

Timely Access Reporting Frequently Asked Questions

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Populating the Report Form

1. What is the date range I should be reporting?

- The Timely Access Network Reporting should be a “snapshot” of the Plan’s network as of December 31, 2014.
- The Timely Access Annual Compliance Report should reflect the time period of January 1, 2014 through December 31, 2014.

2. Do I have to enter a code in the Look-up Code tab?

No. The Look-up Code tab is an optional tool provided to health plans (“Plans”) to populate certain fields if the Plan should use a different code or codes for specific categories such as languages or specialties, for example.

3. If the language or specialty we use is not listed on the Look-up Code tab, can we add it to the tables on the Look-up Code worksheet?

No. Additional languages or specialties cannot be added to the Look-up Code tab. If your Plan uses languages or specialties that are not included on the Department Look-up Code tab, then the Plan must indicate “Other” (or enter the Plan’s specified code for “Other”) under the Specialty or Language column of the particular spreadsheet. The columns entitled Specialty (Other) or Language (Other) are required fields in which the Plan will define “Other” or enter “N/A”.

4. What is the Health Plan ID for the Plan-to-Plan Contract field? Is this an internal code to be populated by the Department or provided to us?

A Health Plan ID is the Plan’s Department Plan ID or Knox-Keene license number. You can look up the number on the Department’s public website: <http://wpsso.dmhc.ca.gov/hpsearch/viewLicensedHealthPlan.aspx>. The Health Plan ID for the Plan-to-Plan Contract field is only to be populated to reflect the Plan ID of another Plan with which you contract. Do not put your own Health Plan ID in this field. See the Timely Access Network Reporting General Instructions for more information about populating this field.

5. Do I need to report Tax Identification Numbers (“TINS”) in the report?

No, TINs are not included in the reports. The finalized templates for March 31, 2015 submission do not require health plans to submit TINs.

6. The Reports asks for “current” number of patients assigned.” As of what date should I report this information?

Wherever the template indicates “current” number of enrollees, the plan should report that number as it was on December 31, 2014.

7. My plan offers a PPO product in which patients are not assigned to PCPs. How should I populate the “Current Number of Enrollees Assigned to Provider” field for these types of products?

For Measurement Year 2014 (due March 31, 2015), the methodology described below for reporting “Number of Patients Assigned” for PPO products will be accepted by DMHC. Please note, if the Plan maintains more than one PPO product (e.g. PPO Full Network, PPO Narrow Network, etc.), please separately calculate the number of patients assigned for each PPO product using the following methodology:

1. Identify the total number of enrollees in that PPO product residing in that county as of December 31, 2014.
2. Identify the total number of PCPs in that PPO product practicing in that county as of December 31, 2014
3. Divide the number of enrollees (item 1) by the number of PCPs (item 2)
4. Place the resulting number in the column entitled "Current Number of Enrollees Assigned to Provider" for each PCP located within that county and contracted in the specific PPO product.

The DMHC continues to research the best way to capture this data for PPO products and this methodology may change for Measurement Year 2015.

8. My plan offers a PPO product in which patients are not assigned to PCPs. How should I populate the "Accepting New Patients" field for these types of products?

The Plan must complete the "Accepting New Patients" column for each PCP in the PPO network. If the PCP is continually accepting new referrals, the Plan may enter "Y" in this column. If the Plan maintains a contract with the physician under which the physician must accept all patients from this product line, the Plan may enter "Y" in this column. If the Plan does not have a contractual clause that requires the physician to accept all patients and the Plan does not have specific information as to whether or not the provider is accepting new patients, the Plan may enter "NA" in this field.

9. My Plan assigns patients to a delegated provider group and the group then assigns the patients to individual PCPs. How do I complete the "Current Number of Enrollees Assigned to Provider" tab?

If the Plan assigns to a delegated provider group, please first list all of the individual physicians available through that delegated group on the PCP Report template. Second, clarify with the group whether they assign patients to a particular provider within the group. If the group or site assigns patients to specific individual PCPs, obtain that information from the group and list the number of patients assigned for each PCP on the plan's provider list. If no assignment is made, i.e. a patient may see any PCP within the group or site at any time and does not have a particular PCP identified on their membership card, the DMHC will accept the following methodology:

1. Identify the total number of enrollees assigned to the group
2. Identify the total number of individual PCPs available through the group
3. Divide the number of enrollees (item 1) by the number of PCPs (item 2)
4. Place the resulting number in the column entitled "Current Number of Enrollees Assigned to Provider" for each individual PCP associated with that group.

10. My Plan utilizes a staff model arrangement where the Plan assigns enrollees to a particular group or site. How do I complete the "Current Number of Enrollees Assigned to Provider" tab?

In a staff model arrangement, where enrollees are assigned to a particular group or site, please first list all of the individual physicians available through that delegated group on the PCP Report template. Second, clarify with the group whether they assign patients to a particular provider within the group. If the group or site assigns patients to specific individual PCPs, list the number of patients assigned for each PCP on the plan's provider list. If no assignment is made, i.e. a patient may see any PCP within the group or site at any time and does not have a particular PCP identified on their membership card, then the DMHC will accept the following methodology:

1. Identify the total number of enrollees assigned to the group or site
2. Identify the total number of individual PCPs available through the group or site
3. Divide the number of enrollees (item 1) by the number of PCPs (item 2)
4. Place the resulting number in the column entitled "Current Number of Enrollees Assigned to Provider" for each individual PCP associated with that group or site.

11. How do I report "Current Number of Enrollees Assigned to Provider" when the PCP has multiple addresses, specialties, or other record types.

For Measurement Year 2014, the DMHC recommends the following methodology:

1. If you are submitting data by Specific Record Type (i.e. separate Profile, Address, Specialty, Medical Group, and Admitting Privileges records): place the total number of enrollees assigned to the physician in the profile record by participating network. You should have a separate profile record for each participating network associated with that provider. If the physician has a different number of patients assigned at each location or by separate medical groups within the same participating network, please add all number of patients assigned across locations and medical groups for that provider in the relevant participating network and place that number in the profile record. If there is more than one profile record for the physician for the same participating network (e.g. to report multiple languages, multiple licenses, etc.), the plan may choose one of two options: 1. repeat the total number of patients assigned to the provider in all subsequent profile records for that physician within that participating network; or 2. place the total number of patients assigned to the provider in the first profile record for that

physician within that participating network and then enter "999999" in all subsequent profile records for that physician in that participating network.

Example 1: Robert West is contracted in two of the plan's participating network, has 3 locations and participates in two medical groups. For the Full HMO Group network, Dr. West has 100 patients assigned to him by Facey Medical Group and 150 patients assigned to him by Health Care Partners, for a total of 250 patients assigned to Dr. West in the Full HMO Group network. For the Full HMO Individual network, Dr. West has 200 patients assigned to him by Facey Medical Group and 300 patients assigned to him by Health Care Partners, for a total of 500 patients assigned to Dr. West in the Full HMO Individual Network. To enter data for Dr. West by specific record type, the relevant fields of the plan's spreadsheet would look like this:

SEPARATE ALL RECORD TYPE EXAMPLE 1										
PCP Record Type	First Name	Last Name	Assigned Enrollees	Participating Network	Medical Group	Address	City	County	State	Zip
Profile	West	Robert	250	Full HMO Group Market						
Profile	West	Robert	500	Full HMO Individual Market						
Address	West	Robert				123 Main Street	San Gabriel	Los Angeles	CA	91776
Address	West	Robert				456 Van Owen Street	Burbank	Los Angeles	CA	91111
Address	West	Robert				789 Orange Street	Valencia	Los Angeles	CA	92222
Medical Group/IPA	West	Robert			Facey Medical Group					
Medical Group/IPA	West	Robert			Health Care Partners					

Example 2: In addition to the facts set forth in Example 1, Dr. West speaks two languages, so the plan must enter 2 profile records for Dr. West for each participating network. In that scenario, the relevant fields of the plan's spreadsheet would look like this:

SEPARATE ALL RECORD TYPE EXAMPLE 2											
PCP Record Type	First Name	Last Name	Provider Language	Assigned Enrollees	Participating Network	Medical Group	Address	City	County	State	Zip
Profile	West	Robert	Farsi	250	Full HMO Group Market						
Profile	West	Robert	Spanish	500	Full HMO Individual Market						
Profile	West	Robert	Farsi	250	Full HMO Group Market						
Profile	West	Robert	Spanish	500	Full HMO Individual Market						
Address	West	Robert					123 Main Street	San Gabriel	Los Angeles	CA	91776
Address	West	Robert					456 Van Owen Street	Burbank	Los Angeles	CA	91111
Address	West	Robert					789 Orange Street	Valencia	Los Angeles	CA	92222
Medical Group/IPA	West	Robert				Facey Medical Group					
Medical Group/IPA	West	Robert				Health Care Partners					

1. If you are submitting data by All Record Types: place the total number of enrollees assigned to the physician by participating network. If the physician has a different number of patients assigned at each location or by different medical groups within the same participating network, please add all number of patients assigned across locations and medical groups for each participating network and enter that information in one of two ways: 1. place that number in all subsequent All Record Types records for that physician within that participating network; or 2. place the total number of patients assigned to the provider in the first All Record Types record for that physician within that participating network and then enter "999999" in all subsequent All Record Types records for that physician in that participating network.

Example: Robert West is contracted in two of the plan's participating network, has 3 locations and participates in two medical groups. For the Full HMO Group network, Dr. West has 100 patients assigned to him by Facey Medical Group and 150 patients assigned to him by Health Care Partners, for a total of 250 patients assigned to Dr. West in the Full HMO Group network. For the Full HMO Individual network, Dr. West has 200 patients assigned to him by Facey Medical Group and 300 patients assigned to him by Health Care Partners, for a total of 500 patients assigned to Dr. West in the Full HMO Individual Network. To enter data for Dr. West by All Record Types, the relevant fields of the plan's spreadsheet would look like this:

ALL RECORD TYPE EXAMPLES										
PCP Record Type	First Name	Last Name	Assigned Enrollees	Participating Network	Medical Group	Address	City	County	State	Zip
ALL Record Types	West	Robert	250	Full HMO Group Market	Facey Medical Group	123 Main Street	San Gabriel	Los Angeles	CA	91776
ALL Record Types	West	Robert	250	Full HMO Group Market	Facey Medical Group	456 Van Owen Street	Burbank	Los Angeles	CA	91111
ALL Record Types	West	Robert	250	Full HMO Group Market	Facey Medical Group	789 Orange Street	Valencia	Los Angeles	CA	92222
ALL Record Types	West	Robert	250	Full HMO Group Market	Health Care Partners	123 Main Street	San Gabriel	Los Angeles	CA	91776
ALL Record Types	West	Robert	250	Full HMO Group Market	Health Care Partners	456 Van Owen Street	Burbank	Los Angeles	CA	91111
ALL Record Types	West	Robert	250	Full HMO Group Market	Health Care Partners	789 Orange Street	Valencia	Los Angeles	CA	92222
ALL Record Types	West	Robert	500	Full HMO Individual Market	Facey Medical Group	123 Main Street	San Gabriel	Los Angeles	CA	91776
ALL Record Types	West	Robert	500	Full HMO Individual Market	Facey Medical Group	456 Van Owen Street	Burbank	Los Angeles	CA	91111
ALL Record Types	West	Robert	500	Full HMO Individual Market	Facey Medical Group	789 Orange Street	Valencia	Los Angeles	CA	92222
ALL Record Types	West	Robert	500	Full HMO Individual Market	Health Care Partners	123 Main Street	San Gabriel	Los Angeles	CA	91776
ALL Record Types	West	Robert	500	Full HMO Individual Market	Health Care Partners	456 Van Owen Street	Burbank	Los Angeles	CA	91111
ALL Record Types	West	Robert	500	Full HMO Individual Market	Health Care Partners	789 Orange Street	Valencia	Los Angeles	CA	92222

Please Note: for Measurement Year 2015, the Plan will be asked identify the number of patients assigned by location. Please begin making changes to the Plan's data collection process now so that the Plan will be able to provide this level of data for Measurement Year 2015.

12. My plan does not capture CA license for hospitals or ancillary providers. How do I populate the Hospitals and Other Contracted Providers report templates?

If no California license number exists for a particular other contracted provider type, the Plan may enter "NA" in the "CA License" column, but the Plan MUST enter the provider's NPI in the "NPI" column.

For all hospitals and for those other contracted providers who do have a California license but for whom the Plan does not maintain the license number in its database, the DMHC recommends that the Plan utilize the Department of Consumer Affairs website (<http://www.dca.ca.gov/>), Office of Statewide Health Planning and Development website (<http://www.oshpd.ca.gov/>), or the NPI database (<https://nppes.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do>) to identify the provider license, hospital license or NPI number, respectively, of its providers.

13. Are the fields of "Accepting New Patients" and "Current Number of Enrollees Assigned to Provider" required for hospitals?

The fields "Accepting New Patients" and "Current Number of Enrollees Assigned to Provider" are not included on the Hospital Spreadsheet; however, they are required fields on the Clinics Spreadsheet.

14. My plan contracts with medical groups who contract with their own hospitalist groups and my plan does not track or maintain which groups use which hospitalists at each specific hospital. How do I complete the Hospital, Hospital NPI, and Hospitalist fields in the PCP and Specialist Timely Access Spreadsheets?

Where the Plan's physicians are contracted via a medical group and that medical group maintains a contract with a hospitalist group for admitting privileges, please report admitting privileges on the PCP, Specialist, or Mental Health Timely Access Report spreadsheets as follows:

1. Where the Plan has confirmation from the medical group that **all physicians** within that group may utilize the hospitalist group to admit to specific hospitals, please identify all hospitals with which the hospitalist group maintains admitting privileges and enter each hospital name in the "Hospital" column on the PCP and Specialist template for each physician associated with that medical group. Please also enter a "Y" in the Hospitalists column in those templates.
 - a. Example: Dr. Jones, a specialist, is part of ABC Medical Group. ABC Medical Group has a contract with XYZ Hospitalist Group. XYZ Hospitalist group has hospitalists who can admit to Memorial Hospital and General Hospital. On the Specialist Spreadsheet in the Timely Access Report Templates, enter Dr. Jones twice. On the first entry, list "General Hospital" in the "Hospital" column. On the second entry, list "Memorial Hospital" in the "Hospital" column. For each of these entries, enter "Y" in the "Hospitalist" column.
2. Where the Plan has confirmed that **some physicians** within the medical group may utilize the hospitalist group to admit to specific hospitals, please identify all hospitals with which the hospitalist group maintains admitting privileges and enter each hospital name in the "Hospital" column on the PCP or Specialist template for only those physicians identified by the medical group.

15. My plan does not track if a provider is accepting referrals. How do I populate the "Accepting New Patients/Referrals" columns in the PCP, Specialist and Mental Health templates?

The "Accepting New Patients" field is to identify if the provider accepts new patients versus accepting existing or past patients. The plan would populate the field with an "N" if the provider does not accept any new patients even though the provider is able to accept appointments for existing or past patients. If the provider maintains a contract with the plan for this plan product under which the provider is required to accept all patients or all referrals, please place a "Y" in this category. If the plan does not know if the provider is accepting new patients or referrals, and the contract does not require the provider to take all patients and referrals, please enter "NA" in the "Accepting New Patients" column.

16. My plan does not have real time information on staff changes that may impact the language(s) spoken in a provider office. How do I complete the Facility Language column?

Please enter this information to the best of the plan's knowledge. The "Facility Language" column is required for the Plan's quarterly Covered California submission and is optional for the DMHC's timely access filing, therefore the column may be left blank for the purposes of the plan's timely access submission to DMHC.

17. What hospital services qualify as “tertiary care” as required in the Hospitals template?

Typically, a tertiary care hospital is one which provides highly specialized, complex medical care performed by highly trained specialists and subspecialists often using advanced technology in state of the art facilities, including sophisticated intensive care facilities. Generally, these hospitals may be academic medical centers, or specialized children’s hospitals in the case of the pediatric population. The hospital should be licensed or accredited, as applicable, to perform the treatment. Examples of such services might include complex cardiac procedures, complex neurosurgery, organ transplantation, treatment of severe burns, neonatology or other very complex treatments or procedures. The Department does not have a standard list of services that we consider to be "tertiary care." If the Plan considers a hospital to provide tertiary care, it may place a "Y" in the “Tertiary Care” column. If the Plan does not know if the hospital provides tertiary care please enter "NA."

18. What is a Network Tier ID?

The Network Tier ID column only applies to those plans that operate a tiered PPO network. A tiered PPO network is a product in which the Plan offers more than one “participating network” at different levels of cost-sharing, as well as an out-of-network benefit. For example, in a tiered network, an enrollee may access a plan-defined group of participating providers (“Tier 1”) and pay only 20% of the cost, or they can choose to access a separate plan-defined group of participating providers (“Tier 2”) and pay 40% of the cost, or they can choose to access a provider outside of the participating network and pay 60% of the cost. When completing the Timely Access Report spreadsheets, the Plan would identify the Tier 1 providers as a “1” in the “Network Tier ID” column, then it would identify the Tier 2 providers as a “2” in the “Network Tier ID” column.

19. My Plan does not maintain the office number, suite number, building, or other location identifier for providers in a distinct field, therefore I cannot complete the “Address 2” column. Will this cause the data to be kicked out or rejected?

The Address 2 field is an option for plans that separate the number of the office, suite, building, or other location identifier. The validation tool will accept this information in the “Address” or “Address 2” field. If the Plan does not separate out the office number, suite number, building, or other location identifier into a separate column, please leave the “Address 2” field blank.

20. The mental health provider I am listing in the “Mental Health” template is a licensed marriage and family therapist and also a qualified autism services provider. How do I report this information when both descriptors are supposed to be placed in the “Type of Licensure/Certificate” field?

If the provider has more than one descriptor that fits in the “Type of Licensure/Certificate” field, please complete multiple records for the provider to capture the variation. If you are reporting data by specific record type, enter two profile records for the provider, one in which you identify the “Type of Licensure/Certificate” as licensed marriage and family therapist, and another in which you identify the “Type of Licensure/Certificate” as qualified autism services provider. If you are submitting data as “All Record Types,” complete an additional row(s) for the provider to identify both license types.

21. The provider templates refer to an "Optional Set-Up". What is this?

The “Optional Set-up” references the data elements to be cross walked within the Lookup Code Setup tab. If your database uses a coding system, abbreviation, or any terminology that varies from the lookup code to identify key data elements, please be sure to crosswalk the Plan’s terminology to the DMHC’s terminology in the Lookup Code Setup tab.

Website Access and Report Submission

22. If I have a Quality Improvement Fee Plan (“QIF Plan”), do I have to file twice?

It depends. Only Plans with counterpart QIF Plans will see the QIF checkbox option at the top of the web form. This checkbox is selected only if the Primary Plan and the QIF Plan have identical networks. The Plan will login and submit its Timely Access Report for one Plan ID and then login again under the counterpart Plan ID to select the QIF checkbox indicating that the report has been filed by reference. If the primary plan and QIF have different networks, then each should file its own separate Timely Access Report reflecting so.

23. Do I have to submit all of the report forms provided?

No. Only the report forms that are applicable to the Plan’s network should be completed, uploaded, and submitted to the Department.

24. Can I upload Excel spreadsheets previously distributed by the Department or my own spreadsheet with the same information?

No. Because specific programming has been embedded into the finalized report forms for validation purposes, the Plan **must** save, complete, and upload the finalized Department Excel spreadsheets only available at the Department's public website: <http://www.dmhc.ca.gov/LicensingReporting/SubmitHealthPlanFilings.aspx#timely>.

25. Where do I get login/password access to the Department web portal or eFile application?

Each health plan has an identified Administrative Contact who is able to assign login/password access to the Department web portal or additional access to the eFile application specifically if the user currently has login/password access to another secure application on the web portal.

26. Why won't the system accept my submission after adding my Plan's information to the sample report forms provided?

Sample report forms will not be accepted as a valid report submission. **The sample report forms are for viewing purposes only.** Only the finalized Department Excel spreadsheets available at the Department's public website will be accepted.

27. It is taking a really long time for my report form to upload and/or validate. Is this normal?

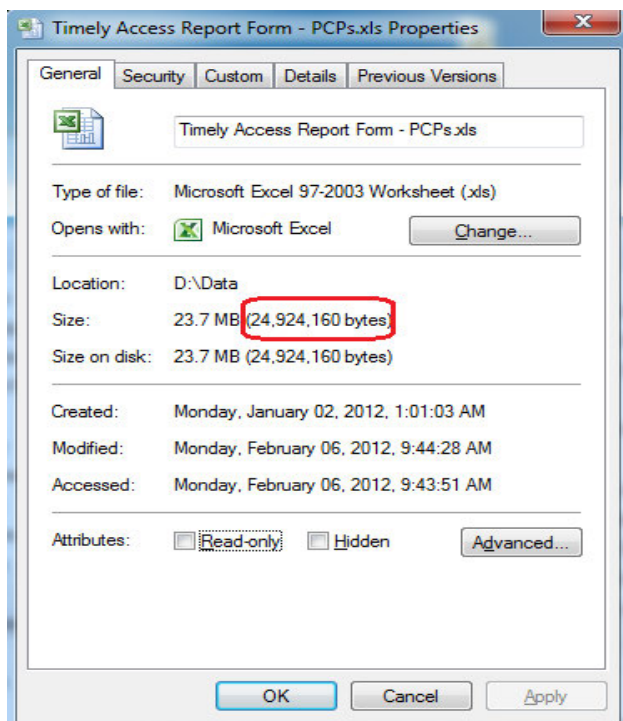
Yes. Due to the amount of data contained in the spreadsheets and, depending on the bandwidth or internet speed of each Plan's internet connection, a report form upload may take upwards of up to 1 minute or more.

The normal waiting time for the validation process should be within 5-10 minutes. If multiple users request the data validation at the same time, the waiting time for the validation process may be longer. If you don't receive an email notification for the validation result within an hour, feel free to contact Jeff Kral jkral@dmhc.ca.gov for assistance.

28. The system won't let me upload my report form due to its size. How do I submit?

Due to the programming imbedded into the Department report form for the validation functionality, plus the data input by the Plans, a single completed report form may become fairly large and even exceed the 25MB limit. The Plan may divide its information and upload multiple report forms for a single network type category.

You may verify the file size by checking the file properties. Make sure the actual size of the file is under 25,000,000 bytes (25 MB).



29. Does the portal accept .XLSX files? I have been having trouble uploading some test .XLSX files and noticed that the template samples are .XLS files. Are either type compatible with the portal?

Yes. The system will accept the .xlsx file extension. The report form provided by the Department is in .xls file extension (Excel 2003), but you may save the file as .xlsx format (Excel 2007/Excel 2010) and upload to the system.

Validation Tool

30. What is the “Validate Report(s)” button? I don’t recall seeing the validation process outlined in any of the Department’s portal instructions.

The validate function was covered in the webinars conducted by the Department. **All report forms must be validated before the Timely Access Report may be completed and successfully submitted to the Department.**

After a plan has uploaded the report form for a particular network category (e.g. PCP, Specialist, Hospital, etc.), the “Validate Reports” button must be selected. The system will validate your uploaded data in a background process. It will scan the report and verify that the report form(s) uploaded for a particular category meets the criteria as defined on the instruction tab of the specific spreadsheet (e.g. required fields populated appropriately, valid data lengths, all four record types included for each physician or specialist, etc.). Once the validation process is complete, you will receive an email notification regarding the validation result.

31. My report form won’t validate and I got an error report. How do I fix it?

If the validate function detects errors, the error report generated is very specific as to which tab and row number the error is located and then details the specific error for that field. Please see the instruction tab of the spreadsheet to verify the information and data length or format of the required/requested information for that field.

To fix an identified error, please do the following:

- a. Access the original Excel file on your own network and make the corrections to the original spreadsheet.
- b. Select the **Remove** link to delete the previously uploaded report form from the web portal/eFile application.
- c. Upload the newly corrected report form to the web portal.
- d. Select “Validate Reports.”

32. I am getting the "data length is invalid" validation error, but the data looks correct to me in the report form. What could be the problem?

There are probably some extra spaces within the data. The system will count spaces as part of the data length, so please remove leading and trailing spaces from the data.

33. Why can't I open the validation error report?

The validation error report will be generated in an Excel 2007 format. If you do not have Excel 2007 or later version, you can download the Microsoft Excel Viewer from this link (<http://www.microsoft.com/en-us/download/details.aspx?id=10>) to open the error report. Notice that if you are using Excel 2003 with Microsoft Office Compatibility Pack to open the error report, you may not be able to see the full report.