67.2.1.(b) and (c)(2), (3), (4), and (9)
Subject to subsections (a) and (b) of this section, a plan may rely, for the purposes of satisfying the requirements for geographic accessibility, on the standards of accessibility set forth in Item H of Section 1300.51 and in Section 1300.67.2.
The facts and circumstances to be included in a discussion of the reasons justifying the standards of accessibility proposed by the plan pursuant to subsection (a) or (b) of this section shall include, to the extent relevant, but shall not necessarily be limited to the following:
...
(b) If, in its review of a plan license application or a notice of material modification, the Department believes the accessibility standards set forth in Item H of Section 1300.51 and/or Section 1300.67.2 are insufficiently prescribed or articulated or are inappropriate given the facts and circumstances with regard to a portion of a plan's service area, the Department shall inform the plan that the Department will not allow application of those standards to that portion of the plan's service area. The Department shall also inform the plan of the Department's reasons for rejecting the application of those standards.
(c) The facts and circumstances to be included in a discussion of the reasons justifying the standards of accessibility proposed by the plan pursuant to subsection (a) or (b) of this section shall include, to the extent relevant, but shall not necessarily be limited to the following:
...
(2) whether the plan contract is a full-service health care service plan contract or a specialized health care service plan contract, and if the latter, whether emergency services need not be covered;
(3) the uniqueness of the services to be offered;
(4) whether the portion of the service area involved is urban or rural;
...
(9) the availability and distribution of other types of providers;

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28 CCR 1300.67.2.2.(c) and (d)

…

(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

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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

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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

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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- elapsed 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.

28 CCR 1300.68

Every health care service plan shall establish a grievance system pursuant to the requirements of Section 1368 of the Act.

(a) The grievance system shall be established in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's grievance system. The following definitions shall apply with respect to the regulations relating to grievance systems:

(1) "Grievance'' means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. Where the plan is unable to distinguish between a' grievance and an inquiry, it shall be considered a grievance.

(2) "Complaint'' is the same as "grievance.''

(3) "Complainant'' is the same as "grievant,'' and means the person who filed the grievance including the enrollee, a representative designated by the enrollee, or other individual with authority to act on behalf of the enrollee.

(4) "Resolved'' means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the plan's grievance system, including entities with delegated authority.

(A) If the plan has multiple internal levels of grievance resolution or appeal, all levels must be completed within 30 calendar days of the plan's receipt of the grievance.

(B) Grievances that are not resolved within 30 calendar days, or grievances referred to the Department's complaint or independent medical review system, shall be reported as "pending'' grievances pursuant to subsection (f) below. Grievances referred to external review processes, such as reviews of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, or the Medi-Cal Fair Hearing process, shall also be reported pursuant to subsection (f) until the review and any required action by the plan resulting from the review is completed.

(b) The plan's grievance system shall include the following:

(1) An officer of the plan shall be designated as having primary responsibility for the plan's grievance system whether administered directly by the plan or delegated to another entity. The officer shall continuously review the operation of the grievance system to identify any emergent patterns of grievances. The system shall include the reporting procedures in order to improve plan policies and procedures.

(2) Each plan's obligation for notifying subscribers and enrollees about the plan's grievance system shall include information on the plan's procedures for filing and resolving grievances, and the telephone number and address for presenting a grievance. The notice shall also include information regarding the Department's review process, the independent medical review system, and the Department's toll-free telephone number and website address.

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(3) The grievance system shall address the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities. The system shall ensure all enrollees have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. Plans shall develop and file with the Department a policy describing how they ensure that their grievance system complies with this subsection within 90 days of the effective date of this regulation.
(4) The plan shall maintain a toll-free number, or a local telephone number in each service area, for the filing of grievances.
(5) A written record shall be made for each grievance received by the plan, including the date received, the plan representative recording the grievance, a summary or other document describing the grievance, and its disposition. The written record of grievances shall be reviewed periodically by the governing body of the plan, the public policy body created pursuant to section 1300.69, and by an officer of the plan or his designee. This review shall be thoroughly documented.
(6) The plan grievance system shall ensure that assistance in filing grievances shall be provided at each location where grievances may be submitted. A “patient advocate’’ or ombudsperson may be used.
(7) Grievance forms and a description of the grievance procedure shall be readily available at each facility of the plan, on the plan’s website, and from each contracting provider’s office or facility. Grievance forms shall be provided promptly upon request.
(8) The plan shall assure that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) on the grounds that the complainant filed a grievance.
(9) The grievance system shall allow enrollees to file grievances for at least 180 calendar days following any incident or action that is the subject of the enrollee’s dissatisfaction.
(c) Through periodic medical surveys under Section 1380 of the Act, the Department shall periodically review the plan’s grievance system, including the records of grievances received by the plan, and assess the effectiveness of the plan policies and actions taken in response to grievances.
(d) The plan shall respond to grievances as follows:
(1) A grievance system shall provide for a written acknowledgment within five (5) calendar days of receipt, except as noted in subsection (d)(8). The acknowledgment will advise the complainant that the grievance has been received, the date of receipt, and provide the name of the plan representative, telephone number and address of the plan representative who may be contacted about the grievance.
(2) The grievance system shall provide for a prompt review of grievances by the management or supervisory staff responsible for the services or operations which are the subject of the grievance.
(3) The plan’s resolution, containing a written response to the grievance shall be sent to

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the complainant within thirty (30) calendar days of receipt, except as noted in subsection (d)(8). The written response shall contain a clear and concise explanation of the plan's decision. Nothing in this regulation requires a plan to disclose information to the grievant that is otherwise confidential or privileged by law.
(4) For grievances involving delay, modification or denial of services based on a determination in whole or in part that the service is not medically necessary, the plan shall include in its written response, the reasons for its determination. The response shall clearly state the criteria, clinical guidelines or medical policies used in reaching the determination. The plan's response shall also advise the enrollee that the determination may be considered by the Department's independent medical review system. The response shall include an application for independent medical review and instructions, including the Department's toll-free telephone number for further information and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814.
(5) Plan responses to grievances involving a determination that the requested service is not a covered benefit shall specify the provision in the contract, evidence of coverage or member handbook that excludes the service. The response shall either identify the document and page where the provision is found, direct the grievant to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific health care service or benefit requested by the enrollee. In addition to the notice set forth at Section 1368.02(b) of the Act, the response shall also include a notice that if the enrollee believes the decision was denied on the grounds that it was not medically necessary, the Department should be contacted to determine whether the decision is eligible for an independent medical review.
(6) Copies of grievances and responses shall be maintained by the Plan for five years, and shall include a copy of all medical records, documents, evidence of coverage and other relevant information upon which the plan relied in reaching its decision.
(7) The Department's telephone number, the California Relay Service's telephone numbers, the plan's telephone number and the Department's Internet address shall be displayed in all of the plan's acknowledgments and responses to grievances in 12-point boldface type with the statement contained in subsection (b) of Section 1368.02 of the Act.
(8) Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity or experimental or investigational treatment, and that are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response. The plan shall maintain a log of all such grievances containing the date of the call, the name of the complainant, member identification number, nature of the grievance, nature of resolution, and the plan representative's name who took the call and resolved the grievance. The information contained in this log shall be periodically reviewed by the plan as set forth in subsection (b).
(e) The plan's grievance system shall track and monitor grievances received by the plan, or any entity with delegated authority to receive or respond to grievances. The

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system shall:
(1) Monitor the number of grievances received and resolved; whether the grievance was resolved in favor of the enrollee or plan; and the number of grievances pending over 30 calendar days. The system shall track grievances under categories of Commercial, Medicare and Medi-Cal/other contracts. The system shall indicate whether an enrollee grievance is pending at: (1) the plan's internal grievance system; (2) the Department's consumer complaint process; (3) the Department's Independent Medical Review system; (4) an action filed or before a trial or appellate court; or (5) other dispute resolution process. Additionally, the system shall indicate whether an enrollee grievance has been submitted to: (1) the Medicare review and appeal system; (2) the Medi-Cal fair hearing process; or (3) arbitration.
(2) The system shall be able to indicate the total number of grievances received, pending and resolved in favor of the enrollee at all levels of grievance review and to describe the issue or issues raised in grievances as (1) coverage disputes, (2) disputes involving medical necessity, (3) complaints about the quality of care and (4) complaints about access to care (including complaints about the waiting time for appointments), and (5) complaints about the quality of service, and (6) other issues.
(f) Quarterly Reports
(1) All plans shall submit a quarterly report to the Department describing grievances that were or are pending and unresolved for 30 days or more. The report shall be prepared for the quarters ending March 31st, June 30th, September 30th and December 31st of each calendar year. The report shall also contain the number of grievances referred to external review processes, such as reconsiderations of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, the Medi-Cal fair hearing process, the Department's complaint or Independent Medical Review system, or other external dispute resolution systems, known to the plan as of the last day of each quarter.
(2) The quarterly report shall include:
(A) The licensee's name, quarter and date of the report;
(B) The total number of grievances filed by enrollees that were or are pending and unresolved for more than 30 calendar days at any time during the quarter under the categories of Commercial, Medicare, and Medi-Cal/other products offered by the plan;
(C) A brief explanation of why the grievance was not resolved in 30 days, and indicate whether the grievance was or is pending at: (1) the plan's internal grievance system; (2) the Department's consumer complaint process; (3) the Department's Independent Medical Review system; (4) court; or (5) other dispute resolution processes. Alternatively, the plan shall indicate whether the grievance was or is submitted to: (1) the Medicare review and appeal system; (2) the Medi-Cal fair hearing process; or (3) arbitration.
(D) The nature of the unresolved grievances as (1) coverage disputes; (2) disputes involving medical necessity; (3) complaints about the quality of care; complaints about access to care (including complaints about the waiting time for appointments); (5) complaints about the quality of service; and (6) other issues. All issues reasonably described in the grievance shall be separately categorized.
(E) The quarterly report shall not contain personal or confidential information with

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respect to any enrollee.
(3) The quarterly report shall be verified by an officer authorized to act on behalf of the plan. The report shall be submitted in writing or through electronic filing to the Department's Sacramento Office to the attention of the Filing Clerk no later than 30 days after each quarter. The quarterly report shall not be filed as an amendment to the plan application.
(4) The quarterly report shall be filed in the format specified in subsection (i).
(g) An enrollee may submit a grievance to the Department. The Department shall notify the plan, and within five (5) calendar days after notification, the plan shall provide the following information to the Department:
(1) A written response to the issues raised by the grievance.
(2) A copy of the plan's original response sent to the enrollee regarding the grievance.
(3) A complete and legible copy of all medical records related to the grievance. The plan shall inform the Department if medical records were not used by the plan in resolving the grievance.
(4) A copy of the cover page and all relevant pages of the enrollee's Evidence of Coverage (EOC), with the specific applicable sections underlined. If the plan relied solely on the EOC, the plan shall notify the Department of that fact.
(5) All other information used by the plan or relevant to the resolution of the grievance.
(6) The Department may request additional information or medical records from the plan. Within five (5) calendar days of receipt of the Department's request, the plan shall forward information and records that are maintained by the plan or any contracting provider. If requested information cannot be timely forwarded to the Department, the plan's response will describe the actions being taken to obtain the information or records and when receipt is expected.
(h) Nothing in this section shall preclude an enrollee from seeking assistance directly from the Department in cases involving an imminent or serious threat to the health of the enrollee or where the Department determines an earlier review is warranted. In such cases, the Department may require the plan and contracting providers to expedite the delivery of information.
The Department may consider the failure of a plan to timely provide the requested information as evidence in favor of the enrollee's position in the Department's review of grievances submitted under subsection (b) of Section 1368 of the Act.

28 CCR 1300.70(b)(2)(G)(5) and (6) *(Applicable to delegated groups only)*

…

(b) Quality Assurance Program Structure and Requirements.

…

(2) Program Requirements.
In order to meet these obligations each plan's QA program shall meet all of the following requirements:

…

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(G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees.
If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:
...
(5) Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the plan and/or delegated providers.
(6) Ensure that health services include appropriate preventive health care measures consistent with professionally recognized standards of practice. There should be screening for conditions when professionally recognized standards of practice indicate that screening should be done.