

**MEASUREMENT YEAR 2017
 DEPARTMENT OF MANAGED HEALTH CARE
 PROVIDER APPOINTMENT AVAILABILITY SURVEY METHODOLOGY**

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PROVIDER APPOINTMENT AVAILABILITY SURVEY METHODOLOGY**

This document outlines the Provider Appointment Availability Survey (“PAAS”) Methodology developed by the Department of Managed Health Care (“Department”), pursuant to the Knox-Keene Health Care Service Plan Act of 1975.¹ For measurement year 2017 (“MY 2017”), health plans are required to use either (1) the PAAS Methodology or (2) the Department’s Provider Appointment Availability Audit Methodology. Step-by-step instructions for using the PAAS methodology are set forth below.

All health plans that submit annual *Timely Access Compliance Reports* must have the administrative capacity to gather compliance data in accordance with this mandatory methodology, validate compliance data, and identify and rectify compliance data errors to ensure the accuracy of all documents submitted to the Department in connection with *Timely Access Compliance Reports*.

The reporting goal of the PAAS Methodology is for health plans to report compliance rates in the following format:

Table 1 – Reporting Goal

Survey Type (PCP)	Product Type	County	Provider Group / IPA	Number of Providers in Provider Group within Selected County	Target Survey Sample Size	Number of Providers Surveyed	Number of Providers Responded	Target Survey Sample Size Achieved
PCP	Commercial	Butte	ABC, Inc.	10	9	10	10	y
PCP	Medi-Cal	Butte	ABC, Inc.	5	5	5	5	y
PCP	Individual / Family Plan	Butte	ABC, Inc.	5	5	5	5	y

¹ California Health and Safety Code sections 1340 et seq. (the “Act”). References herein to “Section” are to Sections of the Act. References to “Rule” refer to the regulations promulgated by the Department at California Code of Regulations, title 28.

Table 1a – Reporting Goal Continued

Number of Providers Responded to Urgent Care Appointment w/no Prior Auth w/in 48 Hours	Number of Providers with an Urgent Care Appointment w/no Prior Auth w/in 48 Hours	Rate of Compliance Urgent Care Appointment w/no Prior Auth w/in 48 Hours	Number of Providers Responded to Non-Urgent Appointment w/in 10 Days	Number of Providers with a Non-Urgent Appointment w/in 10 Days	Rate of Compliance Non-Urgent Appointment w/in 10 Days
10	10	100%	10	10	100%
5	3	60%	5	4	80%
5	3	60%	5	4	80%

STEP 1: Determine Which Networks to Survey

Section 1367.03, subd. (f)(3) (as enacted by SB 964) requires each health plan to report separately its rate of compliance with the time elapsed standards for commercial, Medi-Cal, and individual/family plan products. If a health plan uses the same network for all products, the plan must randomly sample that network only once and use the sample to calculate and report rates of compliance for each product separately. If a health plan maintains separate networks for commercial, Medi-Cal, and/or individual/family product networks, the health plan will need to include all providers in the networks serving the commercial, Medi-Cal, and individual/family plan products into separate Provider Contact Lists and repeat the random sampling steps listed below for each product, as applicable. The health plan must allocate the responses for each product to report a separate rate of compliance for each network, in accord with Section 1367.03 subd. (f)(3). Even if a health plan maintains the same provider network for all products and, as a result, conducts the survey using one sample of providers across all products, the health plan must report rates separately for each product.

Health plans must report the networks serving the lines of business set forth below using the Product Type identifiers in Table 2. For MY 2017, health plans are not required to report Cal MediConnect networks.

Table 2 – Reporting Cross-Walk

Lines-of-Business	Product Type
HMO Individual Market	Individual/Family Plan
HMO Small Group Market	Commercial
HMO Large Group Market	Commercial
PPO Individual Market	Individual/Family Plan
PPO Small Group Market	Commercial
PPO Large Group Market	Commercial

Lines-of-Business	Product Type
EPO Individual Market	Individual/Family Plan
EPO Small Group Market	Commercial
EPO Large Group Market	Commercial
Tiered EPO/PPO Individual Market	Individual/Family Plan
Tiered EPO/PPO Group Market	Commercial
Covered CA HMO Individual Market	Individual/Family Plan
Covered CA HMO Small Group Market	Commercial
Covered CA PPO Individual Market	Individual/Family Plan
Covered CA PPO Small Group Market	Commercial
Covered CA EPO Individual Market	Individual/Family Plan
Covered CA EPO Small Group Market	Commercial
Covered CA Tiered EPO/PPO Individual Market	Individual/Family Plan
Covered CA Tiered EPO/PPO Small Group Market	Commercial
Medi-Cal	Medi-Cal
Healthy Kids	Commercial
MRMIP	Commercial
Medi-Cal Access (“AIM”)	Commercial
IHSS	Commercial
Employer Group	Commercial
Other	Commercial

Plan-to-Plan Agreements

With the exception of the two scenarios set forth below, health plans that contract with another full service Knox-Keene Act licensed plan to deliver health care services to health plan enrollees must report a rate of compliance on the *Results Template* for all providers who are a part of the health plan’s network, whether these providers are contracted with the health plan directly or via a plan-to-plan arrangement. The health plan may survey these providers directly or obtain survey data from the subcontracting health plan (or plan partner).² In addition, the health plan should report the plan-to-plan arrangement on the health plan’s Profile in the Timely Access Portal and include a narrative that briefly explains the arrangement in the Comment/Narrative section of the Compliance Report. The health plan must indicate which products and counties are served through the contractual relationship with the subcontracting health plan.

² If a provider or provider group is in both the reporting health plan’s directly contracted network and the subcontracting health plan’s network in a single county, the health plan should report the provider or provider group’s rate of compliance only once.

- **Exception 1:** Health plans contracting with a Knox-Keene Act licensed full service health plan, utilizing the audit methodology, may report rates of compliance for the subcontracting health plan’s provider groups by indicating this arrangement on the health plan's Profile in the Timely Access Portal and including a narrative in the Comment/Narrative section that briefly explains the arrangement and the method the subcontracting health plan uses to determine compliance. The health plan must identify the scope of services provided and the products and counties that are served through this contractual relationship.
- **Exception 2:** Health plans that contract with a Knox-Keene Act licensed mental health plan to deliver mental health care services to its enrollees may report timely access data for the subcontracting health plan’s provider groups by indicating this arrangement on the health plan's Profile in the Timely Access web portal and in the Comment/Narrative section of the Timely Access Portal. The health plan must indicate the scope of services that are delivered to its enrollees through the subcontracting health plan (including both psychiatric and non-physician mental health provider services) and the products and counties that are served through this contractual relationship. (See the Mental Health Provider Addendum for further information.)

STEP 2: Identify Participating Provider Groups

A participating provider group (“PG”) is defined as a “medical group, independent practice association, or any other similar organization” that contracts with a health plan.³ (See Section 1367, subd. (g).) A health plan will need to identify all PGs participating within in each county of the health plan’s service area. When identifying its PGs, it may be helpful for health plans to note those PGs that have special capabilities or contact requirements, such as a central call center for Primary Care Physicians (“PCP”) or specialty-specific scheduling, in order to help determine the best number and time to contact providers.

STEP 3: Create Provider Contact List

The Provider Contact List is used to select a random sample of providers to survey. For MY 2017, health plans must survey and report a rate of compliance for PCPs, five separate specialty physician types, three ancillary providers and non-physician mental health providers⁴:

- (1) PCPs⁵
- (2) Cardiologists (including Cardiovascular Disease and Pediatric Cardiology)
- (3) Endocrinologists
- (4) Gastroenterologists

³ This includes clinics licensed under Health & Safety Code section 1204, subd. (a).

⁴ Please refer to the Mental Health Addendum for the three options for assessing psychiatrists, child and adolescent psychiatrists, and non-physician mental health providers’ compliance with the time elapsed standards. To provide guidance to health plans electing Option 2, the instructions for the phone survey include psychiatrists, child and adolescent psychiatrists, and non-physician mental health providers.

⁵ The health plan may include, for example, Family Practice, General Practice, Pediatrics, OB/GYN, or Internal Medicine. Health plans should include only those providers that have agreed to serve as a PCP for the health plan.

- (5) Psychiatrists
- (6) Child and Adolescent Psychiatrists
- (7) Physical Therapy Appointments
- (8) MRI Appointments
- (9) Mammogram Appointments
- (10) Non-Physician Mental Health Providers (PhD and above (including Psychologist) and Master Degree Providers)

Using the Department's *Provider Contact List Template*, create four or more separate data sets that identify the PCP physicians, specialist physicians, non-physician mental health providers, and ancillary providers for each PG within the health plan's network(s). The health plan must include the data fields listed in the *Provider Contact List Template*.

To simplify this process, the Department's *Provider Contact List Template* includes the same (or very similar) database fields as the Department's Annual Provider Network Report Forms (Provider Roster or G Data). Specialties, counties and other look-up codes are available on the Department website in the provider network submission templates. Health plans must include the Provider Contact List (prior to de-duplicating) when submitting its *Timely Access Compliance Report*. The health plan must retain a copy of each Provider Contact List for submission to the Department prior to removing the duplicate entries.

Individually Contracted Providers

In addition to all group-based providers, the health plan must survey individually contracted PCPs, specialty care physicians by type, non-physician mental health providers, and ancillary providers of the types listed in this methodology in the health plan's network(s).

Each health plan may create a contact list for each individually contracted provider type selected for survey by either:

- Including individually contracted provider(s) in the same contact list as the Provider Contact List described above, with "Individually Contracted Provider" in the provider group name field for these providers (to allow a sample to be pulled as if this subpopulation, taken together, constituted a single PG/county); or
- Create a second contact list just for individually contracted provider(s). (Some health plans may wish to collaborate and work together to survey PGs that contract with multiple health plans. In that case, the collaborating health plans may wish to create a second contact list for individually contracted providers since the health plans may not be able to pool its surveying resources for these types of providers.)

De-duplicating the Provider Contact List

Once the Provider Contact Lists are complete, the data sets should be reviewed and duplicate entries removed so that the health plan may select the appropriate sample of each provider type to survey. Duplicate entries are rows where the same provider name and provider group appear more than once in a single county. A provider should be listed either: (a) once per PG/county, or b) once per county as an individually contracted provider.

- Providers who are members of multiple PGs should appear on the Provider Contact List for each PG in which they participate.
- Providers who are members of one or more PGs and are also individually contracted with the health plan, should be included only on the Provider Contact List under the PG(s).
- For providers in a group with multiple addresses in a county, choose any single location within the county (providers that appear in multiple provider groups are not duplicate entries – this is explained in more detail under Step 4: Sample Size Selection.).
- Individually contracted providers with multiple addresses in a single county should be listed only once on the Provider Contact List; for those with multiple addresses, choose any single location in a county for those with multiple addresses.

Table 3 provides guidance for removing duplicate records for two hypothetical PCPs, Dr. Cook and Dr. Smith. Dr. Cook has four contact records in Marin County. For Dr. Cook, keep the single contact record for the One Medical PG, and keep only one record for the Happy IPA PG. The contact for Dr. Cook’s individually contracted location in Marin County should be removed because he has PG location in the county. After de-duplication, Dr. Cook will have two records to be used for the sample section. Dr. Smith has four contact records: two locations in San Francisco as an individually contracted provider and two locations in two other counties for the One Medical PG. Keep only one of the San Francisco locations, but keep both the One Medical locations as they are in two different counties. After de-duplication, Dr. Smith will have three records remaining to be used for the random sample selection process set forth in Step 4.

Table 3 - Sample De-duplication

Provider	Address	County	PG	De-Duplication Rule
Bob Cook	100 Main, Novato	Marin	One Medical	Keep
Bob Cook	300 1st, San Rafael	Marin	Happy IPA	Keep only one county PG location. (Choose any one to remove)
Bob Cook	200 North, Novato	Marin	Happy IPA	
Bob Cook	100 South, Mill Valley	Marin	Individually Contracted Provider	Remove
Jan Smith	303 1st, SF	San Francisco	Individually Contracted Provider	Keep only one county location. (Choose any one to remove)
Jan Smith	200 Broadway, SF	San Francisco	Individually Contracted Provider	
Jan Smith	30 Main, Oakland	Alameda	One Medical	Keep
Jan Smith	20 El Camino, Hillsdale	San Mateo	One Medical	Keep

STEP 4: Sample Size Selection

Compliance rates must be calculated “for each of the health plan’s contracted provider groups located in each county of the health plan’s service area.” (See Rule 1300.67.2.2, subd. (g)(2)(B).) Health plans are also required to report a separate rate of compliance with the time elapsed standards for the health plan’s commercial, Medi-Cal and/or individual/family plan products. (Section 1367.03, subd. (f)(3) (as amended by SB 964).) In order to meet these requirements, the Department’s PAAS Methodology calculates an appropriate sample size of providers for each provider group in each county (“PG/county”), which then allows a random sample to be selected for each contracted PG in each county. (See Step 5: Random Sample Selection Process for the random sample methodology.)

- **Example:** If a health plan’s service area includes County A and County B, then the health plan will need to determine the appropriate sample size for each provider group in both County A and County B.

If the provider group participates in separate products and the number of providers participating in the commercial network is different from the number participating in the health plan’s Medi-Cal and/or individual family network, the health plan must calculate a sample size for each product. Samples sizes for each PG/county will need to be calculated separately for PCPs, each of the five specialty physician types, each of the three ancillary provider types, and non-physician mental health providers.

Select a Sample Size for each Provider Type

For MY 2017, health plans must report rates of compliance for PCPs, five separate specialty physician types, three ancillary providers, and non-physician mental health providers. The sample selection process for a single specialty, single ancillary provider type, or non-physician mental health providers is the same as the process for PCPs described below in Table 3. Thus, health plans should follow the sample size selection process described below for PCP to generate samples for each of the 10 provider types. (This means that for each county, a health plan will need to determine the appropriate sample size for each of the 10 provider types set forth above.) The oversampling process for replacement of PCPs who are ineligible or who decline to respond, described below, applies in the same way to other provider types selected to be surveyed.

Determine the Number of Providers in Each Group/IPA

In some medical groups and IPAs, the entire provider panel participates in any network in which the medical group or IPA contracts. However, in other medical groups (and within many IPAs), the number of providers participating in the commercial network may be different from the number participating in the health plan’s Medi-Cal and/or individual family network.

- **Example:** If an IPA has 10 cardiologists, all 10 may participate in the health plan’s commercial network, but only 7 may choose to participate in the health plan’s Medi-Cal network.

If a PG/county participates in separate health plan networks and all the same providers in

that PG/county participate in each network (i.e., the panel is the same for each network), then the health plan may select only one sample for the PG/county and use that sample for each network. If, however, a PG/county has a different number of providers participating in the commercial network from the Medi-Cal and/or individual family network, the health plan must select separate samples for each network. Therefore, prior to identifying sample sizes, the health plan should run a “crosstabs” or other analysis to determine for each PG/county whether participation is the same across networks.

Federally Qualified Health Center

PCPs practicing in a Federally Qualified Health Center (“FQHC”) should be treated as being in a single provider group and the survey results for one PCP in a FQHC may be attributed to the remaining PCPs practicing in the FQHC. (As indicated above, the sample process for all provider types is the same for PCPs. FQHCs should be treated as a single provider for specialty physicians, ancillary providers, and non-physician mental health providers.)

- **Example:** If 10 PCPs practice in a FQHC, the health plan should treat the FQHC as a provider group with 10 PCPs. In this example, the health plan would normally need to survey all 10 PCPs to meet the sample size requirements. However, since enrollees are assigned to an FQHC and not to a PCP, the health plan needs to survey this FQHC only once to determine the next available PCP appointment. This survey result would be attributed to all 10 PCPs and serve as the rate of compliance for appointments within standards for the FQHC.

Determine the Sample Size for each PG/County

The health plan will calculate the sample size for each PG/county based on the number of providers in the Provider Contact List after de-duplication. (By combining all individually contracted PCPs into one group identified as “Individually Contracted Providers” in each county, individually contracted providers can be treated as a PG/county for purposes of determining sample sizes and reporting rates of compliance.) For PG/counties a health plan may either:

- **Sample:** Use the attached Sample Size Chart in Appendix 1 to determine the appropriate sample (and include an oversample for replacements as described below); or
- **Census:** Select all PCPs (this option is available to allow health plans to collect information on all providers for internal monitoring and corrective action purposes).

Table 4 – Example: Determining Survey Sample Size

County	Provider Group Name	Total Number of PCPs in Provider Group within County	Sample Size (From Appendix 1)
Butte	Provider Group 1	2	2
Butte	Provider Group 2	50	<p><u>Sample</u>: 31 sample size + oversample for any necessary replacements. (See Sample Size Chart in Appendix 1 and the “Select a Random Sample for Replacements” section under Step 4.)</p> <p><u>Census</u>: Choose to survey all 50 providers.</p>

- Example:** If in Butte County the health plan contracts with two Provider Groups (Provider Group 1 and Provider Group 2), the health plan will need to determine the appropriate sample size for each of the two provider groups. For Provider Group 1, the appropriate sample size is 2 PCPs based on the Sample Size Chart in Appendix 1. In Provider Group 2, the health plan must either use the Sample Size Chart to determine the appropriate sample size or choose to sample all 50 PCPs.

For each county, a health plan may only report either: (a) the sample size provided in the sample size chart or (b) a census that includes all PCPs in a provider group. A health plan may not utilize a sample size larger than the number provided in the sample size chart unless the number reflects all PCPs in the provider group. If a health plan desires for internal purposes to survey a larger sample but not all PCP providers in the provider group, the health plan may do so but should report only the number of PCP providers identified by the sample size chart in the order randomly selected, in accordance with this methodology.

- Example:** If the sample size chart indicates that a sample of 25 PCPs is appropriate for PG 2 in Butte County, then the health plan may not report survey results for 27 PCPs. The health plan may choose to survey two additional providers for its internal purposes, but it should not include these two additional survey responses in the results reported to the Department. In addition, health plans should clearly indicate in the reporting whether the health plan surveyed a sample of providers, or all providers.

Select a Random Sample for Replacements

The PAAS Methodology requires health plans to randomly sample and survey the number of PCPs indicated by the sample size chart for each PG/county. A PCP selected for the sample may be replaced by another PCP if the PCP in the selected sample (1) declined to respond or (2) was erroneously selected and is ineligible for the survey. (To ascertain whether a provider was erroneously selected and ineligible, see Replacements: Ineligible Providers in

Step 8.)

To allow for the replacement of PCPs that decline to respond and erroneously selected PCPs, the health plan will need to:

- Select an oversample of additional PCPs for the PG/county using the random sample selection process below in Step 5: Random Sample Selection Process. The size of the oversample may be (1) 100% of the provider group to best ensure the likelihood of meeting the target sample size or (2) estimated based on the health plan's previous years' experience regarding ineligible providers and the percentage of providers that declined to respond. The oversample selection should be surveyed only if replacements are needed.
 - **Example:** If the PG/county has 200 PCPs, the sample size chart indicates that a random sample of 56 should be identified. The health plan must select an oversample to hold in reserve should replacements be needed. For a sample of 56 PCPs, the health plan can either (1) include the remaining 144 providers in the random selection process for replacements in the oversample; or (2) calculate the total percentage of PCPs that were ineligible and did not respond from the prior year. If the health plan calculates that 35% of the PCPs did not respond or were ineligible in MY 2016, the health plan would select an oversample of at least 20 providers ($.35 \times 56 = 19.5$). Not all providers in the oversample may need to be called. If the health plan calls the first 56 PCPs and 5 refuse to respond or are found to have retired or left the network, the health plan can replace those 5 with the first 5 PCPs from the oversample and report the resulting rate of compliance for required sample size of 56 PCPs.
- Provide surveyors with the entire provider list in random sample order. (See Appendix 2: Random Number Generation.) If a replacement PCP is needed, the surveyor should continue down the list from the last sampled PCP, always using the next available PCP as a replacement until the required sample size is reached. The health plan should continue to replace PCPs until either the required sample size is reached or all PCPs have been selected.

STEP 5: Random Sample Selection Process

Once a health plan has determined the appropriate sample size for each PG/county and network, it can use the random sample selection process described below to select those providers that will be surveyed.

Using the random number tools in MS Excel or SAS, assign a random number to each provider in the Provider Contact List. (See Appendix 2 - Random Number Generation for the methodologies). Sort data by PG/county and each subgroup (e.g., PCP, specialty). Within each subgroup, sort in order of random numbers. Select the number of providers indicated by the Sample Size Chart in Appendix 1 for each PG/county (and include an oversample for replacements), or select all providers. (See Step 4: Sample Size Selection for instructions). Some providers may appear more than once on the Provider Contact List because they are contracted with more than one PG in a single county. Unless the provider is listed with the

same physical address and phone number for each PG on the Provider Contact List, health plans are required to call both of the provider's offices (if the provider was selected in the random sampling process in each PG).

- **Example:** If Doctor A is selected to be surveyed in PG 1 and PG 2 for a single county, then the health plan will need to call that doctor twice, unless the phone number and address for Doctor A is the same. If the physical address and phone number are the same, then the health plan can report the survey results from a single survey for Doctor A in both PG 1 and PG 2.

In addition, the de-duplicated Provider Contact List may also include multiple providers at the same address and phone number (presumably, because the providers work in the same office). In this case, health plans may inquire during the initial survey call if the health plan can ask about the appointment availability for other doctors working in the same office.

- **Example:** Assume Doctor A, Doctor B, and Doctor C are selected for survey and all three doctors work at the same physical address and have the same office phone number. When the health plan calls to survey Doctor A, the health plan can ask the office scheduler (or other appropriate office representative) whether they are also able to respond to questions regarding Doctor B and Doctor C's availability. If so, then the health plan can conduct the survey for Doctor B and Doctor C during the same phone call.

STEP 6: Engage in Provider Outreach

In order to accurately report network performance across the time elapsed standards, it is critical for the health plan to obtain survey responses from a meaningful number of providers. Prior to commencing administration of the survey questions, the Department recommends that health plans engage providers through advance outreach efforts. Based upon feedback from health plan representatives concerning activities undertaken during prior measurement years, it appears that simple, strategic communications with health plan-contracted providers can yield a significant decrease in non-response rates, putting the health plan (and its contracted providers and provider groups) in the best position to demonstrate compliance with Timely Access appointment availability standards.

Health plans should consider outreach communications that:

- Inform providers about the importance of participating in the survey;
- Help the provider or provider group to understand what the survey is, why it is being done, and the types of questions that will be asked;
- Identify the date range during which the survey is likely to occur;
- Let providers know that rates of compliance reported for the provider or provider group will become publicly available information; and
- Remind providers about any contractual obligations indicating that they must provide appointment availability information to the health plan.

While the Department encourages health plans to communicate with all providers selected to participate in the survey, special focus may be needed for the health plan's provider groups

and provider types that had high non-response rates in prior measurement years. Health plans are required to report the percentage of providers that declined to participate in the survey (or failed to respond to the survey) for each PG in each county.

In situations where the volume of non-responding providers does not allow for completion of the survey in accordance with the methodology's target sample sizes, the health plan may be required to institute a corrective action plan that includes steps necessary to secure responses from the number of providers necessary to fully complete the PAAS survey in future years. Continued inability by a health plan to reach target sample sizes and complete the PAAS survey may result in referral to the DMHC Office of Enforcement."

STEP 7: Survey Questions

The Department has developed four PAAS Survey Tools (containing the survey script), to be used with the PAAS Methodology. The appropriate Survey Tool must be used, based on the provider type being surveyed. Some health plans may wish to include additional questions over and above those included in the Department's PAAS. As such, health plans may incorporate additional survey questions into the Department's PAAS Methodology so long as the following conditions are met:

- All of the Department's PAAS Methodology processes and sample sizes are used;
- All of the Department's PAAS administration procedures are followed;
- The Department's PAAS questions are included as a block without modification to individual items or changes in item order;
- The Department's PAAS questions are placed at the beginning of the survey;
- The resulting survey is not too exhaustive (which may decrease willingness to respond or may frustrate those who do respond); and
- The results for the Department's PAAS questions are transferred to the Department's PAAS *Results Template*.

Health plans must use the MY 2017 PAAS Survey Tool questions that were developed by the Department. Health plans may use a different software/program for capturing survey results if the following requirements are met:

- The survey questions are identical to the survey questions in the MY 2017 PAAS Survey Tool;
- The health plan captures the same data fields included in the MY 2017 PAAS Survey Tool; and
- The health plan must capture the raw data used to populate the *Results Template* and transfer the raw data into the *Raw Data Template* as part of its annual *Timely Access Compliance Report* submission.

STEP 8: Administering the Survey

The Department's PAAS Methodology presumes that all surveys will be initiated telephonically (during the phone call health plans may offer providers the option to complete the survey online, by fax or via a call-back number). The survey calls must be conducted between May 1, 2017 and December 31, 2017. The phone surveys should be conducted in two waves. For each PG/county, approximately 50% (and no more than 60%) of the

providers should be surveyed in each wave. Waves may be of any duration necessary to complete the assigned calls. Waves should be spaced at least six weeks apart. It is also recommended that during the second wave, health plans should attempt to schedule calls for a given PG on a different day of the week than previous calls. Additional notes for the surveyor:

- If the provider reports that the wait time would depend upon whether the patient is a new or existing patient, request the dates for both and use the later date (longer duration time).
- If the provider reports that patients are served on a walk-in or same day basis, ask the provider to confirm that walk-in slots are available that same day and, if so, enter the date and approximate time that a patient walking in at the time of the call would be seen. A confirmed slot for that date would be compliant.
- For surveys of PCPs, the “other practitioner/provider” mentioned in Questions 2 and 4 does not have to be a physician; the appointment may be with a nurse practitioner or physician assistant.
- Survey calls must be conducted during normal business hours.

Replacements: Ineligible Providers

A provider was erroneously selected and/or ineligible if he/she:

- Was erroneously identified as participating or is no longer participating in the health plan’s network;
- Was erroneously identified as practicing in, or is no longer practicing in the PG in that county;
- Has retired or for other reasons is no longer practicing;
- Was listed in the database under an incorrect specialty (e.g., is not a PCP); or
- Was listed in the database under an incorrect telephone number.

Depending on the circumstances, the health plan’s discovery that a provider was erroneously selected and/or ineligible for the PAAS, may also inform the health plan regarding a change of information requiring update of the health plan’s online provider directory or directories, in accordance with the requirements set forth in Section 1367.27, subd. (e).

Replacements: Non-Responding Providers

If a provider does not respond to one or more applicable items or declines to participate in the survey, that provider may be replaced with a provider from the oversample. To limit the number of phone calls to providers, inform the provider’s office of the additional options for responding to the survey, as soon as the surveyor learns that the provider is unable to participate at that time or has declined to participate. (See Additional Response Options, below which allows a provider to schedule a follow-up phone call or take the survey via fax or email.) In addition, health plans should consider engaging in outreach to non-responding providers from past surveys to encourage participation in this year’s survey and remind those providers of any contractual obligations to cooperate and provide information to the health plan.

Additional Response Options

To maximize response rates while minimizing disruption to provider schedules, the health plan may offer the following options:

- If a provider answers the call and declines to respond to the survey at the time of the call, but is willing to participate later, the health plan may offer the provider the option to:
 - Receive a follow-up call within 48 hours (upon request, calls may be scheduled at the provider's convenience); or
 - Complete the survey online, by fax or via a call-back number within 48 hours.
- If a provider office does not answer the call, the surveyor may leave a message requesting the provider complete the survey online or by fax (or optionally at the health plan's discretion via a call-back number) within 48 hours of the message.

If the provider does not complete the survey via one of the additional options listed above within 48 hours, the provider should be recorded as a non-responder and replaced with a provider from the oversample.

STEP 9: Calculating Compliance Rates

On March 31st, as part of its annual *Timely Access Compliance Report*, each health plan must submit the following items to the Department for PCPs, Specialists, Ancillary Providers, and Non-Physician Mental Health Providers:

- *Results Template* with the rate of compliance for each PG/group and for each group of individually contracted provider(s) for each county in the health plan's service area;
- *Raw Data Template*; and
- *Provider Contact List Template*.

The above materials should be submitted through the Timely Access web portal using the Department's templates (*all of which can be found on the DMHC's public Timely Access web page*).

Calculating Timeframes

Timeframes should be calculated consistently across all health plans, in accord with the following instructions:

- Urgent appointments are measured in hours and include weekends and holidays. Health plans must capture the date and time the provider responded to the questions and the date and time of the first available appointment identified by the provider's office.
- Non-urgent appointment standards are set forth in the Timely Access regulation in business days. For consistency, all health plans should use the following calculation:
 - When calculating calendar days, exclude the first day (e.g., the day of the

- request) and include the last day;
- Do not count or calculate business days; rather
 - Count 14 calendar days (including weekends and holidays) to calculate the 10 business days standards; and
 - Count 21 calendar days (including weekends and holidays) to calculate the 15 business days standards.
- For example: If a request for a PCP appointment is made on Tuesday the 15th, the PCP's office would have to identify an appointment on or before Tuesday the 29th in order to meet the 10 business day standard (calculated by counting forward 14 calendar days) for non-urgent primary care appointments.⁶

Survey Questions

On the *Results Template*, a compliance rate should be calculated for each PG/county for each health plan product using the Questions set forth in the Survey Tool for each provider type surveyed. In addition, the percentage of providers that declined to participate in the survey and were replaced as a result should be included on the *Results Template* in each PG/county for each provider type surveyed.

Primary Care Physicians

Questions 1-2 (Urgent Appointments)

- If the response to Question 1 results in a calculation indicating that: "Yes, there is an available appointment within 48 hours," the provider should be counted as compliant for urgent appointments in Calculation 1.
- If the provider's response results in a calculation indicating: "No, there is no available appointment within 48 hours," the surveyor should move to Question 2.
- If the response to Question 2 results in a "Yes, there is an available appointment within 48 hours" calculation, the provider should be counted as compliant in Calculation 2.
- If the response to Question 2 results in a calculation indicating: "No, there is no available appointment within 48 hours," the provider should be counted as non-compliant in Calculation 2.
- On the *Raw Data Template*, record the date and time of the appointment(s) and whether the appointment was available within 48 hours of the phone call made to the provider's office.

Referral of a patient to a different provider in a different office (e.g. a separate urgent care center) cannot be counted as the initially surveyed provider providing an appointment. If provider's office indicates that it does not offer urgent appointments, record "NA" on the *Raw Data Template*.

Add the total number of compliant providers based on Calculations 1 and 2 for each PG.

⁶ In this example, days would be counted as follows: Tuesday the 15th is not counted (because, as the day of the request, it is excluded), Day 1: Wednesday the 16th, Day 2: Thursday the 17th, Day 3: Friday the 18th, Day 4: Saturday the 19th, Day 5: Sunday the 20th, Day 6: Monday the 21st, Day 7: Tuesday the 22nd, Day 8: Wednesday the 23rd, Day 9: Thursday the 24th, Day 10: Friday the 25th, Day 11: Saturday the 26th, Day 12: Sunday the 27th, Day 13: Monday the 28th, Day 14: Tuesday the 29th.

Record this number (the numerator) on the Results *Template* in the “Number of Providers with an Urgent Care Appointment w/no Prior Auth w/in 48 Hours” field. Calculate the total number responding, which includes compliant and non-compliant providers. Do not count “NA” responses in the denominator or numerator for the 48 hour urgent appointment standard. Record this number (the denominator) in the “Number of Providers Responded to Urgent Care Appointment w/no Prior Auth w/in 48 Hours” field. Divide the total number compliant (numerator) by the total number responding (denominator). On the *Results Template*, record the rate of compliance for each product as a percentage (e.g., 89%) by using the following fields in the Results Template and the formula set forth below:

$$\frac{\text{Number of Providers with an Urgent Care Appointment w/no Prior Auth w/in 48 Hrs}}{\text{Number of Providers that Responded to Urgent Care Appointment w/no Prior Auth w/in 48 Hrs}} = \text{Rate of Compliance}$$

Note: Use “NA” (rather than 0%) if the 48 hour standard is not applicable to all providers within the entire PG.

Questions 3-4 (Non-Urgent Appointments)

- If the response to Question 3 results in a calculation indicating that: “Yes, there is an available appointment within 10 business days,” the provider should be counted as compliant in Calculation 3.
- If the provider’s response results in a calculation indicating: “No, there is no available appointment within 10 business days,” the surveyor should move to Question 4.
- If the response to Question 4 results in a “Yes, there is an available appointment within 10 business days” calculation, the provider should be counted as compliant in Calculation 4.
- If the response to Question 4 results in a calculation indicating: “No, there is no available appointment within 10 business days,” the provider should be counted as non-compliant in Calculation 4.
- On the *Raw Data Template*, record the date and time of the appointment(s) and whether the appointment was available within 10 business days of the phone call made to the provider’s office.

Add the total number of compliant providers from Calculations 3 and 4 for each PG. Record this number (the numerator) on the Results *Template* in the “Number of Providers with a Non-Urgent Care Appointment w/in 10 Days” field. Calculate the total number responding, which includes compliant and non-compliant providers. Record this number (the denominator) in the “Number of Providers Responded to Non-Urgent Care Appointment w/in 10 Days” field. Divide the total number compliant (numerator) by the total number responding (denominator). On the *Results Template*, record the rate of compliance for each product as a percentage (e.g., 89%)

by using the following fields in the Results Template and the formula set forth below:

$$\frac{\text{Number of Providers with a Non-Urgent Care Appointment w/in 10 Days}}{\text{Number of Providers that Responded to Non-Urgent Care Appointment w/in 10 Days}} = \text{Rate of Compliance}$$

Note: Use “NA” (rather than 0%) if the 10 business day standard is not applicable to all providers within the entire PG (e.g., all providers surveyed were found to be ineligible).

Question 5 (Interpreter Services) – Record the provider’s response (Yes or No) on the *Raw Data Template*. For each PG in each county, count the number of “Yes” responses and record this number (numerator) on the *Results Template* in the “Number of Providers Aware of Plan’s Obligation to Provide Interpreter Services” field. Use the “Number of Providers Responded” as the denominator to calculate and record a percentage in the “Rate of Providers Aware of Plan’s Obligation to Provide Interpreter Services” field.

Question 6 (Interpreter Services) – Record the provider’s response on the *Raw Data Template*. For each PG in each county, use the “Number of Providers Responded” as the denominator and the number of providers responding to each item as the numerator to calculate the percentage of providers that facilitate interpretation for each response. Record the percentage on the *Results Template* for each of the following items: Telephone, In-office, Patient’s Friend or Relative, Other Mechanism, I do not know, and Interpreter services are not available.

Calculating the Percentage of Non-Responding Providers

If a provider is eligible but does not respond to one or more items or declines to participate in the survey, that provider must be replaced with a provider selected from the oversample (if any oversample providers are available). The health plan should report the percentage of providers that declined to respond to one or more survey question for each provider type in each PG in each county. Count the number of non-responding providers from the sample and any oversample (the numerator). Count the number of providers who responded to the survey and those who declined to respond (the denominator). Divide the number of non-responding providers (the numerator) by the sum of the responding providers and non-responding providers (the denominator) to record the percentage of non-responding providers on the *Results Template*.

Table 5 – Calculating the Percentage of Non-Responding Providers

Number of Providers in PG/County	37
Target Survey Sample Size	27
Phone calls made to the initial sample of 27:	
Providers that responded to all survey questions	21
Providers that declined to answer or did not respond to message within 48 hours	4
Providers that were ineligible (e.g., retired)	2
Phone calls made to providers from the oversample that were used as replacements for ineligible providers and providers that declined to respond:	
Providers from oversample that responded to survey questions	6
Providers from oversample that were ineligible or declined to respond*	0
Number of Non-Responding Providers	4
Number of Providers Responded (21 initial and 6 replacements)	27
Add the Number of Providers Responded and the Number of Non-Responding Providers (27+4) (denominator)	31
Percentage of Non-Responding Providers ($4/31=.129$)	13%

*Eligible providers from the oversample may decline to respond. These should be counted in “Number of Non-Responding Providers” and replaced until the “Target Survey Sample Size” is achieved.

Specialists

Questions 1-2 (Urgent Appointments)

- If the response to Question 1 results in a calculation indicating that: “Yes, there is an available appointment within 96 hours,” the provider should be counted as compliant for urgent appointments in Calculation 1.
- If the provider’s response results in a calculation indicating: “No, there is no available appointment within 96 hours,” the surveyor should move to Question 2.
- If the response to Question 2 results in a “Yes, there is an available appointment within 96 hours” calculation, the provider should be counted as compliant in Calculation 2.
- If the response to Question 2 results in a calculation indicating: “No, there is no available appointment within 96 hours,” the provider should be counted as non-compliant in Calculation 2.
- On the *Raw Data Template*, record the date and time of the appointment(s) and whether the appointment was available within 96 hours of the phone call made to the provider’s office.

Referral of a patient to a different provider in a different office (e.g. a separate urgent care

center) cannot be counted as the initially surveyed provider providing an appointment. If provider’s office indicates that it does not offer urgent appointments, record “NA” on the *Raw Data Template*.

Add the total number of compliant providers based on Calculations 1 and 2 for each PG. Record this number (the numerator) on the *Results Template* in the “Number of Providers with an Urgent Care Appointment w/Prior Auth w/in 96 Hours” field. Calculate the total number responding, which includes compliant and non-compliant providers. Do not count “NA” responses in the denominator or numerator for the 96 hour urgent appointment standard. Record this number (the denominator) in the “Number of Providers Responded to Urgent Care Appointment w/Prior Auth w/in 96 Hours” field. Divide the total number compliant (numerator) by the total number responding (denominator). On the *Results Template*, record the rate of compliance for each product as a percentage (e.g., 89%) by using the following fields in the Results Template and the formula set forth below:

$$\frac{\text{Number of Providers with an Urgent Care Appointment w/Prior Auth w/in 96 Hours}}{\text{Number of Providers that Responded to Urgent Care Appointment w/Prior Auth w/in 96 Hours}} = \text{Rate of Compliance}$$

Note: Use “NA” (rather than 0%) if the 96 hour standard is not applicable to all providers within the entire PG.

Questions 3-4 (Non-Urgent Appointments)

- If the response to Question 3 results in a calculation indicating that: “Yes, there is an available appointment within 15 business days,” the provider should be counted as compliant in Calculation 3.
- If the provider’s response results in a calculation indicating: “No, there is no available appointment within 15 business days” the surveyor should move to Question 4.
- If the response to Question 4 results in a “Yes, there is an available appointment within 15 business days” calculation, the provider should be counted as compliant in Calculation 4.
- If the response to Question 4 results in a calculation indicating: “No, there is no available appointment within 15 business days,” the provider should be counted as non-compliant in Calculation 4.
- On the *Raw Data Template*, record the date and time of the appointment(s) and whether the appointment was available within 15 business days of the phone call made to the provider’s office.

Add the total number of compliant providers from Calculations 3 and 4 for each PG. Record

this number (the numerator) on the Results *Template* in the “Number of Providers with a Non-Urgent Care Appointment w/in 15 Days” field. Calculate the total number responding, which includes compliant and non-compliant providers. Record this number (the denominator) in the “Number of Providers Responded to Non-Urgent Care Appointment w/in 15 Days” field. Divide the total number compliant (numerator) by the total number responding (denominator). On the *Results Template*, record the rate of compliance for each product as a percentage (e.g., 89%) by using the following fields in the Results Template and the formula set forth below:

$$\frac{\text{Number of Providers with a Non-Urgent Care Appointment w/in 15 Days}}{\text{Number of Providers that Responded to Non-Urgent Care Appointment w/in 15 Days}} = \text{Rate of Compliance}$$

Note: Use “NA” (rather than 0%) if the 15 business day standard is not applicable to all providers within the entire PG.

Question 5 (Interpreter Services) – Record the provider’s response (Yes or No) on the *Raw Data Template*. For each PG in each county, count the number of “Yes” responses and record this number (numerator) on the *Results Template* in the “Number of Providers Aware of Plan’s Obligation to Provide Interpreter Services” field. Use the “Number of Providers Responded” as the denominator to calculate and record a percentage in the “Rate of Providers Aware of Plan’s Obligation to Provide Interpreter Services” field.

Question 6 (Interpreter Services) – Record the provider’s response on the *Raw Data Template*. For each PG in each county, use the “Number of Providers Responded” as the denominator and the number of providers responding to each item as the numerator to calculate the percentage of providers that facilitate interpretation for each response. Record the percentage on the *Results Template* for each of the following items: Telephone, In-office, Patient’s Friend or Relative, Other Mechanism, I do not know, and Interpreter services are not available..

Calculating the Percentage of Non-Responding Providers

If a provider is eligible but does not respond to one or more items or declines to participate in the survey, that provider must be replaced with a provider selected from the oversample (if any oversample providers are available). The health plan should report the percentage of providers that declined to respond to one or more survey question for each provider type in each PG in each county. Count the number of non-responding providers from the sample and any oversample (the numerator). Count the number of providers who responded to the survey and those who declined to respond (the denominator). Divide the number of non-responding providers (the numerator) by the sum of the responding providers and non-responding

providers (the denominator) to record the percentage of non-responding providers on the *Results Template*. (See Table 5, above for an example of how to calculate the percentage of Non-Responding Providers.)

**Non-Physician Mental Health Providers
Questions 1-2 (Urgent Appointments)**

- If the response to Question 1 results in a calculation indicating that: “Yes, there is an available appointment within 96 hours,” the provider should be counted as compliant for urgent appointments in Calculation 1.
- If the provider’s response results in a calculation indicating: “No, there is no available appointment within 96 hours,” the surveyor should move to Question 2.
- If the response to Question 2 results in a “Yes, there is an available appointment within 96 hours” calculation, the provider should be counted as compliant in Calculation 2.
- If the response to Question 2 results in a calculation indicating: “No, there is no available appointment within 96 hours,” the provider should be counted as non-compliant in Calculation 2.
- On the *Raw Data Template*, record the date and time of the appointment(s) and whether the appointment was available within 96 hours of the phone call made to the provider’s office.

Referral of a patient to a different provider in a different office (e.g. a separate urgent care center) cannot be counted as the initially surveyed provider providing an appointment. If provider’s office indicates that it does not offer urgent appointments, record “NA” on the *Raw Data Template*.

Add the total number of compliant providers based on Calculations 1 and 2 for each PG. Record this number (the numerator) on the *Results Template* in the “Number of Providers with an Urgent Care Appointment w/Prior Auth w/in 96 Hours” field. Calculate the total number responding, which includes compliant and non-compliant providers. Do not count “NA” responses in the denominator or numerator for the 96 hour urgent appointment standard. Record this number (the denominator) in the “Number of Providers Responded to Urgent Care Appointment w/Prior Auth w/in 96 Hours” field. Divide the total number compliant (numerator) by the total number responding (denominator). On the *Results Template*, record the rate of compliance for each product as a percentage (e.g., 89%) by using the following fields in the Results Template and the formula set forth below:

$$\frac{\text{Number of Providers with an Urgent Care Appointment w/Prior Auth w/in 96 Hours}}{\text{Number of Providers that Responded to Urgent Care Appointment w/Prior Auth w/in 96 Hours}} = \text{Rate of Compliance}$$

Note: Use “NA” (rather than 0%) if the 96 hour standard is not applicable to all providers within the entire PG.

Questions 3-4 (Non-Urgent Appointments)

- If the response to Question 3 results in a calculation indicating that: “Yes, there is an available appointment within 10 business days,” the provider should be counted as compliant in Calculation 3.
- If the provider’s response results in a calculation indicating: “No, there is no available appointment within 10 business days,” the surveyor should move to Question 4.
- If the response to Question 4 results in a “Yes, there is an available appointment within 10 business days” calculation, the provider should be counted as compliant in Calculation 4.
- If the response to Question 4 results in a calculation indicating: “No, there is no available appointment within 10 business days,” the provider should be counted as non-compliant in Calculation 4.
- On the *Raw Data Template*, record the date and time of the appointment(s) and whether the appointment was available within 10 business days of the phone call made to the provider’s office.

Add the total number of compliant providers from Calculations 3 and 4 for each PG. Record this number (the numerator) on the *Results Template* in the “Number of Providers with a Non-Urgent Care Appointment w/in 10 Days” field. Calculate the total number responding, which includes compliant and non-compliant providers. Record this number (the denominator) in the “Number of Providers Responded to Non-Urgent Care Appointment w/in 10 Days” field. Divide the total number compliant (numerator) by the total number responding (denominator). On the *Results Template*, record the rate of compliance for each product as a percentage (e.g., 89%) by using the following fields in the *Results Template* and the formula set forth below:

$$\frac{\text{Number of Providers with a Non-Urgent Care Appointment w/in 10 Days}}{\text{Number of Providers that Responded to Non-Urgent Care Appointment w/in 10 Days}} = \text{Rate of Compliance}$$

Note: Use “NA” (rather than 0%) if the 10 business day standard is not applicable to all providers within the entire PG.

Question 5 (Interpreter Services) – Record the provider’s response (Yes or No) on the *Raw Data Template*. For each PG in each county, count the number of “Yes” responses and record this number (numerator) on the *Results Template* in the “Number of Providers Aware of Plan’s Obligation to Provide Interpreter Services” field. Use the “Number of Providers Responded” as the denominator to calculate and record a percentage in the “Rate of

Providers Aware of Plan’s Obligation to Provide Interpreter Services” field.

Question 6 (Interpreter Services) – Record the provider’s response on the *Raw Data Template*. For each PG in each county, use the “Number of Providers Responded” as the denominator and the number of providers responding to each item as the numerator to calculate the percentage of providers that facilitate interpretation for each response. Record the percentage on the *Results Template* for each of the following items: Telephone, In-office, Patient’s Friend or Relative, Other Mechanism, I do not know, and Interpreter services are not available.

Calculating the Percentage of Non-Responding Providers

If a provider is eligible but does not respond to one or more items or declines to participate in the survey, that provider must be replaced with a provider selected from the oversample (if any oversample providers are available). The health plan should report the percentage of providers that declined to respond to one or more survey question for each provider type in each PG in each county. Count the number of non-responding providers from the sample and any oversample (the numerator). Count the number of providers who responded to the survey and those who declined to respond (the denominator). Divide the number of non-responding providers (the numerator) by the sum of the responding providers and non-responding providers (the denominator) to record the percentage of non-responding providers on the *Results Template*. (See Table 5, above for an example of how to calculate the percentage of Non-Responding Providers.)

Ancillary

Question 1 (Non-Urgent Appointments)

- If the response to Question 1 results in a calculation indicating that: “Yes, there is an available appointment within 15 business days,” the provider should be counted as compliant in Calculation 1.
- If the provider’s response results in a calculation indicating: “No, there is no available appointment within 15 business days” the surveyor should move to Question 2.
- If the response to Question 2 results in a “Yes, there is an available appointment within 15 business days” calculation, the provider should be counted as compliant in Calculation 2.
- If the response to Question 2 results in a calculation indicating: “No, there is no available appointment within 15 business days,” the provider should be counted as non-compliant in Calculation 2.
- On the *Raw Data Template*, record the date and time of the appointment(s) and whether the appointment was available within 15 business days of the phone call made to the provider’s office.

Add the total number of compliant providers from Calculations 1 and 2 for each PG. Record this number (the numerator) on the *Results Template* in the “Number of Providers with a Non-Urgent Care Appointment w/in 15 Days” field. Calculate the total number responding, which includes compliant and non-compliant providers. Record this number (the denominator) in the “Number of Providers Responded to Non-Urgent Care Appointment w/in 15 Days” field. Divide the total number compliant (numerator) by the total number responding (denominator). On the

Results Template, record the rate of compliance for each product as a percentage (e.g., 89%) by using the following fields in the Results Template and the formula set forth below:

$$\frac{\text{Number of Providers with a Non-Urgent Care Appointment w/in 15 Days}}{\text{Number of Providers that Responded to Non-Urgent Care Appointment w/in 15 Days}} = \text{Rate of Compliance}$$

Note: Use “NA” (rather than 0%) if the 15 business day standard is not applicable to all providers within the entire PG.

Question 2 (Interpreter Services) – Record the provider’s response (Yes or No) on the *Raw Data Template*. For each PG in each county, count the number of “Yes” responses and record this number (numerator) on the *Results Template* in the “Number of Providers Aware of Plan’s Obligation to Provide Interpreter Services” field. Use the “Number of Providers Responded” as the denominator to calculate and record a percentage in the “Rate of Providers Aware of Plan’s Obligation to Provide Interpreter Services” field.

Question 3 (Interpreter Services) – Record the provider’s response on the *Raw Data Template*. For each PG in each county, use the “Number of Providers Responded” as the denominator and the number of providers responding to each item as the numerator to calculate the percentage of providers that facilitate interpretation for each response. Record the percentage on the *Results Template* for each of the following items: Telephone, In-office, Patient’s Friend or Relative, Other Mechanism, I do not know, and Interpreter services are not available.

Calculating the Percentage of Non-Responding Providers

If a provider is eligible but does not respond to one or more items or declines to participate in the survey, that provider must be replaced with a provider selected from the oversample (if any oversample providers are available). The health plan should report the percentage of providers that declined to respond to one or more survey question for each provider type in each PG in each county. Count the number of non-responding providers from the sample and any oversample (the numerator). Count the number of providers who responded to the survey and those who declined to respond (the denominator). Divide the number of non-responding providers (the numerator) by the sum of the responding providers and non-responding providers (the denominator) to record the percentage of non-responding providers on the *Results Template*. (See Table 5, above for an example of how to calculate the percentage of Non-Responding Providers.)

STEP 10: Quality Assurance Process

Health plans are required to utilize an external vendor to validate the health plan's timely access data and conduct a quality assurance review of the health plan's *Timely Access Compliance Report*, prior to submission to the Department. Each health plan must have a quality assurance process to ensure that it followed the PAAS methodology and that the Timely Access Compliance Report submitted to the Department is true, complete and accurate, pursuant to Section 1396. At a minimum, the external vendor's data validation and quality assurance review must ensure all of the following:

- The health plan used the Department's required templates for MY 2017.
- The health plan reported survey results for all provider types that were required to be surveyed, as applicable, based on the composition of the health plan's network during MY 2017.
- The *Timely Access Compliance Report* (including the *Provider Contact List Template*, the *Raw Data Template*, and the *Results Template*) accurately reflects and reports compliance for providers who were under contract with and part of the health plan's DMHC-regulated network(s) at the time the *Provider Contact List* was generated.
- All rates of compliance for the health plan recorded on the *Results Template* are accurately calculated, consistent with, and supported by data entered on the health plan's *Raw Data Template*.
- The administration of the survey followed the mandatory Department methodology for MY 2017, including, but not limited to, conducting the survey during the appropriate measurement year and ensuring adherence to all target sample sizes and other parameters required under the methodology.

As part of its *Timely Access Compliance Report*, the health plan must include an *External Vendor Validation Report* prepared by the external vendor outlining the results of the vendor's data validation and quality assurance review and including details regarding the vendor's review of each verification item identified above. In addition, the *External Vendor Validation Report* shall summarize the vendor's findings and identify any changes and/or corrections made by the health plan or the external vendor as a result of the data validation and quality assurance review.

If the external vendor's data validation and quality assurance review identified errors or issues that the health plan is unable to correct (e.g., the survey was conducted during the wrong measurement year, the health plan failed to survey a mandated provider type that existed in the health plan's network, or the health plan was unable to survey the required target sample size), the *External Vendor Validation Report* must include this information, and the health plan must explain why it was unable to comply with the mandatory Department-issued methodology and identify steps to be taken by the health plan to ensure compliance during future reporting years.

The *External Vendor Validation Report* and any accompanying health plan explanations must be submitted through the Department Timely Access Web Portal, in the Comment/Narrative section.

Appendix 1: Sample Size Chart⁷

To determine the correct sample size, look up the number of de-duplicated providers in the PG/county in the “Number of Providers” column. In addition, an oversample must also be randomly selected and provided to the surveyor with this sample, in the event that one of the providers selected as part of the sample declines to respond or is ineligible for the survey for a reason identified in “Replacements: Ineligible Provider” section in Step 8, above. (See the “Select a Random Sample for Replacements” section under Step 4.)

Number of Providers in County PG	Number of Providers Sampled	Number of Providers in County PG	Number of Providers Sampled	Number of Providers in County PG	Number of Providers Sampled
1	1	35	25	180-189	55
2	2	36-40	27	190-204	56
3	3	41-45	29	205-220	57
4	4	46-50	31	221-232	58
5	5	51-55	33	233-250	59
6	6	56-60	34	251-269	60
7	7	61-65	36	270-293	61
8	8	66-70	37	294-318	62
9-10	9	71-75	39	319-349	63
11	10	76-80	40	350-385	64
12	11	81-85	41	386-412	65
13-14	12	86-90	42	413-460	66
15	13	91-95	43	461-529	67
16	14	96-100	44	530-598	68
17-18	15	101-105	45	599-680	69
19	16	106-110	46	681-794	70
20-21	17	111-120	47	795-912	71

⁷ Sample sizes were calculated to produce confidence limits of +- 8% for an expected compliance rate of 85% with a 95% confidence level. In other words, we would be 95% sure that the actual county PG compliance rate is within +-8% given a compliance rate estimate of 85%. This table was created using a sample size calculation with a finite population correction: $n = [N * p(1-p)] / [((d^2 / (Z^2)) * (N-1)) + p(1-p)]$, where n is the sample size, N represents the number of providers in a county PG (population size), p is the rate of .85, d is the confidence limit of .08, and Z is the score of 1.96 required for a 95% confidence level. These target sample sizes are expected produce confidence limits of +- 2% or lower at the health plan level of reporting for most health plan networks.

Number of Providers in County PG	Number of Providers Sampled	Number of Providers in County PG	Number of Providers Sampled	Number of Providers in County PG	Number of Providers Sampled
22-23	18	121-125	48	913-1,138	72
24	19	126-130	49	1,139-1,435	73
25-26	20	131-139	50	1,436-2,112	74
27-28	21	140-150	51	2,113-3,339	75
29-30	22	151-159	52	3,340-10,000	76
31-32	23	160-170	53		
33-34	24	171-179	54		

- Example:** If the PG/county has 84 PCPs, select the sample size of 41. While only 41 PCPs will be surveyed, the remaining 43 PCPs are also selected for replacements. (Although the health plan could have selected a smaller percentage based on the percentage of providers that were ineligible or declined to be surveyed in prior years, the remainder of the group was also randomly selected as an oversample to ensure that the health plan will meet the target sample size for the PG/County.)

Appendix 2: Random Number Generation

Excel Method

Once a health plan has determined the appropriate sample size for each PG/county, it will need to determine which providers to call and survey. Use the Random Number Generation tool (described below) to identify which providers to survey from the de-duplicated Provider Contact List.

1. Open the Excel workbook of the Provider Contact List.
2. For each PG/county, place the PCPs, Cardiologists, Endocrinologists, Gastroenterologists, Psychiatrists, Child and Adolescent Psychiatrists, Non-Physician Mental Health Providers, Physical Therapy Appointments, MRI Appointments, and Mammogram Appointments in separate workbook tabs. (If it is preferable to keep all data in one workbook tab, perform steps 1-11 below. Then perform the sort in step 12 by Provider Group, County, PCP, Specialty/Subspecialty and then Random Number.)
3. Create a new column to the left of "A" on your spreadsheet by moving cursor to the break line next to column "A." Right click and click on "insert." This will create a new blank column to the left of column A. (Alternatively, highlight column A and select "insert" then "insert sheet columns.")
4. Place cursor in column A in the cell beside the first provider.
5. Go to "formulas."
6. Click on "insert function."
7. Select a function = "RAND" (if RAND is not an option initially, use "search for a function" and type in "random"). The formula should result in "=Rand()" in the cell.
8. Copy and paste the function down column A beside each provider in the table.
9. If done correctly, a list of numbers with decimals in column A will be generated.
10. To convert the formula to a numeric value for sorting purposes, highlight Column A, from the "Home" tab select "copy," "paste," and "paste values."
11. Highlight the entire spreadsheet by clicking on the very top left of the spreadsheet (gray area where A and 1 intersect).
12. Go to Data, select "Sort," and sort by column A. Be sure to check "my data has headers" so that your headers will remain in the first row.
13. Starting with the first row, use the number of rows indicated by the sample size calculator (plus additional rows for the oversample unless the health plan intends to supply the surveyors with the entire list, in random order) as your survey list. It may be helpful to add a column to label the primary sample vs. oversample/remaining cases so that the surveyor will not call, oversample cases beyond those needed as replacements.

SAS Method

A simple random sample may be generated using the SURVEYSELECT procedure in SAS. Using the simple random sample methodology and no stratification in the sample design, the selection probability is the same for all units in the sample.

Mental Health Provider Addendum

Rule 1300.67.2.2, subd. (c)(5)(B), (D), and (E) requires health plans to ensure access to mental health services with specialty physicians (i.e., psychiatrists) and non-physician mental health providers. Health plans must report rates of compliance for these providers with the following timeframes:

Psychiatrists and Child and Adolescent Psychiatrists

- Urgent appointments (with prior authorization) – 96 hours from request
- Non-urgent appointments – 15 business days from request

Non-Physician Mental Health Providers

- Urgent appointments (with prior authorization) – 96 hours from request
- Non-urgent appointments – 10 business days from request

SB 964 requires health plans to report rates of compliance with each of these time elapsed standards separately for commercial, Medi-Cal and/or individual/family plan products. As such, if the health plan uses a separate network for these product lines, the health plan will need to repeat the random sampling steps listed below for each network. Note that even if a health plan uses the same provider network for all products and, therefore, uses one sample of providers to conduct the survey for all products, the health plan is still required to report rates separately for each product.

Plan-to-Plan Arrangements

Health plans that contract with another Knox-Keene Act licensed health plan to provide mental health services in a specific county are not required to report a rate of compliance to the Department for the specific counties for which the health plan has contracted with another health plan. Instead, a health plan that contracts with another Knox-Keene Act licensed health plan to provide mental health services must indicate the following in the health plan's Profile and in the Comment/Narrative section of its Timely Access web portal:

- (1) The name of the subcontracting health plan that provides mental health services,
- (2) The counties in which the subcontracting health plan provides mental health services for the primary contracting health plan,
- (3) The scope of services that are obtained through the subcontracting health plan (including psychiatric and non-physician mental health provider services), and
- (4) The products that are served through this contractual relationship.

If a health plan has counties for which it does not contract with another Knox-Keene Act licensed health plan to provide mental health services or for which it contracts with other providers in addition to a subcontracting Knox-Keene Act licensed health plan, the health plan must conduct a survey and report a rate of compliance for those counties/providers. (See "Plan-to-Plan Agreements" for further information related to

reporting health plan-to-health plan arrangements.)

Options for Reporting Rates of Compliance for Mental Health Providers

To demonstrate compliance with urgent and non-urgent appointment standards, health plans may use any of the three options described below. Given the differences in the ways health plans currently arrange for urgent vs. non-urgent appointments, health plans may select a different option for measuring and reporting compliance with urgent standards than the one selected for non-urgent standards. However, health plans may only use one option for measuring a given standard (e.g., health plans may not use actual appointment wait time data to measure some providers on the urgent non-physician mental health appointment standard, and then measure other providers on the same standard through the use of phone survey data).

Using one of the three options set forth below, health plans should survey and submit results for the following mental health provider types:

- Psychiatrist
- Child and Adolescent Psychiatrist
- Non-Physician Mental Health Provider⁸
 - PhD and above (including Psychologist)
 - Masters Degree Provider

Option 1: Actual Appointment Wait Time Information: This data should be drawn from a health plan's own data system, having been collected by health plan clinical/case management staff that identified a situation in which a member required an urgent appointment and then arranged for and tracked that appointment. Under this option, health plans should *not* pull a sample of providers. Instead, the health plan should provide the rate of compliance based upon *all* appointments requested during the measurement year. Generally this data would only be available for the urgent appointment standards listed above; however, if the health plan collects the data for non-urgent appointments, this option may also be used for non-urgent appointment standards for non-physician mental health providers. For psychiatrists and child and adolescent psychiatrists, health plans may only use this method for urgent appointment standards.

For each appointment, the health plan should compare the date and time of the member's call requesting an appointment, to the date and time for which the appointment was set. If an appointment for urgent care services that requires prior authorization was scheduled within 96 hours of the request for appointment, the appointment should be counted as compliant. (See Step 9: Calculating Compliance Rates for further information related to calculating hours and business days.) For each standard, add the total number of compliant appointments and divide that number by the total number of appointments. As noted above, if the health plan has commercial, Medi-Cal and/or individual/family plan products, the urgent appointments should be classified by product and the rate of compliance should be reported separately for each product and each standard. Although

⁸ Psychiatric mental health nurses should be included in the non-physician mental health provider appointment standards.

health plans may have few PG/counties in their mental health networks, the law requires the separate reporting of rates of compliance for each medical group. All individually contracted providers should be combined into one group for purposes of calculating and reporting compliance rates.

Option 2: Phone Survey: Administration of the phone survey and creation of Provider Contact List(s) should be performed based upon instructions previously described in the PAAS Methodology.

The sample sizes, random selection process, replacement/oversampling process, reporting of rates separately for each network, reporting of rate separately for each standard, and all other instructions described earlier for PCPs must be applied in the same way when surveying and measuring mental health providers by telephone. Use the instructions described in the PAAS Methodology (above) and the Survey Tool when surveying mental health specialist physicians and non-physician mental health providers.

Option 3: Online Survey: The survey will be administered via email either directly by the health plan or by using an online survey vendor. Please Note: this option is available only in connection with measurement of the rate of compliance for psychiatrists, child and adolescent psychiatrists, and non-physician mental health providers.

The online survey must be conducted annually in two waves, at least six weeks apart. No sampling is permitted. An email must be sent to all providers for whom the health plan has email addresses. Approximately 50% (and no more than 60%) of the providers should be surveyed in each wave.

After sending the initial email invitation regarding the survey, a reminder email must be sent 24 hours later, notifying providers who have not responded that they only have 24 hours remaining to respond. The official time period for the survey is 48 hours.

The online survey must ask the provider to identify the date of his/her next available non-urgent appointment (and urgent appointment unless measured by another option). Language to be used for the Online Survey Tool is set forth below. Health plans are permitted to make minor adjustments to the introductory language, add language that allows confirmations of the provider's identifying information, and add a short number of additional questions or items that allow the health plan to survey or measure other concerns.

Responses to online surveys for the permitted provider types must be submitted using the Department's *Results Template*. All directions for calculating the figures on the *Results Template* must be consistent with Step 9: Calculating Compliance Rates, including questions related to interpreter services.

In a narrative, the health plan should include compliance rates for each network, for each of the provider categories listed above, including the total number of providers in the category, the total number and percentage for which the health plan had e-mail

addresses available, and the total number and percentage of responses.

Online Survey Tool

Hello and thank you for participating in this online survey. This online survey is designed to help [insert health plan name] better assess enrollee access to provider services. Please respond to this survey no later than 48 hours of this email message.

[For the follow-up email message sent 24 hours after the original message, the health plan should change the requested response time from 48 hours to 24 hours.]

[Optional: As noted above, health plans may use the online survey as a mechanism to confirm provider contact information by providing a phone number or email address to separately report any updates or corrections to the provider's information.]

1. Urgent services means health care for a condition which requires prompt attention, but does not rise to the level of an emergency. When is your next available appointment date and time for urgent services?

[Allow space for provider to insert date (mm/dd/yy) and time (hh:mm am/pm).]

[If no appointment is available within 96 hours, the responding provider should be directed to answer Question 2. (Weekends and holidays must be included when calculating hours.)]

2. Is there another practitioner in the same physical office who could see the patient sooner? If so, on what date and time is the earliest appointment for urgent services?

[Allow space for provider to insert date (mm/dd/yy) and time (hh:mm am/pm).]

3. When is your next available appointment date and time for non-urgent services?

[Allow space for provider to insert date (mm/dd/yy) and time (hh:mm am/pm).]

[If no appointment is available within 15 business days (calculated as 21 calendar days) for psychiatrist or 10 business days (calculated as 14 calendar days) for non-physician mental health providers, the responding provider should be directed to answer Question 4. When calculating calendar days exclude the first day (e.g., the day of request) and include the last day. Weekends and holidays must be included when calculating calendar days.]

4. Is there another practitioner in the same physical office who could see the patient sooner? If so, on what date and time is the earliest appointment for non-urgent services?

[Allow space for provider to insert date (mm/dd/yy) and time (hh:mm am/pm).]

5. Are you aware that health plans are required to provide and coordinate interpreter services at the time of a patient's scheduled appointment?

- Yes, I was aware.
- No, I was not aware.

6. How are interpreter services provided to patients at your office? (Select one or more)

- Telephone
- Video-conference
- In-office
- Patient's friend or relative
- Other mechanism
- Interpreter services are not available
- I do not know

Language Assistance Program Assessment Addendum

For MY 2017, the PAAS methodology requires health plans to include questions related to provider language capability and practices, as set forth in the Survey Tool. In addition, health plans are also required to assess provider perspective and concerns with the health plan's language assistance program regarding (1) the coordination of appointments with an interpreter, (2) the availability of an appropriate range of interpreters, and (3) the training and competency of available interpreters. These additional required questions-designed to elicit providers concerns and perspectives-may be posed through one of the following mechanisms:

1. Via a change to the health plan's existing Annual Provider Satisfaction Survey (See Rule 1300.67.2.2, subd. (c)(4) and (d)(2)(C).);
2. In a separate provider survey; or
3. At the end of the PAAS, the health plan may include additional questions regarding these topics.

Results obtained by the health plan during its assessment of the identified language assistance issues identified above must be reported with the plan's *Timely Access Compliance Report* in the Comment/Narrative section.

In addition, health plans are required to utilize information obtained related to provider perspectives and concerns in this area in connection with the plan's timely access monitoring quality assurance activities and language assistance program compliance monitoring for MY 2017. (See Section 1367.01, Rule 1300.67.2.2, subd. (d), and Rules 1300.67.04, subd. (c)(2)(E) and (c)(4)(A).)