Technical Assistance Guide

for Medical Audits

Category 3 –
Access and
Availability of Care

TABLE OF CONTENTS

Introduction

In accordance with California Welfare and Institutions Code Section 14456, the Department of Health Care Services (DHCS) conducts medical audits of Medi-Cal managed care plans (MCPs) on an annual basis. Medical audits evaluate MCPs' compliance with the DHCS contractual requirements and applicable laws and regulations. DHCS' Managed Care Quality and Monitoring Division (MCQMD) is responsible for ensuring overall monitoring and oversight of MCPs. MCQMD designates the Medical Review Branch (MRB) of DHCS' Audits and Investigations Division (A&I) to perform the mandated audits. The audit scope encompasses the following six categories of review:

- Category 1 – Utilization Management
- Category 2 – Case Management and Coordination of Care
- Category 3 – Access and Availability
- Category 4 – Member's Rights
- Category 5 – Quality Improvement
- Category 6 – Administrative and Organizational Capacity

Guidance on Using the Technical Assistance Guide (TAG)

MCQMD and A&I have partnered together to create Technical Assistance Guides (TAG) for each category of review. The TAGs are designed to identify key elements that will be commonly evaluated to inform MCPs of the audit process and increase transparency. To this end, each TAG is broken down by subcategories and includes the following components, as applicable:

- **Contract Language:** This section identifies "key" contract provisions[1] that are the focus of review for each subcategory. While references to specific provisions may assist the MCP with narrowing the scope of review in preparation for the audit, it does not preclude the audit team from investigating the MCP's compliance with other contract requirements not explicitly named. MCPs are ultimately responsible for ensuring compliance with *all* provisions of the DHCS contract as well as any applicable All Plan Letters (APLs) and Plan Letters (PLs). The contract provisions included in the TAG are intended to serve as guidance only as well as a quick point of reference.

- **Documentation Reviewed:** The items listed in this section reflect common *initial* documentation requests and not subsequent follow-up requests that may be warranted after initial review and interviews with the MCP. The initial documentation request includes, but is not limited to: policies and procedures, organizational charts, committee meeting minutes, monitoring reports, data logs, etc. While the documentation provides the audit team with a general overview of the operational structure and the team may glean insight regarding compliance with some contractual requirements, it is not all encompassing. Therefore, to ease the burden of further document requests made onsite, the MCP is advised to submit

[1] The TAGs cite language from the general Two-Plan Boilerplate Contract. Each MCP should reference its own Plan-specific contract to confirm requirements.

additional pre-onsite documentation for review (even if not explicitly requested) if the MCP believes that review of such information would assist the audit team with assessing compliance in any of the subcategories.

- **Verification Study (if applicable):** This section appears within a designated subcategory when a verification study (i.e., review of specific files such as grievances, prior authorizations, claims, etc.) may be used to assist with measuring compliance. The MCP is instructed to provide data in a prescribed format (i.e., spreadsheet containing all files for the audit review period). The log will assist the audit team with selection of specific files for onsite review. The audit team is neither precluded from conducting additional verification studies as needed nor expected to consistently conduct all verification studies listed in this TAG.

- **Examples of Best Practices:** This section details examples of best practices. The examples listed include strategies that some MCPs have implemented to either demonstrate compliance with a given standard or successfully remediate an identified deficiency. Every MCP and every audit is unique and best practices do not always transfer seamlessly. While the audit team does not audit to best practices, the burden is on the MCP to demonstrate that it is meeting its contractual obligations. To this end, examples of best practices emphasize the MCP's ability to produce *documented evidence* to substantiate that the MCP is in compliance with the contract requirements. When monitoring efforts reveal patterns of non-compliance, the MCP should similarly be able to produce documented evidence of barrier analysis and remedial actions enacted to substantiate efforts to bring the MCP into compliance.

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1 APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

CONTRACT REQUIREMENT	DOCUMENTATION REVIEWED	VERIFICATION STUDY	EXAMPLES OF BEST PRACTICES
Exhibit A, Attachment 9 – ACCESS AND AVAILABILITY **3. Access Requirements** A. Appointments Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.	-Policies and procedures -Member Handbook/EOC -Provider Manual		-The Plan's policies and procedures demonstrate alignment and consistency with all appointment wait time standards. -The Member Handbook/EOC and Provider Manual clearly display timeframes which are consistent with all appointment wait time standards. -The Plan's policies and procedures detail monitoring activities to ensure timely access to appointments (e.g., Member and Provider Satisfaction surveys, review and generation of internal monitoring reports at a set frequency, examination of access-related grievances, etc.). -The Plan's policies and procedures indicate appropriate follow-up action and re-measurement activities when monitoring efforts identify providers as non-compliant with appointment wait time standards. -The Plan's policies and procedures include processes for follow-up on missed appointments (e.g., standard Plan-prescribed protocols that providers must follow for the rescheduling of appointments, Plan review of providers' internal protocols for the rescheduling of appointments, ongoing provider education and training conducted by the Plan to communicate expectations, periodic monitoring/oversight by the Plan to ensure providers follow prescribed protocols/standards, etc.).
B. First Prenatal Visit Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request. (10 business days for COHS)	-Policies and procedures -Member Handbook/EOC -Provider Manual -Provider and Member Satisfaction surveys -Provider newsletters -Internal monitoring reports	-A random sampling of OBGYN providers may be sampled to assess the third-next available appointment for first prenatal appointments.	-The Plan's policies and procedures demonstrate alignment and consistency with the wait time standard for prenatal appointments. -The Member Handbook/EOC and Provider Manual clearly display timeframes which are consistent with the wait time standard for prenatal appointments. -The Plan conducts annual Provider and Member Satisfaction surveys (e.g., PAAS, CAHPs, etc.) which incorporate assessment of timely access to the first prenatal appointment.

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
			-Aside from annual surveys, the Plan conducts internal monitoring on a more frequent basis (e.g., biannual, quarterly, monthly, etc.) to ensure continual compliance with the timely access standard for prenatal appointments (e.g., secret shopper, targeted focused study, collection of data for the third-next available appointment, etc.). -The Plan generates a report card summarizing appointment access survey results and distributes the results to provider groups, imposing CAPs as necessary. -When monitoring efforts reveal instances of non-compliance, the Plan consistently documents follow-up action taken for all non-compliant providers (e.g., issuance of CAPs, re-measurement activities, provider re-training, Provider Services outreach, etc.). -The Plan ensures that all monitoring reports are reviewed by appropriate parties (e.g., Provider Services Department, Access Committee, Quality Improvement Committee, Board, etc.) to conduct root cause analyses and identify opportunities for quality improvement. Review and discussion are evidenced by documented meeting minutes. -The Plan conducts initial and ongoing training for customer service staff who respond to member inquiries and grievances. The Plan provides documented evidence of training (e.g. sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.) which address the appointment wait time standard for prenatal appointments. -The Plan conducts initial and ongoing training for providers. The Plan provides documented evidence of training (e.g. sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.) which address the appointment wait time standard for prenatal appointments.

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
			-The Plan conducts periodic outreach to remind providers about the appointment wait time standard for prenatal appointments (e.g., Provider Manual, provider newsletters, fax blasts, site visits, etc.). -The Plan aggregates grievance data to track and trend complaints related to appointment wait times for quality improvement purposes. -The Plan continually monitors its network of OBGYN providers by receiving, reviewing, and updating its provider rosters on a regular basis.
C. Waiting Times Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments indicated in Paragraph A. Appointments, above.	-Policies and procedures -Provider Manual -Provider and Member Satisfaction surveys -Provider newsletters -Internal monitoring reports		-The Plan's policies and procedures delineate the Plan's internal standard for wait times in providers' offices as well as the time it takes to answer and return telephone calls. -The Plans policies and procedures address monitoring activities to assess compliance with standards for wait times in providers' offices as well as the time it takes to answer and return telephone calls. -The Plan conducts internal monitoring (e.g., Provider and Member Satisfaction surveys, provider site visits secret shopper, targeted focused study, etc.) at a set frequency (e.g., biannual, quarterly, monthly, etc.) to ensure continual compliance and adherence to its internal protocols regarding in-office and telephone wait times. -When monitoring efforts reveal instances of non-compliance, the Plan consistently takes follow-up action for all non-compliant providers and provides documented evidence as substantiation (e.g., issuance of CAPs, re-measurement activities, provider re-training, Provider Services outreach, discussion in Access Committee meeting minutes, etc.). -The Plan ensures that all monitoring reports are reviewed by appropriate parties (e.g., Provider Services Department, Access Committee, Quality Improvement Committee, Board, etc.) to conduct root cause analyses and identify opportunities for quality improvement. Review

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
			and discussion are evidenced by documented meeting minutes. -The Plan conducts initial and ongoing training for providers. The Plan provides documented evidence of training (e.g. sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.) which address in-office and telephone wait times. -The Plan conducts periodic outreach to remind providers about in-office and telephone wait time standards (e.g., Provider Manual, provider newsletters, fax blasts, site visits, etc.). -The Plan aggregates grievance data to track and trend complaints related to in-office wait times for quality improvement purposes.
Exhibit A, Attachment 9 – ACCESS AND AVAILABILITY **4. Access Standards** B. Standards for Timely Appointments Members must be offered appointments within the following timeframes: 3) Non-urgent primary care appointments – within ten (10) business days of request;	-Policies and procedures -Member Handbook/EOC -Provider Manual -Provider and Member Satisfaction surveys -Provider newsletters -Internal monitoring reports	-A random sampling of PCPs may be sampled to assess the third-next available appointment for non-urgent primary care appointments.	-The Plan's policies and procedures demonstrate alignment and consistency with the wait time standard for non-urgent primary care appointments. -The Member Handbook/EOC and Provider Manual clearly display timeframes which are consistent with the wait time standard for non-urgent primary care appointments. -The Plan conducts annual Provider and Member Satisfaction surveys (e.g., PAAS, CAHPs, etc.) which incorporate assessment of timely access to non-urgent primary care appointments. -Aside from annual surveys, the Plan conducts internal monitoring on a more frequent basis (e.g., biannual, quarterly, monthly, etc.) to ensure continual compliance with the timely access standard for non-urgent primary care appointments (e.g., secret shopper, targeted focused study, collection of data for the third-next available appointment, etc.). -The Plan generates a report card summarizing appointment access survey results and distributes the results to provider groups, imposing CAPs as necessary. -When monitoring efforts reveal instances of non-compliance, the Plan consistently

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
			documents follow-up action taken for all non-compliant providers (e.g., issuance of CAPs, re-measurement activities, provider re-training, Provider Services outreach, etc.). -The Plan ensures that all monitoring reports are reviewed by appropriate parties (e.g., Provider Services Department, Access Committee, Quality Improvement Committee, Board, etc.) to conduct root cause analyses and identify opportunities for quality improvement. Review and discussion are evidenced by documented meeting minutes. -The Plan conducts initial and ongoing training for customer service staff who respond to member inquiries and grievances. The Plan provides documented evidence of training (e.g. sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.) which address the appointment wait time standard for non-urgent primary care appointments. -The Plan conducts initial and ongoing training for providers. The Plan provides documented evidence of training (e.g. sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.) which address the appointment wait time standard for non-urgent primary care appointments. -The Plan conducts periodic outreach to remind providers about the appointment wait time standard for non-urgent primary care appointments (e.g., Provider Manual, provider newsletters, fax blasts, site visits, etc.). -The Plan aggregates grievance data to track and trend complaints related to appointment wait times for quality improvement purposes. The Plan utilizes specific codes for use by customer service staff to filter out grievances related to primary care appointments. -The Plan continually monitors its network of primary care providers by receiving, reviewing,

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
			and updating its provider rosters on a regular basis.
4) Appointment with a specialist – within 15 business days of request;	-Policies and procedures -Member Handbook/EOC -Provider Manual -Provider and Member Satisfaction surveys -Provider newsletters -Internal monitoring reports	-A random sampling of specialists may be sampled to assess the third-next available appointment for specialist appointments.	-The Plan's policies and procedures demonstrate alignment and consistency with the wait time standard for specialist appointments. -The Member Handbook/EOC and Provider Manual clearly display timeframes which are consistent with the wait time standard for specialist appointments. -The Plan conducts annual Provider and Member Satisfaction surveys (e.g., PAAS, CAHPs, etc.) which incorporate assessment of timely access to specialist appointments. -Aside from annual surveys, the Plan conducts internal monitoring on a more frequent basis (e.g., biannual, quarterly, monthly, etc.) to ensure continual compliance with the timely access standard for specialist appointments (e.g., secret shopper, targeted focused study, collection of data for the third-next available appointment, etc.). The Plan gathers specific data to monitor appointments by specialty type. -The Plan generates a report card summarizing appointment access survey results and distributes the results to provider groups, imposing CAPs as necessary. -When monitoring efforts reveal instances of non-compliance, the Plan consistently documents follow-up action taken for all non-compliant providers (e.g., issuance of CAPs, re-measurement activities, provider re-training, Provider Services outreach, etc.). -The Plan ensures that all monitoring reports are reviewed by appropriate parties (e.g., Provider Services Department, Access Committee, Quality Improvement Committee, Board, etc.) to conduct root cause analyses and identify opportunities for quality improvement. Review and discussion are evidenced by documented meeting minutes. -The Plan conducts initial and ongoing training for customer service staff who respond to member inquiries and grievances. The Plan

3.1	APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
			provides documented evidence of training (e.g. sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.) which address the appointment wait time standard for specialist appointments. -The Plan conducts initial and ongoing training for providers. The Plan provides documented evidence of training (e.g. sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.) which address the appointment wait time standard for specialist appointments. -The Plan conducts periodic outreach to remind providers about the appointment wait time standard for specialist appointments (e.g., Provider Manual, provider newsletters, fax blasts, site visits, etc.). -The Plan aggregates grievance data to track and trend complaints related to appointment wait times for quality improvement purposes. The Plan utilizes specific codes for use by customer service staff to filter out grievances related to specialist appointments. -The Plan continually monitors its network of specialist providers by receiving, reviewing, and updating its provider rosters on a regular basis.
APL 17-010 (Revised 10/17/17) **Non-Medical Transportation and Non-Emergency Medical Transportation Access Standards** MCPs are contractually required to meet timely access standards. MCPs that have a Knox-Keene license are also required to meet the timely access standards contained in Title 28 CCR Section 1300.67.2.2. The member's need for NMT and NEMT services do not relieve the MCPs from complying with their timely access standard obligations.	-Policies and procedures		-The Plan's policies and procedures address the Plan's prior authorization process for reviewing requests for NEMT and NMT services. -The Plan's policies and procedures delineate monitoring activities to assess both authorization and delivery turnaround times for NEMT and NMT services to ensure members' timely access to appointments.

3.2	URGENT CARE / EMERGENCY CARE		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
Exhibit A, Attachment 9 – ACCESS AND AVAILABILITY **4. Access Standards** B. Standards for Timely Appointments Members must be offered appointments within the following timeframes: 1) Urgent care appointment for services that do not require prior authorization – within 48 hours of a request; 2) Urgent appointment for services that do require prior authorization – within 96 hours of a request;	-Policies and procedures -Member Handbook/EOC -Provider Manual -Provider and Member Satisfaction surveys -Provider newsletters -Internal monitoring reports	-A random sampling of urgent care providers may be sampled to assess the third-next available appointment for urgent care appointments.	-The Plan's policies and procedures demonstrate alignment and consistency with the wait time standard for urgent care appointments. -The Member Handbook/EOC and Provider Manual clearly display timeframes which are consistent with the wait time standard for urgent care appointments. -The Plan conducts annual Provider and Member Satisfaction surveys (e.g., PAAS, CAHPs, etc.) which incorporate assessment of timely access to the urgent care appointments. -Aside from annual surveys, the Plan conducts internal monitoring on a more frequent basis (e.g., biannual, quarterly, monthly, etc.) to ensure continual compliance with the timely access standard for urgent care appointments (e.g., secret shopper, targeted focused study, collection of data for the third-next available appointment, etc.). -The Plan generates a report card summarizing appointment access survey results and distributes the results to provider groups, imposing CAPs as necessary. -When monitoring efforts reveal instances of non-compliance, the Plan consistently documents follow-up action taken for all non-compliant providers (e.g., issuance of CAPs, re-measurement activities, provider re-training, Provider Services outreach, etc.). -The Plan ensures that all monitoring reports are reviewed by appropriate parties (e.g., Provider Services Department, Access Committee, Quality Improvement Committee, Board, etc.) to conduct root cause analyses and identify opportunities for quality improvement. Review and discussion are evidenced by documented meeting minutes. -The Plan conducts initial and ongoing training for customer service staff who respond to member inquiries and grievances. The Plan provides documented evidence of training (e.g. sign-in sheets, dates of training, training schedule, etc.) as well as training materials

3.2	URGENT CARE / EMERGENCY CARE		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
			(e.g., desktop procedures, PowerPoint slides, etc.) which address the appointment wait time standard for urgent care appointments. -The Plan conducts initial and ongoing training for providers. The Plan provides documented evidence of training (e.g. sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.) which address the appointment wait time standard for urgent care appointments. -The Plan conducts periodic outreach to remind providers about the appointment wait time standard for urgent care appointments (e.g., Provider Manual, provider newsletters, fax blasts, site visits, etc.). -The Plan aggregates grievance data to track and trend complaints related to appointment wait times for quality improvement purposes. -The Plan continually monitors its network of urgent care providers by receiving, reviewing, and updating its provider rosters on a regular basis.
Exhibit A, Attachment 9 – ACCESS AND AVAILABILITY **7. Emergency Care** Contractor shall ensure that a Member with an emergency condition will be seen on an emergency basis and that emergency services will be available and accessible within the Service Area 24-hours-a-day.	-Policies and procedures -Member Handbook/EOC -Provider Manual -Provider and Member Satisfaction surveys -Internal monitoring reports		-The Plan's policies and procedures, Member Handbook/EOC, and Provider Manual indicate that emergency services are available 24 hours a day and inform members how to access emergency services. -The Plan conducts annual Provider and Member Satisfaction surveys (e.g., PAAS, CAHPs, etc.) which incorporate assessment of access to emergency services.
Exhibit A, Attachment 6 – PROVIDER NETWORK **5. Emergency Services** Contractor shall have, as a minimum, a designated emergency service facility, providing care on a 24 hours a day, 7 days a week basis. This designated emergency service facility will have one or more physicians and one nurse on duty in the facility at all times.	-Provider network data -Provider Directory		-The Plan provides documentation to substantiate that its provider network has at least one designated emergency service facility that provides care on a 24 hours a day, 7 days a week basis. The designated emergency service facility has one or more physicians and one nurse on duty at all times.

3.3	TELEPHONE PROCEDURES / AFTER HOURS CALLS		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
1300.67.2.2(b)(5)(6) (b) Definitions. For purposes of this section, the following definitions apply. 5. "Triage" or "screening" means the assessment of an enrollee's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care, for the purpose of determining the urgency of the enrollee's need for care. 6. "Triage or screening waiting time" means the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care.	-Policies and procedures -Member Handbook/EOC -Provider Manual		-The Plan's policies and procedures, Member Handbook/EOC, and Provider Manual all accurately define "triage."
1300.67.2.2(c)(8)(A)(B) (c) Standards for Timely Access to Care. (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.	-Policies and procedures -Member Handbook/EOC -Provider Manual -Provider and Member Satisfaction surveys -Provider newsletters -Internal monitoring reports		-The Plan's policies and procedures, Member Handbook/EOC, and Provider Manual indicate that telephone triage is available 24 hours per day, 7 days per week and delineate a wait time standard that does not exceed 30 minutes. -The Plan's policies and procedures delineate monitoring activities to ensure that wait times for telephone triage do not exceed 30 minutes for its contracted provider network and/or nurse advice line, as applicable. -The Plan conducts annual Provider and Member Satisfaction surveys (e.g., PAAS, CAHPs, etc.) which incorporate assessment of telephone triage within 30 minutes. -When monitoring efforts reveal instances of non-compliance (for either its contracted provider network and/or nurse advice line, as applicable), the Plan consistently documents follow-up action taken for all non-compliant providers (e.g., issuance of CAPs, re-measurement activities, provider re-training, Provider Services outreach, etc.). -The Plan ensures that all monitoring reports are reviewed by appropriate parties (e.g., Provider Services Department, Access Committee,

3.3	TELEPHONE PROCEDURES / AFTER HOURS CALLS		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
			Quality Improvement Committee, Board, etc.) to conduct root cause analyses and identify opportunities for quality improvement. Review and discussion are evidenced by documented meeting minutes. -The Plan aggregates grievance data to track and trend complaints related to telephone triage wait times for quality improvement purposes.
(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.	-Policies and procedures -Member Handbook/EOC -Provider Manual		-The Plan's policies and procedures, Member Handbook/EOC, and Provider Manual clearly delineate how telephone triage is provided to members (e.g., through the Plan's contracted provider network and/or nurse advice line, etc.). -The Plan provides evidence to demonstrate that information on how to access telephone triage services is well-publicized to members.
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.	-Policies and procedures -Provider contracts -Internal monitoring reports		-If telephone triage is provided through its contracted provider network, the Plan's policies and procedures and/or provider contracts require those contracted providers to maintain telephone triage procedures that inform members during and after business hours of the wait time for a return call (no more than 30 minutes) and how to obtain urgent or emergency care. -The Plan conducts internal monitoring (e.g., documented review of policies and procedures, periodic audits, etc.) to ensure that providers who provide telephone triage maintain procedures that inform members during and after business hours of the wait time for a return call (no more than 30 minutes) and how to obtain urgent or emergency care. -When monitoring efforts reveal instances of non-compliance, the Plan consistently documents follow-up action taken for all non-compliant providers (e.g., issuance of CAPs, re-measurement activities, provider re-training, Provider Services outreach, etc.).

3.3	TELEPHONE PROCEDURES / AFTER HOURS CALLS		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
			-The Plan ensures that all monitoring reports are reviewed by appropriate parties (e.g., Provider Services Department, Access Committee, Quality Improvement Committee, Board, etc.) to conduct root cause analyses and identify opportunities for quality improvement. Review and discussion are evidenced by documented meeting minutes.
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.	-Policies and procedures -Member Handbook/EOC -Internal monitoring reports		-If telephone triage is provided through its contracted provider network, and monitoring efforts reveal instances of non-compliance, the Plan additionally provides telephone triage through a Plan-contracted or operated triage or screening service (e.g., nurse advice line, etc.). -The Plan provides evidence to demonstrate that information on how to access the Plan-contracted or operated triage or screening service is well-publicized to members.
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.	-Policies and procedures -Internal monitoring reports		-The Plan's policies and procedures indicate that telephone triage (whether provided through its contracted provider network and/or a nurse advice line, as applicable) is provided by only licensed staff who can assess, evaluate, advise, and make decisions regarding the condition of a member or determine when a member needs to be seen by a licensed medical professional. -The Plan conducts internal monitoring (e.g., documented review of policies and procedures for its contracted provider network and/or nurse advice line, periodic audits, attestations, etc.) to ensure that telephone triage (whether provided through its contracted provider network and/or a nurse advice line, as applicable) is provided by only licensed staff who can assess, evaluate, advise, and make decisions regarding the condition of a member or determine when a member needs to be seen by a licensed medical professional. -When monitoring efforts reveal instances of non-compliance (for either its contracted provider network and/or nurse advice line, as applicable), the Plan consistently documents follow-up action taken for all non-compliant

3.3	TELEPHONE PROCEDURES / AFTER HOURS CALLS		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
			providers (e.g., issuance of CAPs, re-measurement activities, provider re-training, Provider Services outreach, etc.). -The Plan ensures that all monitoring reports are reviewed by appropriate parties (e.g., Provider Services Department, Access Committee, Quality Improvement Committee, Board, etc.) to conduct root cause analyses and identify opportunities for quality improvement. Review and discussion are evidenced by documented meeting minutes.
Exhibit A, Attachment 9 – ACCESS AND AVAILABILITY **3. Access Requirements** D. Telephone Procedures Contractor shall require providers to maintain a procedure for triaging Members' telephone calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters.	-Policies and procedures -Internal monitoring reports		-If telephone triage is provided through its contracted provider network, the Plan conducts internal monitoring (e.g., documented review of policies and procedures, periodic audits, etc.) to ensure that those providers maintain procedures for triaging members' telephone calls and providing telephone medical advice, if applicable. -The Plan conducts internal monitoring (e.g., documented review of policies and procedures, periodic audits, etc.) to ensure that all providers maintain procedures for providing access to telephone interpreters. -When monitoring efforts reveal instances of non-compliance (for either its contracted provider network and/or nurse advice line, as applicable), the Plan consistently documents follow-up action taken for all non-compliant providers (e.g., issuance of CAPs, re-measurement activities, provider re-training, Provider Services outreach, etc.). -The Plan ensures that all monitoring reports are reviewed by appropriate parties (e.g., Provider Services Department, Access Committee, Quality Improvement Committee, Board, etc.) to conduct root cause analyses and identify opportunities for quality improvement. Review and discussion are evidenced by documented meeting minutes.
E. After Hours Calls At a minimum, Contractor shall ensure that a physician or an appropriate licensed professional	-Policies and procedures -Provider contracts -Internal monitoring reports		-The Plan provides documented evidence (e.g., policies and procedures, provider contracts, internal monitoring reports, etc.) that at a

3.3	TELEPHONE PROCEDURES / AFTER HOURS CALLS		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
under his/her supervision will be available for after-hours calls.			minimum, a physician or an appropriate licensed professional under his/her supervision is available for after-hours calls.
Exhibit A, Attachment 13 – MEMBER SERVICES **2. Member Services Staff** A. Contractor shall maintain the capability to provide Member services to Medi-Cal Members or potential members through sufficient assigned and knowledgeable staff. **1300.67.2.2(c)(10)** (c) Standards for Timely Access to Care. (10) Plans shall ensure that, during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed ten minutes.	-Policies and procedures -Internal monitoring reports		-The Plan's policies and procedures delineate a wait time standard of no more than ten minutes for a member to speak with a Plan customer service representative. -The Plan's policies and procedures delineate monitoring activities to ensure that the wait time for a member to speak with a Plan customer service representative does not exceed ten minutes. -The Plan conducts internal monitoring at a set frequency (e.g., biannual, quarterly, monthly, etc.) to ensure continual compliance with the wait time to speak with a Plan customer service representative (e.g., call center monitoring reports, etc.). -When monitoring efforts reveal instances of non-compliance, the Plan consistently documents follow-up action taken (e.g., hiring additional staff, discussion in Access Committee meeting minutes, re-measurement activities, etc.). -The Plan ensures that all monitoring reports are reviewed by appropriate parties (e.g., Provider Services Department, Access Committee, Quality Improvement Committee, Board, etc.) to conduct root cause analyses and identify opportunities for quality improvement. Review and discussion are evidenced by documented meeting minutes. -The Plan conducts initial and ongoing training for customer service staff to ensure staff are knowledgeable in Plan processes and requirements. The Plan provides documented evidence of training (e.g. sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.). -The Plan conducts internal monitoring at a set frequency (e.g., biannual, quarterly, monthly, etc.) to measure the performance of customer

3.3	TELEPHONE PROCEDURES / AFTER HOURS CALLS		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
			service staff and utilizes tools which assess knowledge and competence.

3.4	SPECIALIST AND SPECIALTY SERVICES		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
Exhibit A, Attachment 6 – PROVIDER NETWORK **6. Specialists** Contractor shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care in accordance with Title 22 CCR Section 53853(a) and W & I Code section 14182(c)(2). **53853(a)** (a) Each plan in a designated region shall retain sufficient professional medical staff, including adequate numbers of specialists and subspecialists, to provide access to preventive and managed health care services to its members. **14182(c)(2)** (c) Prior to exercising its authority under this section and Section 14180, the department shall ensure that each managed care health plan participating in the demonstration project is able to do all of the following: (2) Ensure and monitor an appropriate provider network, including primary care physicians, specialists, professional, allied, and medical supportive personnel, and an adequate number of accessible facilities within each service area. Managed care health plans shall maintain an updated, accurate, and accessible listing of a provider's ability to accept new patients and shall make it available to enrollees, at a minimum, by phone, written material, and Internet Web site.	-Policies and procedures -Provider Directory (online and hardcopy) -Internal monitoring reports		-The Plan's policies and procedures delineate internal monitoring processes to ensure an adequate network of specialty providers. -The Plan generates and reviews various reports by specialty type (e.g., referral tracking, encounter data, utilization patterns, Member and Provider Satisfaction surveys, GeoAccess, grievance trends, etc.) at a set frequency (e.g., biannual, quarterly, monthly, etc.) to ensure continual oversight and monitoring of its specialty network. -The Plan ensures that all monitoring reports are reviewed by appropriate parties (e.g., Provider Services Department, Access Committee, Quality Improvement Committee, Board, etc.) to conduct root cause analyses and identify opportunities for quality improvement. Review and discussion are evidenced by documented meeting minutes. -When gaps in specialty care are identified, the Plan consistently documents follow-up action taken (e.g., recruitment and outreach efforts, letters of agreement, provider incentives, re-measurement activities, telehealth, etc.). -The Plan continuously updates its provider rosters to maintain current online and hardcopy Provider Directories.
Exhibit A, Attachment 9 – ACCESS AND AVAILABILITY **3. Access Requirements** F. Unusual Specialty Services Contractor shall arrange for the provision of seldom used or unusual specialty services from specialists outside the network if unavailable within Contractor's network, when determined Medically Necessary.			-When the Plan does not have specialists within its network (including those specialty services that are seldom used or unusual), the Plan consistently provides documentation to substantiate the arrangement and provision of out-of-network services (e.g., letters of agreement, etc.) when medically necessary.

3.5	EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
Exhibit A, Attachment 8 – PROVIDER COMPENSATION ARRANGMENTS **9. Non-Contracting Family Planning Provider's Reimbursement** Contractor shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate. Contractor shall reimburse non-contracting family planning providers for services listed in Exhibit A, Attachment 9, Provision 8, Access to Services with Special Arrangements, provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy.	-Policies and procedures -Member Handbook/EOC -Provider Manual -Desktop procedures -Internal monitoring reports	-An onsite verification study of non-contracted family planning claims may be conducted to confirm that the Plan does not require prior authorization and claims are paid at no less than the Medi-Cal FFS rate.	-The Plan's policies and procedures, Member Handbook/EOC, and Provider Manual clearly indicate that prior authorization is not needed for family planning services, including those services provided by non-contracted providers. -The Plan's claims system does not automatically deny payment for family planning claims due to no prior authorization or non-contracted provider status. -The Plan conducts initial and ongoing training for claims processing staff. The Plan provides documented evidence of training (e.g. sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.) which guide staff to process family planning claims without prior authorization or contracted provider status. -The Plan conducts internal monitoring (e.g., periodic focus audits of denied family planning claims, second-level review of all denied family planning claims, etc.) to ensure that all non-contracted family planning providers are consistently reimbursed at no less than the appropriate Medi-Cal FFS rate. -When monitoring efforts reveal instances of non-compliance, the Plan consistently documents follow-up action taken (e.g., staff re-training, re-measurement activities, etc.).
Exhibit A, Attachment 8 – PROVIDER COMPENSATION ARRANGMENTS **13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization** A. Emergency Services: Contractor is responsible for coverage and payment of Emergency Services and post stabilization care services and must cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the plan. Contractor may not deny payment for treatment obtained when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical	-Policies and procedures -Member Handbook/EOC -Provider Manual -Desktop procedures -Internal monitoring reports	-An onsite verification study of emergency service claims may be conducted to confirm that the Plan does not require prior authorization and readily reimburses contracted and non-contracted providers.	-The Plan's policies and procedures, Member Handbook/EOC, and Provider Manual clearly indicate that prior authorization is not needed for emergency services and post-stabilization care, including those services provided by non-contracted providers. -The Plan's claims system does not automatically deny payment for emergency service claims due to no prior authorization or non-contracted provider status. -The Plan conducts initial and ongoing training for claims processing staff. The Plan provides documented evidence of training (e.g. sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop

3.5	EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
attention would not have had the outcomes specified in 42 CFR 438.114 (a) of the definition of emergency medical condition. Further, Contractor may not deny payment for treatment obtained when a representative of Contractor instructs the enrollee to seek Emergency Services.			procedures, PowerPoint slides, etc.) which guide staff to process emergency service claims without prior authorization or contracted provider status. -The Plan conducts internal monitoring (e.g., periodic focus audits of denied emergency service claims, second-level review of all denied emergency service claims, etc.) to ensure that all emergency service claims submitted by contracted and non-contracted providers are paid. -When monitoring efforts reveal instances of non-compliance, the Plan consistently documents follow-up action taken (e.g., staff re-training, re-measurement activities, etc.).
C. Contractor shall pay for emergency services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the emergency medical condition including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Contractor or the Member is stabilized sufficiently to permit discharge. The attending emergency physician, or the provider treating the Member is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on the Contractor. Emergency services shall not be subject to prior authorization by Contractor.	Same as above	Same as above	Same as above
D. At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for Physician services at the lowest level of emergency department evaluation and management Physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.	-Policies and procedures -Desktop procedures -Internal monitoring reports	-An onsite verification study of emergency service claims may be conducted to confirm that at minimum, the Plan reimburses non-contracted providers at the lowest level of emergency department evaluation and management	-The Plan's policies and procedures indicate that at minimum, the Plan reimburses non-contracted emergency service providers at the lowest level of emergency department evaluation and management Physician's CPT codes (unless a higher level is clearly supported by documentation) and for the facility fee and diagnostic services. -The Plan conducts initial and ongoing training for claims processing staff. The Plan provides documented evidence of training (e.g. sign-in

3.5	EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
		Physician's CPT codes (unless a higher level is clearly supported by documentation) and for the facility fee and diagnostic services.	sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.) which guide staff to reimburse non-contracting emergency service at the correct level. -The Plan conducts internal monitoring (e.g., periodic focus audits of paid emergency service claims, etc.) to ensure that all emergency service claims are reimbursed at the correct level, and that when claims are reimbursed at a lower level than what was submitted due to a lack of supporting documentation, the denial reason accurately reflects this reason. -When monitoring efforts reveal instances of non-compliance, the Plan consistently documents follow-up action taken (e.g., staff re-training, re-measurement activities, etc.).
Exhibit A, Attachment 8 – PROVIDER COMPENSATION ARRANGMENTS **5. Claims Processing** Contractor shall pay all claims submitted by contracting providers in accordance with this section, unless the contracting provider and Contractor have agreed in writing to an alternate payment schedule. A. Contractor shall comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and Health and Safety Code Sections 1371 through 1371.36. Contractor shall be subject to any remedies, including interest payments provided for in these sections, if it fails to meet the standards specified in these sections. B. Contractor shall pay 90% of all clean claims from practitioners who are in individual or group practices or who practice in shared health facilities, within 30 days of the date of receipt and 99% of all clean claims within 90 days. The date of receipt shall be the date Contractor receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date of the check or other form of payment.	-Policies and procedures -Desktop procedures -Internal monitoring reports	-An onsite verification study of family planning and emergency service claims may be conducted to confirm that all clean claims are paid within the required state and federal timeframes.	-The Plan's policies and procedures for claims processing timeframes demonstrate alignment and consistency with both state (all complete claims paid within 45 working days) and federal (90% of clean claims paid within 30 calendar days; 99% of clean claims paid within 90 calendar days) requirements. -The Plan's policies and procedures delineate internal monitoring processes to ensure clean claims are paid in accordance with both state and federal timeframes (e.g., tracking system which records claims status at 30 calendar-, 45 working-, and 90 calendar-day intervals; generation and review of daily/weekly aging claims reports; periodic audits, etc.). -The Plan ensures that all monitoring reports are reviewed by appropriate parties (e.g., Provider Services Department, Quality Improvement Committee, Board, etc.) to conduct root cause analyses and identify opportunities for quality improvement. Review and discussion are evidenced by documented meeting minutes. -When monitoring efforts reveal instances of non-compliance, the Plan consistently documents follow-up action taken (e.g., hiring

3.5	EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
1300.71(g) (g) Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).			additional staff, staff re-training, re-measurement activities, etc.). -The Plan conducts initial and ongoing training for claims processing staff. The Plan provides documented evidence of training (e.g. sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.) which address both state and federal claims processing timeframes.

3.6	ACCESS TO PHARMACEUTICAL SERVICES		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
Exhibit A, Attachment 10 – SCOPE OF SERVICES **8. Services for All Members** G. Pharmaceutical Services and Provision of Prescribed Drugs 1) Contractor shall cover and ensure the provision of all prescribed drugs and Medically Necessary pharmaceutical services. Contractor shall provide pharmaceutical services and prescription drugs in accordance with all Federal and State laws and regulations including, but not limited to the California State Board of Pharmacy Laws and Regulations, Title 22 CCR Sections 53214 and 53854 and Title 16, Sections 1707.1, 1707.2, and 1707.3. Prior authorization requirements for pharmacy services and provision of prescribed drugs must be clearly described in the Member Services Guide and provider manuals of the Contractor. At a minimum, Contractor shall arrange for pharmaceutical services to be available during regular business hours, and shall ensure the provision of drugs prescribed in emergency circumstances in amounts sufficient to last until the Member can reasonably be expected to have the prescription filled. **53214(a)** (a) Each plan shall provide, either directly or through subcontracts, the services of pharmacies and pharmacists. Such pharmaceutical services shall be available to members during reasonable hours as specified in the contract. **53854(a)(1)(2)** (a) Each plan in a designated region shall at a minimum, make available to members during the hours of operation of each member's primary care service site, either directly or through subcontracts, the services of pharmacies and	-Policies and procedures -Member Handbook/EOC -Provider Manual -Pharmacy Network (including after-hours pharmacies) -Pharmacy Benefits Manager Contract -Internal monitoring reports		-The Plan's policies and procedures, Member Handbook/EOC, and Provider Manual clearly describe the Plan's prior authorization processes for pharmacy services. -The Plan's policies and procedures, Member Handbook/EOC, and Provider Manual clearly delineate how pharmacy services are provided to members (e.g., through its direct network, subcontractors, PBM, etc.). -If the Plan utilizes a PBM, the Plan's policies and procedures and contract with the PBM delineate internal monitoring activities to ensure ongoing oversight. The Plan provides documented evidence to demonstrate oversight at a set frequency (e.g., review of policies and procedures, submission and review of utilization reports, inter-rater reliability, analysis of appeal overturn rates, tracking and trending of pharmacy-related grievances, etc.). -The Plan provides documented evidence that a sufficient network of pharmacies is available to members during regular business hours (e.g., Provider Directory with locations of all pharmacies including posted hours of operation, updated pharmacy network, PBM contract, etc.). -The Plan conducts internal monitoring at a set frequency (e.g., biannual, quarterly, monthly, etc.) to ensure that in emergency circumstances, members are prescribed a sufficient quantity of drugs until the member can be reasonably expected to have the prescription filled (e.g., documented review of hospital policies and procedures, receipt of hospital attestations, periodic audits of ER records, analysis of prescribing ER trends, targeted focus studies, documented review and discussion in Pharmacy & Therapeutics Committee, etc.).

3.6	ACCESS TO PHARMACEUTICAL SERVICES		
CONTRACT REQUIREMENT	**DOCUMENTATION REVIEWED**	**VERIFICATION STUDY**	**EXAMPLES OF BEST PRACTICES**
pharmacists in accordance with title 22, CCR, section 53214. (1) Pharmaceutical services shall, at a minimum, be available to members during established service site hours. (2) When the course of treatment provided to a member by a contracting provider under emergency circumstances requires the use of drugs, a sufficient quantity of such drugs will be provided to the member to last until the member can reasonably be expected to have a prescription filled.			
53854(a)(3) (a) Each plan in a designated region shall at a minimum, make available to members during the hours of operation of each member's primary care service site, either directly or through subcontracts, the services of pharmacies and pharmacists in accordance with title 22, CCR, section 53214. (3) Plans shall establish and document the availability of after hours nonemergency pharmacy services. Plans shall make available by telephone information regarding the availability, location and hours of operation of pharmacies providing such services.	-Policies and procedures -Member Handbook/EOC -Provider Manual -Pharmacy Network (including after-hours pharmacies)		-The Plan's policies and procedures, Member Handbook/EOC, and Provider Manual clearly delineate the availability of after-hours pharmacies and how to obtain services. -The Plan provides documented evidence that a sufficient network of pharmacies is available to members during after-hours (e.g., Provider Directory with locations of all after-hours pharmacies including posted hours of operation, updated pharmacy network, PBM contract, etc.).