

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

California Code of Regulations, title 28, section 1300.67.2.2, subdivision (g)(2)(B) requires health plans to report for each provider group in each county a rate of compliance with the following appointment wait time standards:

- 48 hours for an urgent appointment [with a primary care physician/specialty care physician/non-physician mental health provider/ancillary care provider] that does not require an authorization
- 96 hours for an urgent appointment [with a primary care physician/specialty care physician/non-physician mental health provider/ancillary care provider] that does require an authorization
- 10 business days for a primary care physician appointment
- 15 business days for a specialty care physician appointment
- 10 business days for a non-physician mental health provider appointment
- 15 business days for an ancillary care appointment

Health and Safety Code section 1367.03, subdivision (f)(3), the Department of Managed Health Care (“Department”) has adopted two standardized methodologies that health plans may use to report compliance with the above standards for Measurement Year 2017 (“MY 2017”). Health plans may use the Department’s MY2017 Standardized Provider Appointment Availability Survey Methodology (“PAAS”) or the Department’s MY 2017 Provider Appointment Audit Methodology (“Audit”).

The Audit is based on the premise that health plans will coordinate with providers and/or provider groups to track and measure appointment wait time for enrollees using providers’ appointment scheduling systems; this can be performed as a computerized systems audit or as a manual audit. Health plans that opt to use Audit for MY 2017 may also use the PAAS for those provider groups or counties where providers/provider groups are not able to provide appointment data necessary to complete the Audit. However, results for each provider group in each county must be reported using only one methodology. The health plan may not report data for some providers in a single PG using the audit methodology and others using the telephone survey. Individually contracted providers should be grouped together for each county within the health plan’s service area and treated like a single provider group for each county.

Definitions

Request Date: The date and time the patient or his/her representative (e.g., family member or the PCP’s office) requested an appointment.

Booked Date: Many appointment systems do not currently store a record of the date and time of the patient’s request. For these systems, the date the appointment was

booked may be used as a proxy. The “Booked Date” is defined as the date and time the appointment was scheduled or booked. For example, the Booked Date is the date and time the appointment was entered into the appointment scheduling system. In most cases the Booked Date and the Request Date are the same.

First Offered Date: The date and time of the first appointment that was available and offered to the patient upon patient’s request for an appointment. The patient may accept the offered appointment or may request and book a later appointment based on patient preference.¹

Occurred Date: The date and time at which the appointment occurred. This date and time may generally be the same as the date and time the appointment was scheduled to occur; however, if the patient or provider cancelled, rescheduled or no-showed, the dates will be different.

Urgent appointment: An appointment for services that require prompt attention and pose an imminent and serious threat to someone's health, including loss of life, limb or other major bodily function.

STEP 1: Determine which Networks to Audit

Health and Safety Code section 1367.03, subdivision (f)(3) requires health plans to report separately the rate of compliance with the time elapsed standards for their commercial, Medi-Cal and/or individual/family plan products. If a health plan uses the same network for all products, it may be able to audit its network only once and use the audit results to create rates for all products. If, however, a health plan has separate Medi-Cal networks or separate individual/family product networks, the health plan will need to audit all provider groups in its commercial, Medi-Cal, and individual/family plan provider networks.

If a health plan contracts with another health plan to provide services, the health plan will need to report all provider groups in both of the contracted networks. Health plans that have a single network for all products must report separate rates of compliance for enrollees in commercial, Medi-Cal, and individual/family products. For MY 2017, health plans are not required to report Cal-MediConnect as a separate Medi-Cal network.

¹ Recording the First Offered Date when speaking with a patient to schedule the appointment allows the provider to illustrate the provider’s availability without the influence of patient preference. If not already being collected, providers should consider recording this information so that, even when a patient does not accept the first available appointment, and especially if the patient selects an appointment that is outside the standard, the provider is acknowledged for having the opening available.

STEP 2: Identify Participating Provider Groups and Individually Contracted Providers

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. (See Health & Safety Code section 1367, subdivision (g).)² A health plan will need to identify all PGs participating within in each county of the health plan’s service area.

All health plans are required to audit individually contracted providers. “Individually Contracted Physician” means any physician that contracts individually with the health plan. Likewise, an “individually contracted non-physician mental health provider” means any non-physician mental health provider that contracts individually with the health plan and an “individually contracted ancillary provider” means any ancillary care provider that contracts individually with the health plan.

STEP 3: Create the Provider List

For each PG in each county, the health plan audit and report results for all provider types set forth below:

1. Primary Care Physicians
2. Cardiologists (including Cardiovascular Disease and Pediatric Cardiology)
3. Endocrinologists
4. Gastroenterologists
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)

For MY 2017, health plans must audit and report a rate of compliance for each of the ten provider types (PCPs, five separate specialty physician types, three ancillary providers and non-physician mental health providers) in each provider group in each county. For individually contracted providers, health plans must audit all individually contracted providers in a county. There is no sampling of providers within a provider group permitted in this methodology.

Health plans conducting a computerized systems audit should include in their Timely Access Policies & Procedures a description of the health plan’s process for identifying and reporting rates of compliance for all applicable provider types. The health plan’s policies and procedures should be submitted to the Department through eFiling as an Amendment to Exhibit J-13.

² Participating provider groups include clinics licensed under Health & Safety Code section 1204, subdivision (a).

For manual audit, 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 each of the health plan's network(s). The Department's *Provider Contact List Template* includes the same (or very similar) data 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.

For manual audit, providers who are members of multiple PGs should have an entry for each PG. Providers who are members of one or more PG and are also individually contracted with the health plan should only be included under the PG(s). Once the Provider Contact Lists are complete, the datasets should be reviewed and duplicate entries 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.)

Health plans using manual audit will need to submit the Provider Contact List for each of the ten provider types when submitting their annual reports. In order to create a Provider List for individually contracted providers, the health plan may either:

- (a) Include individually contracted providers in the same Provider Contact List as the one described above with "Individually Contracted Provider" in the provider organization name field for these providers; or
- (b) Create a separate Provider Contact List for individually contracted providers.

Individually contacted providers that are also in a PG should only be counted in the PG.

STEP 4: Determine which Appointments to Include

Before appointment data can be exported or manually recorded in Excel, the health plan must determine which appointments to measure. There are two types of audits that a health plan may conduct for MY 2017. The first is a computerized audit that requires a provider/provider group to export data from its scheduling system and use that data to compute appointment wait times. The second audit option is a manual option that requires health plans or providers/provider groups on behalf of the health plan, to look at specific appointment types and dates and record the appointment wait times manually rather than exporting the data via Excel.

The Department will supply health plans using the manual audit option with the Department's Manual Audit Worksheet, which is an Excel document designed to facilitate the collection of data and calculation of appointment wait times. Health plans are not required to use the Department's Manual Audit Worksheet. Health plans that wish to modify the Department's Manual Audit Worksheet or devise their own audit worksheet, must seek pre-approval from the Department by submitting an Exhibit J-13

in the E-filing system. For purposes of this document, it is assumed that health plans will use the Department's Manual Audit Worksheet.

➤ **First Episode of Care**

Since not all appointments are subject to the Timely Access wait time standards (e.g., preventive care and periodic follow-up care scheduled in advance), scheduling systems may not provide sufficient data to determine which visits have been scheduled in advance outside of the wait time standards. To avoid this complication with advance-scheduled preventive care and follow-up visits, the audit will focus on the first appointment in each new episode of care. Health plans conducting a computerized audit may develop an algorithm for identifying a new episode of care based upon a comparison of procedure and diagnosis codes and/or other identification criteria (e.g., first prenatal visit).

Given that procedure and diagnosis information may not be linked to the scheduling system, as a proxy providers may identify a new episode of care by asking the following questions:

For appointments for adults:

- Is this the first time the patient has had an appointment with this provider?
- Is this the patient's first appointment within a 12 month period?
- For specialists, is this the first visit covered under a new referral?
- Is this a first prenatal visit?

If any of the above are "yes" include this appointment.

For appointments for children:

- If the patient is age 12 or younger, is this visit for an illness or injury (i.e., anything other than a well-child visit)?

If "yes" include this appointment.

Health plans conducting a computerized systems audit should include in their Timely Access Policies & Procedures a description of the health plan's retrospective audit programming specifications that clearly indicates the algorithm and/or programming specifications used to identify new episode of care. Health plans policies and procedures should be submitted via the Department's E-filing web portal as Exhibit J-13.

➤ **Time Periods**

Computerized Systems Audit

To allow sufficient time for all requested appointments to occur and to give providers sufficient time to develop, run and verify programming and to report results, include ALL appropriate appointments requested/booked January 1, 2017 – September 30, 2017.

Manual Audit

The health plan will measure a sample of appointments occurring on four days in the measurement year. If a health plan elects to use the manual audit option, near the end of the first, second, third and fourth quarters of 2017, the Department will post on its website a notification of the date for which data shall be collected for MY 2017. Data should be collected for each date soon after it is posted on the Department's website to allow health plans to use the data for ongoing monitoring and to ensure that data systems are not purged before collection is accomplished.

➤ **Appointment types**

Only urgent and non-urgent appointments should be included. Same day appointments and walk-in visits should be included; the Manual Audit Worksheet will calculate these as zero (0) wait days and count them as compliant. Do not include emergency appointments.

➤ **Networks**

Health plans should include all providers in networks for Commercial, Medi-Cal, and Individual/Family product appointments. Do not include self-pay appointments. When conducting the audit, health plans may include all appointments, regardless of an enrollee's enrollment in a specific health plan or product. However, the health plan must calculate separate rates of compliance for each applicable product.

STEP 5: Conduct Audit

Computerized Systems Audit

The health plan will need to export the necessary data from the provider's computerized appointment scheduling system into Excel in a manner that will allow the health plan to calculate a rate of compliance for each provider type in each provider group and individually contracted providers in each county. Individually contracted providers should be grouped together for each county within the health plan's service area (see Step 2 above regarding individually contracted providers).

Manual Audit

A health plan may permit a provider and/or provider group to conduct this step. The auditor will manually enter into the Department's Manual Audit Worksheet the provider appointment information for the four days determined by the Department. Once the data is compiled into the Manual Audit Worksheet, the auditor will be able to calculate appointment wait times and rate of compliance using the Worksheet.

For both the computerized systems audit and the manual audit methods, health plans should submit the compliance rates found via the audit, but not the audit or audit data, to the Department of Managed Health Care. The health plan should, however, maintain the audit and audit data in a format accessible to the Department's Office of Plan Monitoring, Division of Plan Surveys during onsite surveys, if requested. The Department will provide further instructions regarding the format for reporting compliance results to health plans.

STEP 6: Calculating Compliance Rates

Health plans may calculate a rate of compliance for each provider group in each county using one of the methods outlined below. As explained previously, health plans with separate networks will need to calculate a separate rate of compliance for each PG in each county for each network. Health plans with a single network that applies to all products may report the same rate of compliance for all products types for a particular provider/ provider group; however, the health plan must report separate rates of compliance for enrollees in Medi-Cal, individual/family plan products, and its remaining commercial market enrollees.

Option 1 - Request Date to First Offered Date:

1. For each appointment, subtract Request Date from First Offered Date to get Appointment Wait Time.
2. Compare Appointment Wait Time to the wait time standard applicable to the appointment type.
 - If a non-urgent appointment with a PCP was offered within 10 business days of the request for appointment, the appointment should be counted as compliant. (Many appointment systems will not clearly indicate business days. The health plan may use 14 calendar days as a proxy for 10 business days.)
 - If a non-urgent appointment with a specialist was offered within 15 business days (proxy 21 calendar days) of the request for appointment, the appointment should be counted as compliant.
 - If an appointment for urgent care services that do not require prior authorization was offered within 48 hours of the request for appointment, the appointment should be counted as compliant.
 - If the appointment for urgent care services that require prior authorization was offered within 96 hours of the request for appointment, the appointment should be counted as compliant.
 - If a non-urgent appointment with a non-physician mental health care provider was offered within 10 business days (proxy 14 calendar days) of the request for appointment, the appointment should be counted as compliant.
 - If a non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition was offered within 15 business days (proxy 21 calendar days) of the request for appointment, the appointment should be counted as compliant.

Note: Compliance for urgent appointments must be measured using hours. For example, an appointment for urgent care not requiring prior authorization would be compliant if it was requested on a Monday at 10:00 am and was offered for Wednesday at 8:00 am. It would not be compliant if it was offered for Wednesday at 11:00 am. Compliance for non-urgent appointments may be measured using days without regard to the time of day the appointment was requested, scheduled, or occurred.

3. For each of the ten provider types, add the total number of compliant appointments for each standard and divide that number by the total number of appointments for that standard. For example, if 85 out of 100 non-urgent appointments for a cardiologist were offered (occurred) within 15 business days within Sacramento County, the health plan would report that cardiologist in this provider group in Sacramento County had an 85% rate of compliance.

Option 2 - Booked Date to First Offered Date: Follow instructions for *Request Date to First Offered Date*, replacing *Request Date* with *Booked Date*.

Option 3 - Request Date to Occurred Date: Follow instructions for *Request Date to First Offered Date*, replacing *First Offered Date* with *Occurred Date*.

Option 4 - Booked Date to Occurred Date: Follow instructions for *Request Date to First Offered Date*, replacing *First Offered Date* with *Occurred Date* and replacing *Request Date* with *Booked Date*.

Please account for the following factors:

- If the patient cancelled/no-showed/rescheduled, remove the original appointment from the calculations. If a new appointment was requested or booked within the audit timeframe, use the data of the appointment to determine compliance (e.g., use the date the patient requested the rescheduling as the new Request Date/Booked Date and the date the rescheduled appointment occurred for the Occurred Date).
- If an appointment was rescheduled due to a provider cancellation/postponement, use patient's original request/booking date as the Request Date/Booked Date; do not revise the patient's original request date.
- Same day appointments and walk-in visits should be included, calculated as zero (0) wait days and counted as compliant.
- Results for each provider group in each county must be reported using only one methodology. The health plan may not report data for some providers in a PG using the audit methodology and others using the telephone survey.
- Results for each provider group in each county must be reported using only one of the four options above.

- The Department's Manual Audit Worksheet allows users to enter a booked date (e.g., Option 2 or Option 4), so health plan's using the Department's Manual Audit Worksheet are limited to these two options.

STEP 7: Reporting Compliance Rates

For both the computerized systems audit and the manual audit methods, health plans should submit the compliance rates found via the audit, but not the audit or audit data, to the Department. The health plan must maintain the audit and audit data in a format accessible to the Department's Office of Plan Monitoring, Division of Plan Surveys.

The Department will provide further instructions regarding the format for reporting compliance results to health plans. The results for the providers in each PG in each county must be reported using the Department's Provider Appointment Audit Methodology Results Template.