**§ 1367.031. Information regarding standards for timely access to health care services**

(a) A health care service plan contract that is issued, renewed, or amended on or after July 1, 2017, shall provide information to an enrollee regarding the standards for timely access to care adopted pursuant to Section 1367.03 and the information required by this section, including information related to receipt of interpreter services in a timely manner, no less than annually.

(b) A health care service plan contract that is issued, renewed, or amended on or after July 1, 2022, shall provide information to an enrollee regarding the standards for timely access to care required by Section 1367.03 and the information required by this section, including information related to receipt of interpreter services in a timely manner, no less than annually.

(c) A health care service plan at a minimum shall provide information regarding appointment wait times for urgent care, nonurgent primary care, nonurgent specialty care, and telephone screening established in Section 1367.032 or pursuant to Section 1367.03 to enrollees and contracting providers. The information shall also include notice of the availability of interpreter services at the time of the appointment pursuant to Section 1367.04. A health care service plan may indicate that exceptions to appointment wait times may apply if the department has found exceptions to be permissible.

(d) The information required to be provided pursuant to this section shall be provided to an enrollee with individual coverage upon initial enrollment and annually thereafter upon renewal, and to enrollees and subscribers with group coverage upon initial enrollment and annually thereafter upon renewal. A health care service plan may include this information with other materials sent to the enrollee. The information shall also be provided in the following manner:

(1) In a separate section of the evidence of coverage titled "Timely Access to Care."

(2) At least annually, in or with newsletters, outreach, or other materials that are routinely disseminated to the plan's enrollees.

(3) Commencing January 1, 2018, in a separate section of the provider directory published and maintained by the health care service plan pursuant to Section 1367.27. The separate section shall be titled "Timely Access to Care."

(4) On the internet website published and maintained by the health care service plan, in a manner that allows enrollees and prospective enrollees to easily locate the information.

(e)(1) A health care service plan shall provide the information required by this section to contracting providers on no less than an annual basis.

(2) A health care service plan shall also inform a contracting provider of all of the following:

(A) Information about a health care service plan's obligation under California law to provide or arrange for timely access to care.

(B) How a contracting provider or enrollee can contact the health care service plan to obtain assistance if a patient is unable to obtain a timely referral to an appropriate provider.

(C) The toll-free telephone number and internet website address for the Department of Managed Health Care where providers and enrollees can file a complaint if they are unable to obtain a timely referral to an appropriate provider.

(3) A health care service plan may comply with this subdivision by including the information with an existing communication with a contracting provider.

(f) This section shall apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

**HISTORY:**

Added Stats 2016 ch 500 § 1 (SB 1135), effective January 1, 2017. Amended Stats 2021 ch 724 § 3 (SB 221), effective January 1, 2022; Stats 2022 ch 601 § 2 (SB 225), effective January 1, 2023.

## § 1367.035. Standards for timely access to health care services; Required inclusion of network adequacy data

(a) As part of the reports submitted to the department pursuant to subdivision (f) of Section 1367.03 and regulations adopted pursuant to that section, a health care service plan shall submit to the department, in a manner specified by the department, data regarding network adequacy, including, but not limited to, the following:

(1) Provider office location.

(2) Area of specialty.

(3) Hospitals where providers have admitting privileges, if any.

(4) Providers with open practices.

(5) The number of patients assigned to a primary care provider or, for providers who do not have assigned enrollees, information that demonstrates the capacity of primary care providers to be accessible and available to enrollees.

(6) Grievances regarding network adequacy and timely access that the health care service plan received during the preceding calendar year.

(b) A health care service plan that uses a network for its Medi-Cal managed care product line that is different from the network used for its other product lines shall submit the data required under subdivision (a) for its Medi-Cal managed care product line separately from the data submitted for its other product lines.

(c) A health care service plan that uses a network for its individual market product line that is different from the network used for its small group market product line shall submit the data required under subdivision (a) for its individual market product line separate from the data submitted for its small group market product line.

(d) The department shall review the data submitted pursuant to this section for compliance with this chapter.

(e) In submitting data under this section, a health care service plan that provides services to Medi-Cal beneficiaries pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code shall provide the same data to the State Department of Health Care Services pursuant to Section 14456.3 of the Welfare and Institutions Code.

(f) In developing the format and requirements for reports, data, or other information provided by plans pursuant to subdivision (a), the department shall not create duplicate reporting requirements, but, instead, shall take into consideration all existing relevant reports, data, or other information provided by plans to the department. This subdivision does not limit the authority of the department to request additional information from the plan as deemed necessary to carry out and complete any enforcement action initiated under this chapter.

(g) If the department requests additional information or data to be reported pursuant to subdivision (a), which is different or in addition to the information required to be reported in paragraphs (1) to (6), inclusive, of subdivision (a), the department shall provide health care service plans notice of that change by November 1 of the year prior to the change.

(h) A health care service plan may include in the provider contract provisions requiring compliance with the reporting requirements of Section 1367.03 and this section.

**HISTORY:**

Added Stats 2014 ch 573 § 2 (SB 964), effective January 1, 2015. Amended Stats 2015 ch 303 § 253 (AB 731), effective January 1, 2016.