DEPARTMENT OF MANAGED HEALTH CARE
PROVIDER APPOINTMENT AVAILABILITY SURVEY METHODOLOGY

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Department of Managed Health Care
Provider Appointment Availability Survey Methodology

Included below are step-by-step instructions for using the Provider Appointment Availability Survey (PAAS) Methodology developed by the Department of Managed Health Care. For Measurement Year (MY) 2015, plans are required to use either (1) the PAAS Survey Methodology or (2) the Department's Provider Appointment Availability Audit Methodology.

The ultimate reporting goal will be to produce compliance rates as follows:

Table 1 – Reporting Goal

Network	County	Provider Group	# of PCPs in Group	Target Survey Sample Size	Survey Item 1 Number Compliant	Survey Item 1 Compliance Rate	Survey Item 2	etc.
Commercial	A	1	25					
		2	58	45	35	77.8%[#]		
		3	40	34	29	85.3% [##]		
	B	1						
		6*						
	C	1						
		4						
		6						
		9						
		12	30	27	25	92.6%[###]		
Medi-Cal	A	1	25					
		2	58**	45	35	77.8%		
		3	10***	10				
	C	1						
		4						
		12	30	27	23	85.2%		
Individual	A	1	25					
		2	58	45				

*The plan's commercial and Medi-Cal networks are different (e.g., PGs 6 and 9 chose not to participate in Medi-Cal).

**In County A, PG 2 has 58 PCPs, all 58 participate in the commercial, Medi-Cal and individual/family networks; therefore, the same sample of 45 PCPs can be used for each network.

***In County A, PG 3 has 40 PCPs participating in the commercial network but only 10 chose to participate in the Medi-Cal network; therefore, a distinct PCP sample is required for this PG for each network. The plan will sample 34 PCPs from the commercial network and all 10 of the 10 Medi-Cal PCPs.

#If 45 are sampled and 35 were compliant the compliance rate is 35/45 = 77.8%

##If 34 are sampled and 29 are compliant, the compliance rate is 29/34 = 85.3%

###Although the same sample of providers was used for PG 12 to survey for commercial and Medi-Cal, compliance rates are different. Two providers did not have appointments available for commercial patients within timeframes; however, four providers did not have appointments available for Medi-Cal patients.

STEP 1: Determine which networks to survey.

SB 964 requires plans to report separately its rate of compliance with the time elapsed standards for its commercial, Medi-Cal and/or individual/family plan products. If a plan uses the same network for all products, it will randomly sample that network only once and use the sample to create rates for all products. If, however, a plan has separate Medi-Cal networks or separate individual/family product networks, the plan will need to repeat the random sampling steps listed below for 1) each of its Medi-Cal provider networks and/or 2) each of its individual/family plan provider network.

Note that even if a plan uses the same provider network for all products and, therefore, uses one sample of providers to conduct the survey for all products, the plan must report rates separately for each product. This is because a provider that schedules appointments differently for different products (e.g,, holds a block of appointments specifically for a given product) may be compliant with wait times for one product and non-compliant for another product. The survey tool will verify wait times for each product separately (see Step 8).

Medi-Cal Networks:

A separate Medi-Cal network means any network that is different from the plan's commercial network. In addition, if a plan contracts with another plan to provide Medi-Cal services, the plan will need to separately report each of the contracted networks. For example, if a plan contracts with three other plans to provide Medi-Cal services, the reporting plan will need to separately report all three contracted networks. For MY2015, plans are not required to report Cal-Medi Connect as a separate Medi-Cal network.

Individual/Family Plans:

To the extent that a plan has separate networks for its individual/family products, each network will need to be separately reported. For example, if a plan has an individual HMO product and an individual EPO product that both have separate networks from the plan's larger commercial network, the plan will need to separately report three separate rates of compliance for each

network (HMO, EPO, and greater commercial network) for each applicable county in the plan's network.

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[1]" that contracts with a plan. (*See* Health & Safety Code section 1367(g).) A plan will need to identify all PGs participating within in each county of the plan's service area. When identifying its PGs, it may be helpful for plans to note those PGs that have special capabilities or contact requirements, such as a central call center for Primary Care Physicians (PCPs) or specialty-specific scheduling, in order to help determine the best number and time to contact providers.

STEP 3: Create Provider Contact List

To begin, a plan will need to create at least three separate data sets that identify the physicians, non-physician mental health providers and ancillary providers within the plan's network. For most plans, the simplest approach is to begin by entering the data in an Excel spreadsheet similar to the excel data templates required for the plan's Timely Access Network Data reports. As such, the remainder of these instructions will assume that plans are using Excel and including the data fields listed below.

Table 2 – Provider Contact List Data Fields

Physician Provider Contact List	Non Physician Mental Health Providers	Ancillary Providers
Last Name	Last Name	DBA
First Name	First Name	
NPI	NPI	NPI
Office phone number	Phone Number	Phone Number
CA License	CA License/Certificate (title of the license or certificate the provider holds. For example, Marriage and Family Therapist, Licensed Clinical Social Worker, Nurse, Nurse Practitioner/Physician Assistant, Professional Clinical Counselor (LPCC), Psychologist - PHD-Level.)	CA License
Type of Licensure		
Board Certified (Y/N)		

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[1] This includes clinics licensed under Health & Safety Code section 1204(a).

Participating Network	Participating Network	Participating Network
Name of Network (The name used by the Plan to describe its Participating Network)	Name of Network (The name used by the Plan to describe its Participating Network)	Name of Network (The name used by the Plan to describe its Participating Network)
Address	Address	Address
City	City	City
County	County	County
State	State	State
Zip Code	Zip Code	Zip Code
Specialty Type	Specialty/Area of Expertise	Ancillary Provider Category (i.e., Physical Therapy, Diagnostic Imaging, MRI, Mammogram, Infusion, etc.)
Medical Group / IPA	Medical Group/IPA	Medical Group/IPA

To simplify this process, the Department selected the same (or very similar) database fields as those required by the Department for the submission of provider network data to the Timely Access Web Portal. Also, specialties, counties and other look-up codes are available on the DMHC website in the provider network submission templates. Plans may include in their Provider Contact List additional contact information, including but not limited to, provider email addresses.

Providers who are members of multiple PGs should have an entry for <u>each PG</u>. Providers who are members of a PG(s) as well as individually contracting with the plan should only be included under their PG(s). Once the Provider Contact Lists are complete, the datasets should be reviewed and duplicate entries should be removed. Duplicate entries are rows where the same provider name, provider group, address and phone number appear more than once. (Providers that appear in multiple provider groups are not duplicate entries – this is explained in more detail under Step 4.)

Plans will need to submit the Provider Contact List when submitting their annual reports.

<u>Individually Contracted Primary Care Physicians</u>

"Individually Contracted Primary Care Physician" means any primary care physician that contracts individually with the plan. All plans are required to survey individually contracted PCPs.

<u>Other Individually Contracted Providers</u>

Like PCPs, a specialty care physician, non-physician mental health provider, or ancillary provider may also be considered an "Individually Contracted Provider." An "individually contracted specialty care physician" means any specialty care physician that contracts individually with the plan. Likewise, an individually contracted non-physician mental health provider means any non-physician mental health provider that contracts individually with the

plan and an individually contracted ancillary provider means any ancillary care provider that contracts individually with the plan. All plans are required to survey individually contracted providers.

In order to create a contact list for individually contracted providers, the plan may either:
  (a) Include individually contracted providers in the same contact list as the Provider Contact List described above with "Individually Contracted Provider" in the provider organization name field for these providers (to allow a sample to be pulled as if this subpopulation were a single PG) or;
  (b) Create a second contact list just for individually contracted providers. (Some plans may wish to collaborate and work together to survey PGs that contract with multiple plans. In that case, the collaborating plans may wish to create a second contact list for individually contracted providers since the plans may not be able to pool their surveying resources for these types of providers.)

STEP 4: Sample Size Selection
The Timely Access regulation requires that a compliance rate be calculated "for each of the plan's contracted provider groups located in each county of the plan's service area." (*See* 28 CCR §1300.67.2.2(g)(2)(B)). SB 964 requires plans to report a separate rate of compliance with the time elapsed standards for its commercial, Medi-Cal and/or individual/family plan products. 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") for each network in order that a random sample can be selected for each (see Step 5). For example, if a plan's service area includes County A and County B, then the 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 networks, the Plan must calculate a sample size for each network. Samples sizes for each PG/county will need to be calculated separately for PCPs, for each required specialty, ancillary service and non-physician mental health provider.

In some medical groups and IPAs the entire provider panel participates in any network with 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 plan's Medi-Cal and/or individual family network (e.g., if an IPA has 10 cardiologists, all 10 may participate in the plan's commercial network but only 7 may choose to participate in the plan's Medi-Cal network). If a PG/county participates in separate 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 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 plan must select separate samples for each network. Therefore, prior to identifying sample sizes, the plan should run a crosstabs or other analysis to determine for each PG/county whether participation is the same across networks.

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. For example, if 10 PCPs practice in a FQHC, the plan should treat the FQHC as a provider group with 10 PCPs. In this example, the 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 Plan need only survey this FQHC once to determine the next available PCP appointment. This survey result would be attributed to all 10 PCPs and serve as the ROC for appointments within standards for the FQHC.

Sample sizes for PCPs:

- For PG/counties with 14 or fewer PCPs: select all PCPs, no sampling is permitted.
- For PG/counties with more than 14 PCPs a plan may either:
  - Use the attached Sample Size Chart in Appendix 1 to determine the appropriate sample of PCPs (and include an oversample for replacements as described below unless the plan will give callers the entire list as applicable), or
  - Select all PCPs (this option is available to allow plans to collect information on all providers for internal monitoring and corrective action purposes).
- For individually contracted PCPs (i.e., not part of an IPA or medical group): For sampling purposes, the plan should combine all individually contracted PCPs into one group, similar to a PG/county.
  - For counties with 14 or fewer individually contracted PCPs: select all PCPs in the county, no sampling is permitted.
  - For counties with more than 14 individually contracted PCPs, the plan may either:
    - Use the attached Sample Size Chart to determine the appropriate sample, (and include an oversample for replacements unless the plan will give callers the entire list as applicable), or
    - Select all individually contracted PCPs in the county.

For example, see Table 3 below. If in County A the plan contracts with two Provider Groups, Provider Group 1 and Provider Group 2, the plan will need to determine the appropriate sample size for each of these provider groups. For Provider Group 1, the appropriate sample size is 2 PCPs because the total number of PCPs is less than 14 and as such, all PCPs in the provider group must be surveyed. For Provider Group 2, since there are more than 14 PCPs, the plan must either use the Sample Size Chart to determine the appropriate sample size or choose to sample all 50 of the PCPs.

Table 3 – Determining Survey Sample Size Example: County A		
	Total Number of Providers in Provider Group	**Sample Size**
Provider Group 1	2	2 (all providers)
Provider Group 2	50	40 (using Sample Size Chart, plus an oversample for replacements) or choose to survey all 50 providers.

For each county, a plan may only report either: (a) the sample size provided in the sample size chart or (b) all PCPs in a provider group, but not a larger sample size than the sample size calculated by the sample size chart. If a plan desires, for internal purposes, to survey a larger sample but not all providers in the provider group, the plan should only report on the number of providers identified by the sample size chart. For example, if the sample size chart indicates that a sample of 40 PCPs is appropriate for PG 2 in County A, then the plan may not report survey results for 42 PCPs. The 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, plans should clearly indicate in the reporting whether that plan surveyed a sample of providers or all providers.

Replacements

The PAAS Methodology requires 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 only if the PCP in the selected sample was erroneously selected and is ineligible for the survey. A PCP is ineligible if he/she:

- was erroneously identified as participating or is no longer participating in the plan's network,
- was erroneously identified as being or is no longer a member of the PG/county,
- has expired, retired or for other reasons ceased to practice,
- was listed in the database under an incorrect specialty (i.e., is not a PCP),
- was listed in the database under an incorrect telephone number,

> *Note: If a provider refuses to participate, that provider may <u>not</u> be replaced and must be recorded as non-compliant for each survey item. (See below for additional response options for providers that decline to respond at the time of the call but are willing to respond at a later time).*

To allow for replacements of erroneously selected PCPs, a plan may:

- Select an oversample of additional PCPs for the PG/county (size of the oversample to be estimated based on the plan's previous years experience regarding out-of-date/erroneous information in the database). The oversampled cases should only be surveyed if replacements are needed. For example, if the PG/county has 200 PCPs, the sample size chart indicates that a random sample of 100 should be identified. The Plan may also select an oversample (e.g., 20 PCPs) to hold in reserve should replacements be needed. If the plan calls the first 100 and 5 are found to have retired or left the network, the plan can replace those 5 with the first 5 PCPs from the oversample and report the resulting rate for 100 PCPs.
- Provide callers with the entire provider list in random sample order (see Appendix 2). If a replacement PCP is needed, the caller 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 Plan should continue to replace PCPs until either the required sample size is reached or all PCPs have been selected. Plans are required to update their networks directories to remove or update the contact information (as appropriate) for those providers that have been identified as ineligible for survey. Plans must also ensure that ineligible providers are removed from provider network submissions to the Department.

Additional Response Options

To maximize response rates while minimizing disruption to providers' schedules, the 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 plan may offer the provider the options to:
  - receive a follow-up call within 48 hours (calls may be scheduled at the provider's convenience upon request), or
  - complete the survey online, by fax or via a call-back number within 48 hours of the message.
- If a provider office does not answer the call the surveyor may leave a message requesting the provider to complete the survey online or by fax (or optionally at the plan's discretion via a call-back number) within 48 hours of the message.

Selection of Specialty Care Physicians (SCPs)

In order to obtain more useful survey data for specialty care services, for MY 2015 the Department chose a specialty survey approach that focuses on a set number of specialty practice areas, rather than doing a survey that combines all specialty practices. For MY 2015, the Department's PAAS Methodology will include five separate specialty practice area surveys:
- Allergists
- Dermatologists
- Cardiologists
- Psychiatrists[2] (except for Child & Adolescent Psychiatrists, who will be included in a distinct sample)
- Child & Adolescent Psychiatrists

Sample Selection for Allergists:
- For PG/counties with 14 or fewer Allergists: select all Allergists in the PG/county, no sampling is permitted.
- For PG/counties with more than 14 Allergists a plan may either:
  - Use the sample size chart to determine the number of Allergists to be selected (and include an oversample for replacements unless the plan will give callers the entire list as applicable), or

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[2] Plans that contract with another Knox-Keene licensed plan to provide these mental health services in a specific county are not required to report a rate of compliance for that PG/County to the Department and may instead report the name of the contracting plan and applicable counties. See the mental health services addendum below for more information related to psychiatry services and non-physician mental health services.

- o select all Allergists
- For individually contracted Allergists: For sampling purposes, the plan should combine all individually contracted allergists into one group, similar to a PG/county.
    - o For counties with 14 or fewer individually contracted Allergists: select all Allergists in the county, no sampling is permitted
    - o For counties with more than 14 individually contracted Allergists, the plan may either:
        - ▪ Use the sample size chart to determine the number of Allergists to be selected in the county (and include an oversample for replacements unless the plan will give callers the entire list as applicable), or
        - ▪ select all Allergists in the county.

The sampling selection process for a single specialty is the same as the process for PCPs described above in Table 3. Plans should follow the same sample size selection process described above for Allergists to pull samples for Dermatologists, Cardiologists, Psychiatrists and Child & Adolescent Psychiatrists. This means that for County A, a plan will need to determine the appropriate sample of Allergists, Dermatologists, Cardiologists, Psychiatrists and Child & Adolescent Psychiatrists for a single PG within County A. The oversampling process described above for PCPs applies in the same way to SCPs.

Selection of Ancillary Care Providers
For MY 2015, the Department will be focusing on appointment wait times for ancillary services that are for the diagnosis and treatment of an injury, illness or health condition. As such, plans are required to report appointment wait times for the following ancillary providers:
- Physical Therapy Appointments
- MRI Appointments
- Mammogram Appointments

The sample selection for Ancillary Service Providers should be done the same as for SCPs. For example, the sample selection for Physical Therapy Appointments would be as follows:
- For PG/counties with 14 or fewer Physical Therapy service centers: select all Physical Therapy service centers in the PG/county, no sampling is permitted.
- For PG/counties with more than 14 Physical Therapy service centers a plan may either:
    - o Use the sample size chart to determine the number of Physical Therapy service centers to be selected, (and include an oversample for replacements unless the plan will give callers the entire list as applicable), or
    - o select all Physical Therapy service centers
- For individually contracted Physical Therapy service centers: For sampling purposes, the plan should combine all individually contracted Physical Therapy service centers into one group, similar to a PG/county.
    - o For counties with 14 or fewer individually contracted Physical Therapy service centers: select all Physical Therapy service centers in the county, no sampling is permitted

- For counties with more than 14 individually contracted Physical Therapy service centers, the plan may either:
    - Use the sample size chart to determine the number of Physical Therapy service centers to be selected in the county (and include an oversample for replacements unless the plan will give callers the entire list as applicable), or
    - select all Physical Therapy service centers in the county.

The sampling selection process for a single ancillary care specialty is the same as the process for PCPs described above in Table 3. Plans should follow the same sample size selection process described above for Physical Therapy service centers to pull samples for MRI and mammogram service centers. This means that for County A, a plan will need to determine the appropriate sample of Physical Therapy service centers, MRI service centers and mammogram service centers for a single PG within County A. The oversampling process described above for PCPs and SCPs applies in the same way to Ancillary Providers.

STEP 5: Random Sample Selection Process

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

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 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 (and include an oversample for replacements unless the plan will give callers the entire list as applicable), for each PG/county or select all providers (see sample size instructions above).

Because some providers contract with multiple PGs, it's possible that providers may appear more than once on the Provider Contact List and, therefore, may need to be surveyed more than once. For example, some providers may appear more than once because they are contracted with more than one PG in a single county. In this case, plans are required to conduct the required number of phone calls to the provider's office, unless the provider is listed with the same physical address and phone number for each appearance on the Provider Contact List. For example, if Doctor A appears in PG 1 and PG 2 for a single county, then the 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 plan can report the survey results from a single survey for Doctor A in both PG 1 and PG 2.

In addition, the final 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, plans may inquire during the initial survey call if the plan can ask about the appointment availability for other doctors working in the same office. For 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 plan calls to survey Doctor A, the plan can ask the office scheduler (or other appropriate office representative) whether they are also able to answer questions regarding Doctor B and Doctor C's availability. If so, then the plan can conduct the survey for Doctor B and Doctor C during the same phone call.

Similarly, the plan may find that Doctor A may appear for PG 1 in both the commercial and the Medi-Cal sample under the same address and phone number. In such cases, the plan may ask the corresponding commercial and Medi-Cal survey questions during the same phone call.

STEP 6: Survey Questions

The Department has developed a Provider Appointment Availability Survey Tool to be used with the Methodology. Ancillary Providers are only required to respond to the Survey Tool Questions included entitled MY2015 Ancillary Provider PAAS Tool. PCPs and SCPs must respond to the Survey Tool Questions entitled MY2015 PCP, SCP and Non-Physician Mental Health Tool. The Department understands that some plans may wish to include additional questions over and above those included in the Department's PAAS. As such, 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 first or near 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.

Plans must use the MY2015 PAAS Survey Tool questions that were developed by the Department. Plans may use a different software/program for capturing survey results if the following requirements are met:
1) the survey questions must be identical to the survey questions in the MY2015 PAAS Survey Tool;
2) the plan must capture the same data fields included in the MY2015 PAAS Survey Tool;
3) the plan must use the same look-up codes included in the MY2015 PAAS Survey Tool; and
4) the plan must capture the raw data survey results and include the raw data in an Excel format as part of its annual submission.

STEP 7: Administering the Survey

The Department's PAAS Methodology presumes that all surveys will be initiated telephonically (with the option offered to providers to complete the survey online, by fax or via a call-back

number). The survey calls need to be conducted between May 1, 2015 and December 31, 2015. The phone surveys should be conducted in two waves. For each PG/county, approximately 1/2 (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, 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 says the wait time would depend upon whether the patient is a new or existing patient, ask for the dates for both and use the latest date.
- If the provider says that patients are served on a walk-in or same day basis, ask the provider to confirm that walk-in slots are available that 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.
- The term "non-urgent" appointments are also often referred to as "routine" appointments.
- For surveys of PCPs, the other practitioner/provider mentioned in items 3a, 4b and 5a does not have to be a physician; it can be a nurse practitioner or physician assistant.
- Survey calls should be conducted during normal business hours.

STEP 8: Calculating Compliance Rates

A compliance rate should be calculated for each plan product and, within the product, for each PG/county using questions 2-5.

Question 1 – No compliance rate is applicable; this question is used to direct the surveyor to the appropriate next question.

If the provider answers "yes" to Question 1, then the subsequent wait time questions should be asked up to three times (once for each product – commercial, Medi-Cal and individual/family – in which the provider participates) and the plan should record the next available date/time for each product. If the provider answers "no," the subsequent questions should be asked only once and the response to each question should be used for all products.

Question 2 - No compliance rate is applicable; this question is used to direct the surveyor to the appropriate next question.

Question 3/3a – If the answer to question 3 is, "Yes, there is an available appointment within 96 hours;" the provider should be counted as compliant. If the answer is, "No, there is not an available appointment within 96 hours," the surveyor should move to question 3a. If the answer to 2a is "Yes" the provider should also be counted as compliant. If the answer to 3a is "No;" the provider should be counted as non-compliant. (As noted previously, refusal to answer should be

counted as non-compliant in this and subsequent rate calculations.) Add the total number of compliant providers from 3 and 3a. Divide that total number by the total number surveyed. Report as a percent with one decimal (e.g., 89.5%). If the plan has more than one product, a rate should be calculated for each product for this and subsequent items. Please note, the Ancillary Provider Survey Tool does not include a question 3a.

Question 4/4a/4b – For question 4, no compliance rate is applicable; this question is used to direct the surveyor to the appropriate next question. If the answer to question 4a is, "Yes, there is an available appointment within 48 hours;" the provider should be counted as compliant. If the answer is, "No, there is not an available appointment within 96 hours," the surveyor should move to question 4b. If the answer to 4b is "Yes" the provider should also be counted as compliant. If the answer to 4b is "No;" the provider should be counted as non-compliant. Add the total number of compliant providers from 4a and 4b. Divide that total number by the total number surveyed. Report as a percent with one decimal (e.g., 89.5%). Please note, the Ancillary Provider Survey Tool does not include a question 4b.

Question 5/5a – If the answer to question 5 is, "Yes, there is an available appointment within 10 days for PCP or 15 days for SCP;" the provider should be counted as compliant. If the answer is "No," the surveyor should move to question 5a. If the answer to 5a is "Yes" the provider should also be counted as compliant. If the answer to 5a is "No;" the provider should be counted as non-compliant. Add the total number of compliant providers from 5 and 5a. Divide that total number by the total number surveyed. Report as a percent with one decimal. Please note, the Ancillary Provider Survey Tool does not include a question 5a.

Plans are required to submit as part of their annual report
> (1) a rate of compliance for each provider group/group of individually contracted providers for each county in the plan's service area;
> (2) the plan's raw survey data and
> (3) the plan's Provider Contact list to the Department .

Plans should submit the above materials to the Department website in Excel using DMHC Provider Appointment Availability Survey Template. *(available online)*

APPENDIX 1 -- Sample Size Chart

To determine the correct sample size, look up the number of providers in the PG/county in the "Number of Providers" column. For example, if the PG/county has 104 PCPs, select the sample size of 69. While only 69 PCPs will be surveyed, an oversample must also be added to the sample in the event the plan is unable to contact one of the first 69 PCPs.

Number of Providers	Sample Size	Number of Providers	Sample Size	Number of Providers	Sample Size
1	1	35	30	201 - 205	101
2	2	36 - 40	34	206 - 210	102
3	3	41 - 45	37	211 - 215	103
4	4	46 - 50	40	216 - 220	104
5	5	51 - 55	44	221 - 225	105
6	6	56 - 60	47	226 - 230	107
7	7	61 - 65	49	231 - 235	108
8	8	66 - 70	52	236 - 240	109
9	9	71 - 75	55	241 - 245	110
10	10	76 - 80	58	246 - 250	111
11	11	81 - 85	60	251 - 255	112
12	12	86 - 90	62	256 - 265	113
13	13	91 - 95	65	266 - 270	114
14	14	96 - 100	67	271 - 275	115
15	14	101 - 105	69	276 - 280	116
16	15	106 - 110	71	281 - 285	117
17	16	111 - 115	73	286 - 290	118
18	17	116 - 120	75	291 - 300	119
19	18	121 - 125	77	301 - 305	120
20	19	126 - 130	79	306 - 310	121
21	20	131 - 135	81	311 - 315	122
22	20	136 - 140	82	316 - 325	123
23	21	141 - 145	84	326 - 330	124
24	22	146 - 150	86	331 - 340	125
25	23	151 - 155	87	341 - 345	126
26	24	156 - 160	89	346 - 355	127
27	24	161 - 165	90	356 - 360	128
28	25	166 - 170	92	361 - 370	129
29	26	171 - 175	93	371 - 380	130
30	27	176 - 180	95	381 - 385	131
31	27	181 - 185	96	386 - 395	132
32	28	186 - 190	97	396 - 405	133
33	29	191 - 195	98	406 - 415	134
34	30	196 - 200	100	416 - 425	135

DEPARTMENT OF
Managed
Health Care

Number of Providers	Sample Size	Number of Providers	Sample Size	Number of Providers	Sample Size
426 - 435	136	721 - 740	156	1551 - 1635	176
436 - 445	137	741 - 765	157	1636 - 1725	177
446 - 455	138	766 - 790	158	1726 - 1825	178
456 - 465	139	791 - 815	159	1826 - 1940	179
466 - 480	140	816 - 840	160	1941 - 2065	180
481 - 490	141	841 - 870	161	2066 - 2205	181
491 - 505	142	871 - 900	162	2206 - 2370	182
506 - 515	143	901 - 935	163	2371 - 2550	183
516 - 530	144	936 - 970	164	2551 - 2765	184
531 - 545	145	971 - 1005	165	2766 - 3015	185
546 - 560	146	1006 - 1045	166	3016 - 3305	186
561 - 575	147	1046 - 1085	167	3306 - 3660	187
576 - 590	148	1086 - 1130	168	3661 - 4090	188
591 - 605	149	1131 - 1175	169	4091 - 4635	189
606 - 620	150	1176 - 1225	170	4636 - 5330	190
621 - 640	151	1226 - 1280	171	5331 - 6265	191
641 - 660	152	1281 - 1340	172	6266 - 7580	192
661 - 675	153	1341 - 1405	173	7581 - 9565	193
676 - 695	154	1406 - 1475	174	9566 - 12920	194
696 - 720	155	1476 - 1550	175	12921 - 41649	195
				41650 and above	196

Sample sizes were determined using OpenEpi Open Source Epidemiologic Statistics Software for Public Health. OpenEpi development was supported in part by a grant from the Bill and Melinda Gates Foundation to Emory University, Rollins School of Public Health. Based on previous years' survey data, an anticipated frequency of 85% was used to estimate the sample size. Confidence limits of +- 5% were estimated to allow for reasonably precise results while keeping sample sizes manageable.

APPENDIX 2
Random Number Generation

Once a plan has determined the appropriate sample size for each PG/county, it will need to determine which providers to call and survey. The Random Number Generation tool described below selects the providers that should be surveyed from the contact list.

1. Open the Excel workbook of the Provider Contact List.
2. For each PG/county, place the PCPs, allergists, cardiologists and dermatologists in separate workbook tabs. (See note below)
3. Create a new column to the left of "A" on your spreadsheet by moving cursor to the break line next to column "A". Make sure only column A is highlighted, not the entire spreadsheet. If the entire spreadsheet is highlighted Excel will not be able to create a new column. 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 curser 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")
8. Copy and paste the function down column A beside each provider in the table.
9. If you did this correctly you should get a list of numbers with decimals in column A.
10. Highlight Column A.
11. Select "copy" (without moving from column A), "paste" and "paste values"
12. Highlight the entire spreadsheet by clicking on the very top left of the spreadsheet (gray area where A and 1 intersect)
13. 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.
14. Starting with the first row, use the number of rows indicated by the sample size calculator (plus additional rows for the oversample unless the plan will give callers the entire list in random order) as your survey list. You may wish to add a column to label the primary sample vs. oversample/remaining cases so that the surveyor will not call oversample cases unless needed as replacements.

Note: If you prefer to keep all data in one workbook tab, perform steps 1-12 as above. Perform the sort in step 13 by Provider Group, County, PCP, Specialty/Subspecialty and then Random Number.

Alternate #1   Randomization Process and Generation of Random Sample in SAS

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(c)(5)(D) & (E) requires plans to ensure access to mental health services with specialty physician (i.e., psychiatrist) and non-physician mental health providers within the following timeframes:

1) Urgent physician mental health appointments (with prior authorization) – within 96 hours
2) Urgent physician mental health appointments (w/o prior authorization) – within 48 hours
3) Urgent non-physician mental health appointments (with prior authorization) – within 96 hours
4) Urgent non-physician mental health appointments (w/o prior authorization) – within 48 hours
5) Non-urgent physician mental health appointments – within 15 business days
6) Non-urgent non-physician mental health appointments – within 10 business days

SB 964 requires 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 Plan uses a separate network for these product lines, the plan will need to repeat the random sampling steps listed below for each network. Note that even if a plan uses the same provider network for all products and, therefore, uses one sample of providers to conduct the survey for all products, the plan must report rates separately for each product.

Plans that contract with another Knox-Keene licensed plan to provide these mental health services in a specific county are not required to report this information to the Department for the specific counties for which the plan has contracted with another plan. Instead, a plan that contracts with another Knox-Keene licensed plan to provide mental health services should indicate the following in the narrative section of its Timely Access Report: (1) the name of the plan that provides mental health services and (2) the counties in which that plan provides mental health services. If a plan has counties for which it does not contract with another Knox-Keene licensed plan to provide mental health services or for which it contracts with other providers in addition to the Knox-Keene licensed plan, the plan must conduct a survey and report a rate of compliance for those counties/providers.

Psychiatry services
Psychiatric services are considered specialty care physician services and were therefore discussed in the SCP section described above. Plans have the option of following the instructions for "Actual Appointment Wait Time Information" included below to demonstrate compliance with the standards for urgent psychiatrist appointments. Please note that Urgent Physician Mental Health Appointments (with prior authorization) and Urgent Physician Mental Health Appointments (w/o prior authorization) are the ONLY specialty physician standards to which this option applies.

Non-Physician Mental Health Services
To demonstrate compliance with urgent and non-urgent non-physician mental health services, plans may use either/any of the three options described below. Given the differences in the ways

plans currently arrange for urgent vs. routine appointments, plans may select a different option for measuring and reporting compliance with the urgent standards than for non-urgent standards. However, plans may only use one option for measuring a given standard (e.g., plans may not use actual appointment wait time data to measure some providers on the urgent non-physician mental health appointments standard and measure other providers on the same standard using phone survey data).

Actual Appointment Wait Time Information: The data would be drawn from a plan's own data system, having been collected by plan clinical/case management staff who identified a situation in which a member required an urgent appointment and then arranged for and tracked that appointment. Under this option, plans should *not* pull a sample of providers. Instead the 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 four urgent appointment standards listed above; however, if the plan collects the data for non-urgent appointments, this option may be used for those standards as well.

For each appointment, the Plan should compare the date and time of the member's call requesting an appointment and the date and time for which the appointment was set. If an appointment for urgent care services that does not require prior authorization was scheduled within 48 hours of the request for appointment, the appointment should be counted as compliant. Similarly, if the 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. 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 plan has commercial, Medi-Cal and/or individual/family plan products, the urgent appointments should be classified by network and the rate of compliance should be reported separately for each network and each standard. Although plans may have few PG/counties in their mental health networks, plans are required to report within each network, separate rates of compliance for any existing groups. All remaining individually contracted providers should be combined into one group for calculation of rates.

Phone Survey: Creation of PG/contact list(s) for a phone survey should be performed based upon instructions previously described for PCPs and specialists. A plan should select the following four mental health samples (note that the two physician samples were previously described on page 6 under Selection of SCPs):
- Physician:
    - Psychiatrist (except for Child & Adolescent Psychiatrists, who will be included in a distinct sample)
    - Child & Adolescent Psychiatrist
- Non-Physician Mental Health Provider[3]
    - PhD and above (including Psychologist)
    - Masters-Level Provider

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[3] Psychiatric mental health nurses should be included in the non-physician mental health provider appointment wait time standard.

The sample sizes, random selection process, replacement/oversampling process, reporting of rates separately for each network and each standard and all other instructions described earlier for PCPs apply in the same way to mental health samples.

Although plans may have few PG/counties in mental health, plans are required to select random samples for any existing groups. Plans are also required to select a random sample of individually contracted providers.

Plans should use the PAAS Survey Tool for PCPs, SCPs, and non-physician mental health provides, available online. Plans should follow the instructions for conducting this survey described above in Steps 6-8.

If a provider cannot be reached or refuses to participate, that provider is to be recorded as non-compliant for each survey item. Note: If a provider office does not answer the call or declines to respond to the survey at the time of the call but is willing to participate later (e.g., scheduling staff is absent, office is busy), the plan may make follow-up calls to attempt to obtain a response. Follow-up calls must be made within 48 hours. Calls may be scheduled at the provider's convenience upon request.

Phone survey with option for online, fax or return call response: Instructions listed above for a phone survey should be followed with the modifications described below:
- If a provider office does not answer the call, the surveyor may leave a message requesting the provider to complete the survey online or by fax (or optionally at the plan's discretion via a call-back number) within 48 hours of the message.
- 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 plan may offer the provider the options to:
  o receive a follow-up call within 48 hours, or
  o to complete the survey online, by fax or via a call-back number within 48 hours of the message.

Online Survey: The survey will be administered via email either directly by the plan or by using an online survey vendor. Please note, this option is only available for measuring the rate of compliance for non-physician mental health providers. The online survey must be conducted annually in two waves, at least six weeks apart. No sampling is permitted. In each wave of the survey, an email will be sent to all providers for whom the plan has email addresses. After the initial email invitation for the survey is sent out, a reminder email will be sent 24 hours later notifying providers that they only have 24 more hours to respond. The official time period of the survey is 48 hours. The survey will ask the provider the date of their next available routine appointment (and urgent appointment unless measured by another option) for each plan product in which the provider participates. Please see the Online Survey Tool included below. A plan may make minor adjustments to the survey introductory language and include a small number of additional items to measure other concerns. The responses to the online surveys should be submitted using the Department's Survey Results Template. In the online survey option, non-respondents should not be counted as non-compliant. The plan should calculate compliance rates for each product using the total number of compliant responses to each item divided by the total number of responses. As noted above, if the plan has separate provider networks for

commercial, Medi-Cal and/or individual/family plan products, the urgent appointments should be classified by network and rates reported separately for each network and each standard. The Plan is also required to report within each network separate rates for any existing groups; all remaining individually contracted providers should be combined into one group for calculation of rates.

In its narrative, the Plan should include figures for each network and for each of the four provider categories listed above listing the total number of providers in the category, the total number and percent for which it had e-mail addresses available, and the total number and percent of responses.

Online Survey Tool

Hello and thank you for participating in this online survey. This online survey is designed to help [insert Plan name] to better assess enrollee access to provider services. Please respond to this survey within 24 hours.

1. Do you schedule appointments differently based on whether a patient is enrolled in a commercial plan, Medi-Cal or an individual/family plan product? For example, does your office have separate appointments set aside for patients enrolled in Medi-Cal?
   [Allow space for provider to indicate yes or no]

2. As of today, when is your next available appointment date and time for a commercial enrollee for an urgent appointment? [If a plan requires pre-authorization for urgent appointments, the additional time to schedule an appointment should be taken into account when calculating a plan's rate of compliance.]
   [Allow space for provider to insert date and time]

3. As of today, when is your next available appointment for a commercial enrollee for a non-urgent appointment?
   [Allow space for provider to insert date]

If you indicated yes to question 1, please respond to the remaining questions:

4. As of today, when is your next available appointment date and time for a Medi-Cal enrollee for an urgent appointment? [If a plan requires pre-authorization for urgent appointments, the additional time to schedule an appointment should be taken into account when calculating a plan's rate of compliance.]
   [Allow space for provider to insert date]

5. As of today, when is your next available appointment for a Medi-Cal enrollee for a non-urgent appointment?
   [Allow space for provider to insert date]

6. As of today, when is your next available appointment date and time for a [Insert name of individual/family plan product] enrollee for an urgent appointment? [If a plan requires

pre-authorization for urgent appointments, the additional time to schedule an appointment should be taken into account when calculating a plan's rate of compliance.]
[Allow space for provider to insert date]

7. As of today, when is your next available appointment for [Insert name of individual/family plan product] enrollee for a non-urgent appointment?
[Allow space for provider to insert date]