Timely Access Reporting Frequently Asked Questions

Measurement Year 2015

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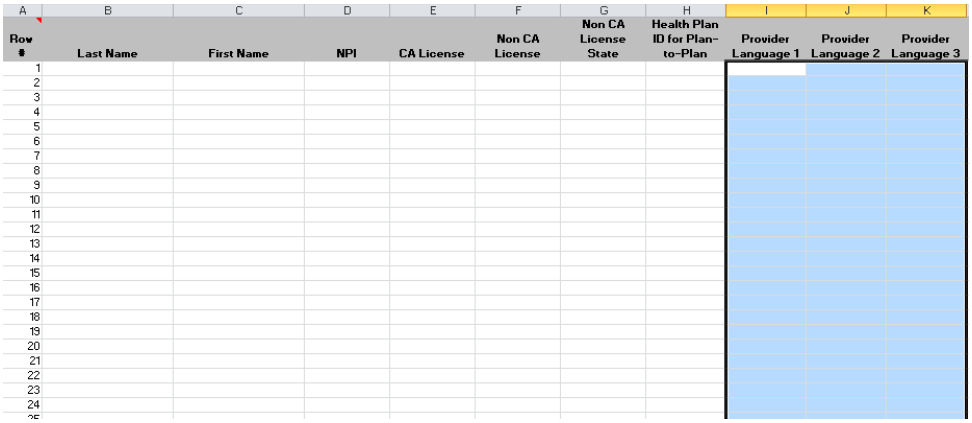
New for Measurement Year 2015

1. What has changed for reporting network data for Measurement Year 2015?

The DMHC has made a few notable changes to the Timely Access Report Forms and the process for submitting health Plan data. The following identifies the major changes for Measurement Year 2015:

- Only "All Record Types" entries will be accepted – the DMHC will no longer be providing Plans with the option of entering their data as "Specific Record Types" (e.g. Profile Record, Address Record, Specialist Record, Medical Group/IPA Record, and Admitting Privileges Record).
- New columns identified in the At-A-Glance – the DMHC has made changes to the columns and fields on the Timely Access Network Report Forms, which are summarized in the "At-A Glance" document posted on the public website: (http://www.dmhc.ca.gov/LicensingReporting/SubmitHealthPlanFilings.aspx#timely).
- Language Reporting – Plans are now asked to report no more than three languages for any single provider. Plans will list the languages spoken by the provider three columns on one row in three columns. Plans no longer need to add multiple rows for multiple languages.



Row #	Last Name	First Name	NPI	CA License	Non CA License	Non CA License State	Health Plan ID for Plan-to-Plan	Provider Language 1	Provider Language 2	Provider Language 3
1										
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3										
4										
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- Profile Tab – Plans will now provide up-front information about their networks directly in the timely access web portal. This also allows Plans to complete all look up codes in one place and only one time. Below is a screenshot of the Profile Tab from the timely access web portal:

- Wait time notification - the TAR Portal now displays the wait time to validate the Plan's files once files are submitted through the data validation process.
- File compression – the web portal now allows Plans to compress a file before downloading it to the portal.
- Grievance Report Template – the DMHC has created a template for providing grievance information as required under Section 1367.035. Click here for instructions for completing the Timely Access and Network Grievance Templates.

Populating Report Forms (Excel Templates)

2. What date range should I report?

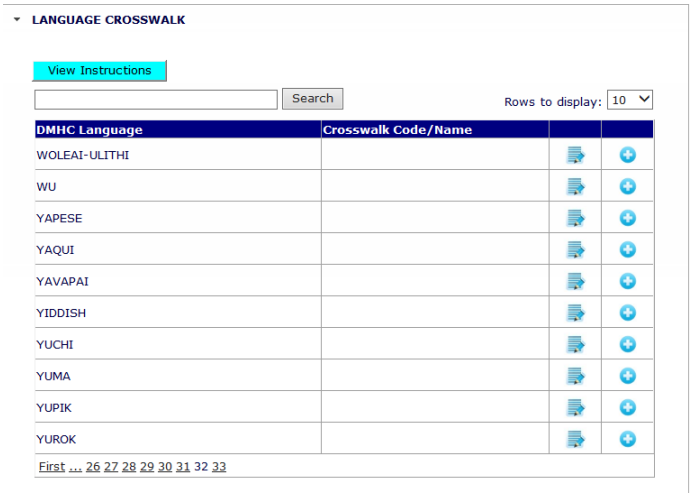
The Timely Access **Network** Reporting should be a "snapshot" of the Plan's network as of December 31, 2015.
The Timely Access Annual **Compliance** Report should reflect the period between January 1, 2015 and December 31, 2015.

3. Do I have to complete Look-up Code tab for each Timely Access Report Form?

No. The Look-up Code tab for each Report Form has been removed. The look up code functions have been consolidated and are now located on Timely Access portal under the "Profile" tab. This tool allows a health plan ("Plans") to link its terminology or codes for specific categories of data to the terminology or codes that that the DMHC requires (e.g. county, language, or specialty, etc.). Health Plans will only have to complete the look up code tables linking its terminology to the Departments' terminology once.

4. If the language the Plan uses is not listed on the "Profile" tab, can I add it to the tables on the Look-up Code worksheet?

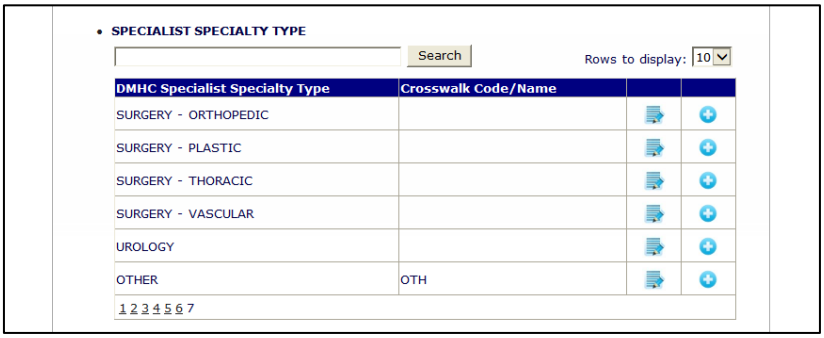
No. Additional languages or specialties cannot be added to the Look-up Codes in the Profile tab. The Plan is limited to the list of languages provided in the Look-Up Code. If the Provider speaks a language not listed in the Look-Up code, do not report that language.



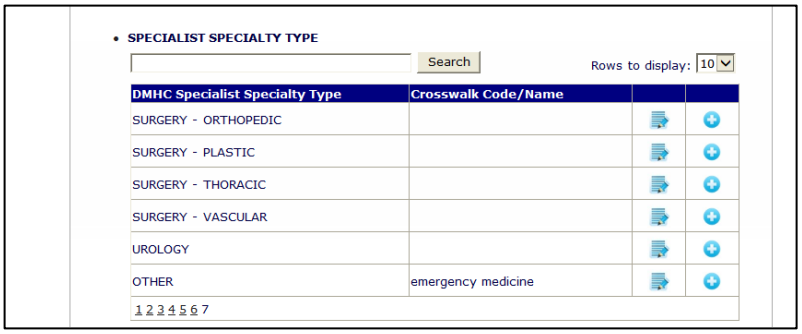
5. If the specialty the Plan uses is not listed on the "Profile" tab, can I add it to the tables on the Look-up Code worksheet?

If a provider practices a specialty that is not included on the Timely Access portal Profile tab, then the Plan must indicate "Other" (or enter the Plan's specified code for "Other") under the Specialty column of the particular spreadsheet. The column entitled "Specialty/Subspecialty (Other)" is a r e q u i r e d field whenever a Plan indicates "Other" in the "Specialty/Subspecialty" field. If the Plan identifies a provider's value as "Other" in that field, the Plan must use the "Specialty/Subspecialty (Other)" column to describe what specialty is associated with that provider. Do not map the other specialty names to the term "Other" in the DMHC Look Up Code. Example:

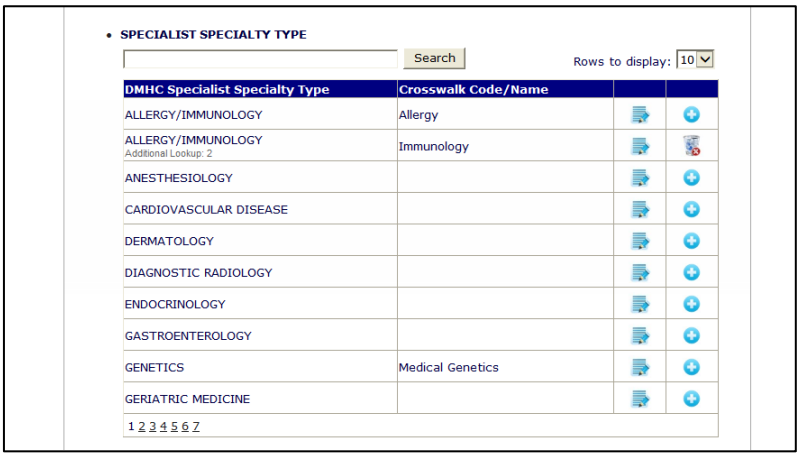
Correct:



Incorrect:



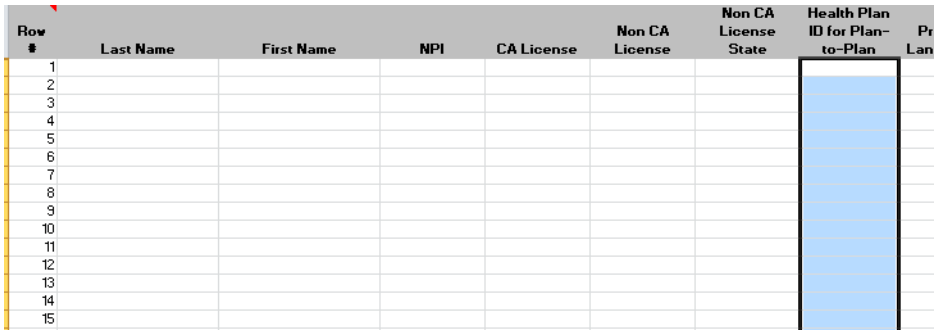
If the Plan lists multiple specialty types that map to the same specialty term as identified by the DMHC in the Look-Up Code, the Plan may make multiple entries in the Profile Page in order to map Plan terminology to the established DMHC terminology. Please see the following example:



Please ensure that the Plan only enters "Other" in the "Specialty/Subspecialty" field if the provider's specialty does not fit within one of the DMHC's specified specialty types identified in the Look-Up Code. If the Plan enters "Other" in the "Specialty/Subspecialty" field and then enters a specialty under "Specialty/Subspecialty (Other)" that is actually included in the DMHC's Look-Up code, the Report Form will not pass validation when submitted through the web portal.

6. What is the Health Plan ID for the Plan-to-Plan Contract field?

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://wpso.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.



Row #	Last Name	First Name	NPI	CA License	Non CA License	Non CA License State	Health Plan ID for Plan-to-Plan	Pr Lan
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7. Do I need to report Tax Identification Numbers ("TINS") in the report?

No. The finalized network report forms for the March 31, 2016 submission do not request Plans to include TINs.

8. The report form has a field titled, "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, 2015.

9. 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 2015 (due March 31, 2016), the methodology described below for reporting "Current Number of Patients Assigned" for PPO products will be accepted by the DMHC. All calculations of patients assigned to providers should be conducted based on "County" and "Name of Network" reported in the Timely Access Network Report Forms. Please note, if the Plan maintains more than one PPO network name (e.g. California Blue PPO, California Gold PPO, etc.), please separately calculate the number of patients assigned for each PPO network using the following methodology:

1. Identify the total number of enrollees in that PPO network name residing in that county as of December 31, 2015.
2. Identify the total number of PCPs in that PPO network practicing in that county as of December 31, 2015
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.
5. Repeat this value in the "Number of Patients Assigned" column for every entry related to the same provider when reporting this Name of Network.

For example, there are 2,000 enrollees in Los Angeles County and 50 PCPs associated with the Plan's "California Blue PPO" Name of Network. On the PCP Timely Access Report Form template, enter "40" in the column "Current Number of Patients Assigned" for every PCP listed on the template with the identified name of network "California Blue PPO" and the identified county of "Los Angeles."

The DMHC continues to research the best way to capture this data for PPO products and this methodology may change for Measurement Year 2016.

10. 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.

11. 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, calculated for each individual Name of Network:

1. Identify the total number of enrollees in the Name of Network assigned to the group
2. Identify the total number of individual PCPs available to this Name of Network 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 that is associated with that group and included in that Name of Network.

Please ensure that the numbers entered in this field are specific to the Name of Network being reported. For example, if the Plan contracts with the same medical group to participate in multiple networks, it must

Identify the number of patients from each Name of Network that are assigned to the providers and report only the number of patients assigned to that provider for the specific Name of Network being reported.

12. 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 for the Name of Network being reported
2. Identify the total number of individual PCPs available through the group or site for the Name of Network being reported
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.

Please ensure that the numbers entered in this field are specific to the Name of Network being reported. For example, if the Plan assigns to the same group or site for participation in multiple networks, it must identify the number of patients from each Name of Network that are assigned to the providers and report only the number of patients assigned to that provider for the specific Name of Network being reported.

13. How do I report "Current Number of Enrollees Assigned to Provider" when the PCP has multiple addresses, specialties, or other data that will warrant multiple rows?

If the Plan must enter multiple rows for the same provider in one Name of Network, report the total number of enrollees assigned to the physician by name of network. If the physician has a different number of patients assigned at each location or by different medical groups within the same name of network, please add all number of patients assigned across locations and medical groups for the name of network being reported and place that number in all subsequent records for that physician within that name of network.

Example: Robert West is contracted in two of the Plan's participating networks, has three locations and participates in two medical groups. For the California Gold HMO 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 California Gold HMO network. For the California Blue HMO 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 California Blue HMO network. To enter data for Dr. West by All Record Types, the relevant fields of the Plan's spreadsheet would look like this:

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

14. 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.

For Measurement Year 2015, the DMHC has added two columns to the Report Templates that will allow the Plan to identify providers who are licensed in a state other than California and to provide the out-of-state license number. Please only report a provider's out-of-state license number if they do not also have a California license number.

15. 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.

16. 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 Network Report templates?

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 template 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.

   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 as being able to admit via a hospitalist.

17. My Plan has multiple categories to describe whether a PCP is accepting new patients. How do I populate the "Accepting New Patients/Referrals" columns in the PCP, Specialist and Mental Health templates?

The purpose of 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.

18. 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 transplant, 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."

19. 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. Please note: If the Plan also maintains an out-of-network benefit, the Plan should not submit the out-of-network providers on its Timely Access Network Report Forms.

20. 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 rejected?

The Address 2 field is an optional field for Plans that separate the number of the office, suite, building, or other location identifier in their own databases. 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.

21. 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?

If the provider is a licensed non-physician mental health provider, please indicate the area in which they hold a license or certificate in the "Type of Licensure/Certificate" column and then indicate what time of autism service provider they are in the "Specialty/Area of Expertise" column. Please remember to complete the Department's preferred terminology for "Type of Licensure/Certificate" and "Specialty/Area of Expertise" or complete a Look Up Code on the Profile Tab in order to connect the Plan's terminology to the Department's terminology.

22. My mental health plan provides both non-physician mental providers as well as psychiatrist. How do I report these provider types in the Timely Access Network Report Forms?

All non-physician mental health providers are reported in the "Timely Access Report Form – Mental Health." All psychiatrists must be reported in the "Timely Access Report Form – Specialists." If your mental health plan offers both provider types, please submit both types of Timely Access Network Report Forms.

Website Access and Report Submission

23. 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.

24. 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. Every Plan must submit an Enrollment Network Report Form. Please be sure your plan has included enrollment information for every Name of Network identified in the Profile Tab when it submits its Enrollment Network Report Form.

25. 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.

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

Each licensed 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. If you do not know who your health plan's Administrative Contact is, please contact the DMHC's Office of Plan Licensing at LicensingeFiling@dmhc.ca.gov for that information.

27. 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.

28. 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. The TAR Portal will identify the wait time to validate the Plan's files once files are submitted. 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.

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

Due to the programming embedded into the Department Timely Access Network 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. If the Plan submits multiple report forms for one provider type, please name the files to clearly identify that all files relate to the same provider type (e.g. "Report Form PCP1," "Report Form PCP2," "Report Form PCP3," etc.).

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).

30. Does the portal accept .XLSX files? Are both .XLSX and .XLS file types 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

31. What is the "Validate Report(s)" button?

The validate function was covered in the webinars conducted by the Department. All report forms must be validated before the Timely Access Report will be 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.) and will ensure that information provided in the Timely Access Network Report Form is consistent with the information provided in the Plan's Profile Tab. Once the validation process is complete, you will receive an email notification regarding the validation result.

32. 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 or the Plan's Profile Tab 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:

3. Access the original Excel file on your own network and make the corrections to the original spreadsheet.
4. Select the **Remove** link to delete the previously uploaded report form from the web portal/eFile application.
5. Upload the newly corrected report form to the web portal.
6. Select "Validate Reports."

Please remember that once you fix an error in a report, you must re-submit the complete report, not just the data that was corrected. The new file will replace the previously-submitted document.

33. 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.

34. 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.