

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

**TECHNICAL ASSISTANCE GUIDE**

**ACCESS AND AVAILABILITY OF SERVICES**

**ROUTINE DENTAL SURVEY**

**OF**

**PLAN NAME**

**DATE OF SURVEY:**

**PLAN COPY**

*Issuance of this September 5, 2012 Technical Assistance Guide renders all other versions obsolete.*

# DENTAL TAG

## ACCESS AND AVAILABILITY OF SERVICES REQUIREMENTS

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

#### STATUTORY/REGULATORY CITATIONS

##### **CA Health and Safety Code section 1367(d)**

(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

##### **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.

**(Section 1367.3 refers to the Department's timely access to care regulations.)**

##### **CA Health and Safety Code section 1367(e)(3)**

(3) The plan shall make all services accessible and appropriate consistent with Section 1367.04.

**(Section 1367.04 refers to Language assistance regulations.)**

##### **28 CCR 1300.67.2(a) and (d)**

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.

(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 ensure 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 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.

##### **28 CCR 1300.67.2.2.(c)(1)**

(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.

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### **28 CCR 1300.67.2.2.(c)(3)**

(c) Standards for Timely Access to Care.

(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.

### **28 CCR 1300.67.2.2.(c)(4)**

(c) Standards for Timely Access to Care.

(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.

### **28 CCR 1300.67.2.2.(c)(7)**

(c) Standards for Timely Access to Care.

(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-elapsing standards, by referring enrollees to, or, in the case of a preferred provider network, by assisting enrollees to locate, available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. Plans shall arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network, when medically necessary for the enrollee's condition. Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

### **28 CCR 1300.70(a)(3)**

(a) Intent and Regulatory Purpose.

(3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.

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

**Staff responsible for the activities described above, for example:**

- Dental 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 dentists within the service area
- Documents describing how the Plan monitors and ensures compliance with network standards.
  - Distribution service area maps indicating location and numbers of enrollees in comparison with dentists
  - Plan primary health care access reports that provide information on provider distributions, closed practices and the like.
- Policies and procedures to periodically update/review the standards for the number and distribution of dentists within the service area
  - Record of periodic review of the standards for the number and distribution of dentists within the service area, including minutes of relevant committee meetings (QM Committee, Public Policy Committee, etc.)
- Corrective action plans for areas where access does not meet the standards

### AA-001 - Key Element 1:

**1. The Plan has established a standard for geographic distribution of specialty/dental care providers.**

**CA Health and Safety Code section 1367(e)(1); 28 CCR 1300.67.2(a) and (d); 28 CCR 1300.67.2.2.(c)(1); 28 CCR 1300.67.2.2.(c)(7)(A); 28 CCR 1300.70(a)(3)**

| Assessment Questions  | Yes | No | N/A |
|---|-----|----|-----|
| 1.1 Does the Plan have an established standard on geographic distribution of specialty/dental care providers? |     |    |     |

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### AA-001 - Key Element 2:

- 2. Can the Plan demonstrate that, throughout the geographic regions designated as the Plan's Service Area, a comprehensive range of specialty/dental services are readily available at reasonable times to all enrollees and, to the extent feasible, that all services are readily accessible to all enrollees.**  
**CA Health and Safety Code section 1367(e)(1); 28 CCR 1300.67.2(a) and (d); 28 CCR 1300.67.2.2.(c)(1); 28 CCR 1300.67.2.2.(c)(7); 28 CCR 1300.70(a)(3)**

| Assessment Questions   | Yes | No | N/A |
|--|-----|----|-----|
| 2.1 Does the Plan have an established standard for the numbers of dental providers which is proportionate to the enrollee population?  |     |    |     |
| 2.2 Can the Plan show reasonable accessibility of dental services within all regions of the Plan's service area?   |     |    |     |
| 2.3 Can the Plan show 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? |     |    |     |

### 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)(1); 28 CCR 1300.67.2.2.(c)(3); 28 CCR 1300.67.2.2.(c)(7); 28 CCR 1300.70(a)(3)**

| Assessment Questions   | Yes | No | N/A |
|--|-----|----|-----|
| 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 If the Plan operates in a service area that has a shortage of Primary care dentists, does the Plan refer enrollees to or assist the enrollee to locate available and accessible contracted providers in neighboring service areas? |     |    |     |
| 3.3 Do the Plan appointment processes include prompt rescheduling of appointments in a manner appropriate for the enrollee health care needs?  |     |    |     |

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

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### Requirement AA-002: Number and Distribution of Specialists

#### STATUTORY/REGULATORY CITATIONS

##### **CA Health and Safety Code section 1345(i)**

(i) "Provider" means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

##### **CA Health and Safety Code section 1367(d)**

(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

##### **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 1367.3.

**(Section 1367.3 refers to the Department's Timely Regulations.)**

##### **28 CCR 1300.67.2(d) and (e)**

(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 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;

##### **28 CCR 1300.67.2.2.(c)(1)**

(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.

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### 28 CCR 1300.67.2.2.(c)(7)

(c) Standards for Timely Access to Care.

(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-elapased standards, by referring enrollees to, or, in the case of a preferred provider network, by assisting enrollees to locate, available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. Plans shall arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network, when medically necessary for the enrollee's condition. Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

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

**Staff responsible for the activities described above, for example:**

- Dental 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 specialists
- Policies and procedures to periodically review and update the standards for the number and distribution of specialists
  - Record of periodic review of the standards for the number and distribution of specialists, including minutes of relevant Committee Meetings (QM Committee, Public Policy Committee, etc.)
- Documents that demonstrate how the Plan ensures that appropriate specialty services are available without delays detrimental to the health of the enrollees, including out of network referrals, if service is unavailable within network, and medically necessary for the enrollee's medical condition.
- Documents that demonstrate how the Plan defines high-volume specialists



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- Documents that define the availability of specialty services (including the number or percentage of open practices)
- Summary referral data indicating number of referrals for each specialty within a given timeframe
- Plan specialist access reports and analysis
- 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.

### AA-002 - Key Element 1:

- 1. The Plan has established a standard for the number of dentists within the service area. The standard provides for at least one full-time equivalent dentist to each 1,200 enrollees or the Plan may provide an alternative mechanism (i.e., via the filing of a material modification) to demonstrate an adequate ratio of dentist to enrollees.**  
**28 CCR 1300.67.2(d) and (e); 28 CCR 1300.67.2.2.(c)(1); 28 CCR 1300.67.2.2.(c)(7)**

| Assessment Questions   | Yes | No | N/A |
|--|-----|----|-----|
| 1.1 Does the Plan have an established standard on the ratio of dentists to enrollees?  |     |    |     |
| 1.2 Does the Plan's standard provide for at least one dentist for each 1,200 enrollees?  |     |    |     |
| 1.3 If "no," has the Plan established an alternative standard?   |     |    |     |
| 1.4 If the Plan has established an alternative standard, has this standard been submitted to the Department via the filing of a material modification? |     |    |     |

### AA-002 - Key Element 2:

- 2. The Plan has established a standard for the distribution of and accessibility to medically required specialists.**  
**CA Health and Safety Code section 1367(d); CA Health and Safety Code section 1367(e)(1); 28 CCR 1300.67.2(d) and (e); 28 CCR 1300.67.2.2.(c)(1); 28 CCR 1300.67.2.2(c)(7)**

| Assessment Question  | Yes | No | N/A |
|--|-----|----|-----|
| 2.1 Does the Plan have an established standard on the distribution of and accessibility to specialists in its network? |     |    |     |

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### End of Requirement AA-002: Number and Distribution of Specialists

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### Requirement AA-003: Hours of Operation and After Hours Service

#### STATUTORY/REGULATORY CITATIONS

##### **CA Health and Safety Code section 1367(d)**

(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

##### **CA Health and Safety Code section 1367(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 1367.3.

**(Section 1367.3 refers to the Department's Timely Access Regulations.)**

##### **28 CCR 1300.67.2(b) and (d)**

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;

(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 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;

##### **28 CCR 1300.67.2(d)**

(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 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;

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### **28 CCR 1300.67.2(f)**

(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 1300.67.2.2.(c)(1), (7) and (10)**

(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.

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

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

(B) A plan operating in a service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring enrollees to, or, in the case of a preferred provider network, by assisting enrollees to locate, available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. Plans shall arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network, when medically necessary for the enrollee's condition. Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

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

### **28 CCR 1300.67.2.2.(c)(7)**

(c) Standards for Timely Access to Care.

(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

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this section, including applicable time-elapsed standards, by referring enrollees to, or, in the case of a preferred provider network, by assisting enrollees to locate, available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. Plans shall arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network, when medically necessary for the enrollee's condition. Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

### **28 CCR 1300.67.2.2.(c)(9)**

(c) Standards for Timely Access to Care.

(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 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.

### **28 CCR 1300.67.2.2.(d)(1)**

(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.

### **28 CCR 1300.70(a)(3)**

(a) Intent and Regulatory Purpose.

(3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.

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### **28 CCR 1300.80(b)(5)(D)**

(b) The onsite medical survey of a plan shall include, but not be limited to, the following procedures to the extent considered necessary based upon prior experience with the plan and in accordance with the procedures and standards developed by the Department.

(5) Review of the overall performance of the plan in providing health care benefits, by consideration of the following:

(D) The practice of health professionals and allied personnel in a functionally integrated manner, including the extent of shared responsibility for patient care and coordinated use of equipment, medical records and other facilities and services;

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

**Staff responsible for the activities described above, for example:**

- Dental 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-003 - 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.**

**CA Health and Safety Code section 1367(d); 28 CCR 1300.67.2(b) and (d); 28 CCR 1300.67.2.2.(c)(1), (7) and (10)**

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| Assessment Questions  | Yes | No | N/A |
|---|-----|----|-----|
| 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 assist enrollees to contracted neighboring service areas when there is a shortage of primary dentists in a particular area? |     |    |     |
| 1.4 Does the Plan arrange for specialty care outside the network if medically necessary for the enrollee?                                     |     |    |     |

### AA-003 - 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)(7); 28 CCR 1300.67.2.2.(c)(9)**

| Assessment Questions  | Yes | No | N/A |
|---|-----|----|-----|
| 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 is 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?                          |     |    |     |

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|   |  |  |  |
|---|--|--|--|
| 2.7 Does the answering service, or answering machine used during non-business hours provide instructions regarding:<br>(a) How enrollees may obtain urgent or emergency care?<br>(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-003 - 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 1300.70(a)(3); 28 CCR 1300.67.2(d);-28 CCR 1300.67.2.2(d)(1); 28 CCR 1300.80(b)(5)(D)**

| Assessment Questions   | Yes | No | N/A |
|--|-----|----|-----|
| 3.1 Has the Plan established standards for hours of operations and after-hours services?                             |     |    |     |
| 3.2 Does the Plan disseminate its standards to providers (e.g., via provider contracts, provider manual, etc.)?      |     |    |     |
| 3.3 Does the Plan have a system of audits and/or monitoring tools used to evaluate provider compliance to standards? |     |    |     |
| 3.4 Does the Plan regularly monitor providers' performance against its standards and evaluate results?               |     |    |     |
| 3.5 Does the Plan implement corrective action and follow-up review to address any deficiencies?                      |     |    |     |
| 3.6 Does the Plan periodically review the appropriateness of its standards and update it when indicated?             |     |    |     |

### End of Requirement AA-003: Hours of Operation and After Hours Service



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### Requirement AA-004: Appointment Availability

#### STATUTORY/REGULATORY CITATIONS

##### **CA Health and Safety Code section 1367(d)**

The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

##### **CA Health and Safety Code section 1367(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 1367.3.

**(Section 1367.3 refers to the Department's timely access to care regulations.)**

##### **28 CCR 1300.67.1(a), (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:

(a) The availability of primary care physicians, who will be responsible for coordinating the provision of health care services to each enrollee;

(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(e) and (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;

(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.

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### **28 CCR 1300.67.2.2.(c)(3), (4), and (6)**

(c) Standards for Timely Access to Care.

(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.

(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.

### **28 CCR 1300.67.2.2.(c)(6)**

(c) Standards for Timely Access to Care.

(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.

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### **28 CCR 1300.67.2.2.(d)(1)**

(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.

### **28 CCR 1300.70(a)(3)**

(a) Intent and Regulatory Purpose.

(3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.

### **28 CCR 1300.70(b)(2)(G)(5)**

(b) Quality Assurance Program Structure and Requirements.

(2) Program Requirements.

(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:

In order to meet these obligations each plan's QA program shall meet all of the following requirements:

(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.

## **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

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### DOCUMENTS TO BE REVIEWED

- Policies and procedures that define appointment availability and the Plan's standards for the provision of covered services in a timely manner
- 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-004 - Key Element 1:

- 1. The Plan ensures that contracted dental provider networks have adequate capacity and availability of licensed health care providers to offer enrollees appointments for covered dental service in accordance with requirements.  
28 CCR 1300.67.2.2.(c)(6)**

| Assessment Questions  | Yes | No | N/A |
|---|-----|----|-----|
| 1.1 Are urgent appointments within the dental plan network offered within 72 hours of the time of request?  |     |    |     |
| 1.2 Are non-urgent appointments offered within 36 business days of the request for appointment?             |     |    |     |
| 1.3 Are preventive dental care appointments offered within 40 business days of the request for appointment? |     |    |     |

### AA-004 - Key Element 2:

- 2. 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 1300.67.1(a), (d) and (e); 28 CCR 1300.67.2(e) and (f); 28 CCR 1300.67.2.2.(c)(3), (4), and (6); 28 CCR 1300.67.2.2.(d)(1)**

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| Assessment Questions  | Yes | No | N/A |
|---|-----|----|-----|
| 2.1 Does the health Plan have a documented system of monitoring and evaluating access to care, including waiting time and appointments consistent with time elapsed standards noted in Key Element 1?                                       |     |    |     |
| 2.2 Does the documented system for monitoring and evaluating access to care include <b>urgent</b> appointments?   |     |    |     |
| 2.3 Does the documented system for monitoring and evaluating access to care include <b>non-urgent</b> appointments?   |     |    |     |
| 2.4 Does the documented system for monitoring and evaluating access to care include <b>preventive</b> dental care appointments?   |     |    |     |
| 2.5 Does the documented system for monitoring and evaluating <b>include rescheduling</b> of appointments to ensure rescheduling is prompt and consistent with health care needs, continuity of care?  |     |    |     |
| 2.6 Does the Plan monitor coordination of language interpreters with scheduled appointments?  |     |    |     |
| 2.7 Does the Plan monitor to ensure providers use an answering service or telephone answering machine during non-business hours?  |     |    |     |
| 2.8 Does the Plan monitor to ensure the answering service provides instructions regarding how enrollees may <b>obtain urgent or emergency</b> care?   |     |    |     |
| 2.9 Does the Plan monitor to ensure the answering service provides information, 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? |     |    |     |
| 2.10 Does the Plan monitor performance against the standards?   |     |    |     |
| 2.11 Does the Plan monitor telephone service accessibility?   |     |    |     |
| 2.12 Does the Plan evaluate network capacity to ensure that its contracted provider network has the adequate capacity and availability of licensed provider to offer enrollees appointments that meet time elapsed standards?               |     |    |     |
| 2.13 When the Plan identifies problems, does it take action to ensure appointment availability?   |     |    |     |
| 2.14 When the Plan identifies problems, does it monitor to assure improvements are maintained?  |     |    |     |

### End of Requirement AA-004: Appointment Availability

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### Requirement AA-005: Enrollee Health Education

#### STATUTORY/REGULATORY CITATIONS

##### **28 CCR 1300.6(f)(8)**

The basic health care services required to be provided by a health care service plan to its enrollees shall include, where medically necessary, subject to any co-payment, deductible, or limitation of which the Director may approve:

- (f) Preventive health services (including services for the detection of asymptomatic diseases), which shall include, under a physician's supervision,
- (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 1300.67.2(g)**

A section of the health education program shall be designated to inform enrollees regarding accessibility of service in accordance with the needs of such enrollees for such information regarding that Plan or area.

##### **28 CCR 1300.70(b)(2)(G)**

- (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:

- (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.

#### 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 Web sites

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

### AA-005 - Key Element 1:

1. 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  | Yes | No | N/A |
|--|-----|----|-----|
| 1.1 Does the Plan have effective health education services that include information regarding personal health behavior and optimal use of preventive services provided under the Plan? |     |    |     |

### AA-005 - Key Element 2:

2. The Plan regularly distributes materials to each enrollee that explain how to access Plan services.

**28 CCR 1300.67.2(g)**

| Assessment Questions   | Yes | No | N/A |
|--|-----|----|-----|
| 2.1 Has the Plan developed materials that explain how to access <b>primary</b> dental care services?   |     |    |     |
| 2.2 Has the Plan developed materials that explain how to access <b>specialty</b> dental care services? |     |    |     |
| 2.3 Has the Plan developed materials that explain how to access <b>after-hours</b> care?               |     |    |     |
| 2.4 Has the Plan developed materials that explain how to access <b>urgent</b> care?                    |     |    |     |
| 2.5 Has the Plan developed materials that explain how to access <b>emergency</b> care?                 |     |    |     |
| 2.6 Does the Plan regularly distribute the materials to enrollees?                                     |     |    |     |

### AA-005 - Key Element 3:

3. The Plan ensures that Health Education Programs conducted by delegated entities inform enrollees how to access services.

**28 CCR 1300.67.2(g); 28 CCR 1300.70(b)(2)(G)**

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| <b>Assessment Questions</b>   | <b>Yes</b> | <b>No</b> | <b>N/A</b> |
|---|------------|-----------|------------|
| 3.1 Does the Plan rely or delegate responsibility for health education to its providers?  |            |           |            |
| 3.2 If the Plan relies on delegation of health education to its contracted providers, does the delegated program inform in enrollee on how to access services?          |            |           |            |
| 3.3 If yes, to 1.2, 1.3, does the Plan have a system of oversight to monitor enrollee information and health education services by its contracted providers?            |            |           |            |
| 3.4 Does the Plan ensure that delegated entities inform enrollees how to access (as applicable to the delegate's responsibilities) <b>primary</b> dental care services? |            |           |            |
| 3.5 Does the Plan ensure that delegated entities inform enrollees how to access (as applicable to the delegate's responsibilities) <b>specialty</b> care services?      |            |           |            |
| 3.6 Does the Plan ensure that delegated entities inform enrollees how to access (as applicable to the delegate's responsibilities) <b>after-hours</b> care?             |            |           |            |
| 3.7 Does the Plan ensure that delegated entities inform enrollees how to access (as applicable to the delegate's responsibilities) <b>urgent</b> care?                  |            |           |            |
| 3.8 Does the Plan ensure that delegated entities inform enrollees how to access (as applicable to the delegate's responsibilities) <b>emergency</b> care?               |            |           |            |

### End of Requirement AA-005: Enrollee Health Education



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### Requirement AA-006: Preventive Health Care

#### STATUTORY/REGULATORY CITATIONS

##### **28 CCR 1300.67(f)(1)**

The basic health care services required to be provided by a health care service plan to its enrollees shall include,

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

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

##### **28 CCR 1300.70(b)(2)(A)**

(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:

(A) There must be a written QA plan describing the goals and objectives of the program and organization arrangements, including staffing, the methodology for on-going monitoring and evaluation of health services, the scope of the program, and required levels of activity.

##### **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:

(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.

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

**Staff responsible for the activities described above, for example:**

- Dental 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-006 - Key Element 1:

1. **The Plan has established preventive care standards. The Plan has disseminated its standards to its providers, regularly monitors performance against the standards and addresses any deficiencies.**  
28 CCR 1300.67(f)(1); 28 CCR 1300.70(b)(2)(A); 28 CCR 1300.70(b)(2)(G)(5) and (6)

| Assessment Questions   | Yes | No | N/A |
|--|-----|----|-----|
| 1.1 Does the Plan have established preventive standards?   |     |    |     |
| 1.2 Does the Plan use appropriate methods in developing or adopting preventive health standards?   |     |    |     |
| 1.3 Does the Plan have an effective mechanism for distributing its standards to participating providers?   |     |    |     |
| 1.4 Does the Plan monitor the provision of preventive services on an individual and Plan-wide basis?   |     |    |     |
| 1.5 Does the Plan regularly measure the level of preventive care provided to enrollees against its established standards?  |     |    |     |
| 1.6 Does the Plan critically evaluate the results of preventive care monitoring?   |     |    |     |
| 1.7 Does the Plan <b><u>develop and implement</u></b> corrective actions or QM Programs with measurable goals to increase levels of preventive care for enrollees? |     |    |     |

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| <b>Assessment Questions</b>  | <b>Yes</b> | <b>No</b> | <b>N/A</b> |
|--|------------|-----------|------------|
| 1.8 Does the Plan re- <b>measure and critically evaluate</b> the results of corrective actions or QM Programs to increase levels of preventive care for enrollees?   |            |           |            |
| 1.9 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? |            |           |            |

### End of Requirement AA-006: Preventive Health Care

## DENTAL TAG

### Requirement AA-007: List of Contracting Providers Available Upon Request

#### STATUTORY/REGULATORY CITATIONS

**CA Health and Safety Code sections 1367.26(a)(1) through (3), and (b) though (g)**

(a) A health care service plan shall provide, upon request, a list of the following contracting providers, within the enrollee's or prospective enrollee's general geographic area:

(1) Primary care (dental) providers.

(2) Medical/(dental) groups.

(3) Independent practice associations.

(b) This list shall indicate which providers have notified the plan that they have closed practices or are otherwise not accepting new patients at that time.

(c) The list shall indicate that it is subject to change without notice and shall provide a telephone number that enrollees can contact to obtain information regarding a particular provider. This information shall include whether or not that provider has indicated that he or she is accepting new patients.

(d) A health care service plan shall provide this information in written form to its enrollees or prospective enrollees upon request. A plan may, with the permission of the enrollee, satisfy the requirements of this section by directing the enrollee or prospective enrollee to the plan's provider listings on its website. Plans shall ensure that the information provided is updated at least quarterly. A plan may satisfy this update requirement by providing an insert or addendum to any existing provider listing. This requirement shall not mandate a complete republishing of a plan's provider directory.

(e) Each plan shall make information available, upon request, concerning a contracting provider's professional degree, board certifications, and any recognized subspecialty qualifications a specialist may have.

(f) Nothing in this section shall prohibit a plan from requiring its contracting providers, contracting provider groups, or contracting specialized health care plans to satisfy these requirements. If a plan delegates the responsibility of complying with this section to its contracting providers, contracting provider groups, or contracting specialized health care plans, the plan shall ensure that the requirements of this section are met.

(g) Every health care service plan shall allow enrollees to request the information required by this section through their toll-free telephone number or in writing.

**CA Health and Safety Code section 1367.26(d)**

(d) A health care service plan shall provide this information in written form to its enrollees or prospective enrollees upon request. A plan may, with the permission of the enrollee, satisfy the requirements of this section by directing the enrollee or prospective enrollee to the plan's provider listings on its website. Plans shall ensure that the information provided is updated at least quarterly. A plan may satisfy this update

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requirement by providing an insert or addendum to any existing provider listing. This requirement shall not mandate a complete republishing of a plan's provider directory.

### CA Health and Safety Code section 1367.26(e) and (g)

(e) Each plan shall make information available, upon request, concerning a contracting provider's professional degree, board certifications, and any recognized subspecialty qualifications a specialist may have.

(g) Every health care service plan shall allow enrollees to request the information required by this section through their toll-free telephone number or in writing.

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

Staff responsible for the activities described above, for example:

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

### DOCUMENTS TO BE REVIEWED

- Plan Provider Directory
- Electronic version of the Plan's Provider Directory and the Plan's online Provider Directory
- Any available updates to the Plan Provider Directory.
- Policies and procedures relevant to the update of contact information for contracted providers.
- Previous versions of the Plan Provider Directory that show that modifications have been made, where needed.
- Documents and correspondence between the Plan and contracted providers that indicate any changes to the provider's contact information.

### AA-007 - Key Element 1:

1. The Plan has a complete list of contracted providers that includes all required information.

CA Health and Safety Code sections 1367.26(a)(1) through (3), and (b) through (g)

| Assessment Questions  | Yes | No | N/A |
|---|-----|----|-----|
| 1.1 Does the Plan have a list of all of its contracted providers?   |     |    |     |
| 1.2 Does the Plan maintain records of each provider's professional degree, board certifications, and any recognized subspecialty qualifications that a specialist may have? |     |    |     |

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| Assessment Questions  | Yes | No | N/A |
|---|-----|----|-----|
| 1.3 Does the Plan's list of contracted providers indicate which providers have notified the plan that they have closed practices?   |     |    |     |
| 1.4 Does the Plan's list of contracted providers indicate which providers are not accepting new patients at this time?  |     |    |     |
| 1.5 Does the Plan's list of contracted providers indicate that the list is subject to change without notice?  |     |    |     |
| 1.6 Does the Plan's list of contracted providers include a telephone number that enrollees can contact to obtain information regarding a particular provider, including whether or not that provider is accepting new patients? |     |    |     |

### AA-007 - Key Element 2:

#### **2. The Plan properly updates its list of contracted providers. CA Health and Safety Code section 1367.26(d)**

| Assessment Questions   | Yes | No | N/A |
|--|-----|----|-----|
| 2.1 Does the Plan either: a) provide the provider list in written form to its enrollees and prospective enrollees upon request or, b) with the permission of the enrollee or prospective enrollee, refer the inquiry to the Plan's Web site? |     |    |     |
| 2.2 Does the Plan have policies and procedures that ensure that all of the information contained in its provider directory is updated quarterly?   |     |    |     |

### Key Element 3:

#### **3. The Plan provides provider information to its enrollees upon telephone or written request. CA Health and Safety Code section 1367.26(e) and (g)**

| Assessment Questions  | Yes | No | N/A |
|---|-----|----|-----|
| 3.1 Does the Plan provide enrollees and prospective enrollees with provider information through their toll-free telephone number or in writing?   |     |    |     |
| 3.2 Does the Plan provide information to enrollees and prospective enrollees about each provider's professional degree, board certifications, and any recognized sub-specialty qualifications that a sub-specialist may have? |     |    |     |

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### End of Requirement AA-007: List of Contracting Providers Available Upon Request