SUMMARY OF HEALTH AND MENTAL HEALTH PLAN COMPLIANCE WITH THE TIMELY ACCESS REGULATION MEASUREMENT YEAR 2011

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SUMMARY OF HEALTH AND MENTAL HEALTH PLAN COMPLIANCE WITH THE TIMELY ACCESS REGULATION MEASUREMENT YEAR 2011

I. EXECUTIVE SUMMARY

The California Department of Managed Health Care (the "Department") is charged with monitoring health care service plan ("health plan" or "plan") compliance with the Knox-Keene Health Care Service Plan Act of 1975 and the California Code of Regulations, title 28[1]. Within the Code of Regulations, Rule 1300.67.2.2, the Timely Access to Non-Emergency Health Care Services Regulation (hereafter referred to as "Timely Access Regulation") requires health plans to meet specified clinical and time-elapsed standards for provision of health care services. The regulation includes wait time standards for appointments as well as for customer service and triage.

The regulation also requires plans to submit a compliance report by March 31 of each year ("Reporting Year") that includes plans' compliance rates for each of the time-specific standards for the previous calendar year ("Measurement Year"). The plans' first compliance reports, which are the basis for this summary report, were based on Measurement Year 2011 and were submitted in Reporting Year 2012. Thirty-three (33) full service health plans and seven (7) mental health plans submitted reports in March 2012.

All data submitted by the plans is self-reported. As part of the triennial survey process, the Department will verify the accuracy of the plans' data.

Analysis of the plans' timely access report submissions revealed the following:

- Plans have revised their access policies and procedures to include the appointment wait time standards required by the Timely Access Regulation, but some revisions and additions are necessary to fully comply with the Timely Access Regulation.

- Plans used a variety of tools and measures to conduct internal monitoring of timely access. These include provider and enrollee surveys, mystery shopper calls, visits to provider offices, analysis of referral frequencies, geographic access reports and/or mapping of provider locations, review of potential quality issues, and enrollee and provider complaints.

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[1] The Knox-Keene Act is codified at California Health and Safety Code section 1340 et seq (Act). All references to "Section" are to sections of the Act. The regulations promulgated from the Act are codified at Title 28 of the California Code of Regulations section 1000 et seq. All references to "Rule" refer to California Code of Regulations, title 28.

- The regulation allows plans to select their own measures to calculate and report their rates of compliance. The most commonly used are:
  - Satisfaction/experience survey administered to enrollees;
  - Appointment availability survey administered to providers;
  - Satisfaction/experience survey administered to providers; and
  - Grievance rates.

- Many plans used a limited number of measures to calculate rates of compliance. Two-thirds of plans used three or fewer measures.

- Not all plans surveyed providers regarding both appointment availability and providers' experiences and concerns.

- Few plans reported information by provider specialty.

- Eight out of the 33 full service plans (24%) and two out of seven mental health plans (29%) identified patterns of non-compliance with the timely access requirements. Within the Measurement Year, no plans reported incidents of non-compliance that resulted in significant harm to an enrollee.

Because the regulations did not require the use of standardized metrics to measure timely access, plans used a variety of approaches to demonstrate compliance with timely access requirements. Since the health plans did not use the same approach, it is difficult to make comparisons between plans to get an impression of compliance with the Timely Access Regulation statewide.

Even though cross-comparisons amongst plans are not yet feasible, the plans' submissions contain a wealth of information that the Department will use to identify specific areas of non-compliance for each plan. If deficiencies or issues of non-compliance have been identified, the Department has addressed such issues with the individual plan(s).

II. BACKGROUND

A. TIMELY ACCESS REGULATION

In 2002, the Legislature passed, and the Governor signed, AB 2179 (Chapter 797, Statutes of 2002)[2], directing the Department to develop and adopt regulations to ensure that enrollees have access to needed health care services in a timely manner. After many years of negotiation and stakeholder input, the Timely Access to Non-Emergency Health Care Services Regulation ("Timely Access Regulation") became effective January 17, 2010.[3] (*See Appendix A*).

Each plan submitted a work plan for achieving compliance with the Department in October 2010. Full service and specialized health plans licensed by the Department were required to fully implement the policies, procedures and systems necessary to comply with the regulation by January 17, 2011.

The regulation requires each health plan to contract with adequate numbers of physicians and other health care providers in each geographic area to meet the following clinical and time-elapsed standards:

- Enrollees must be offered appointments for covered health care services within a time period appropriate for their condition(s).

- Enrollees must be offered appointments within the following timeframes:

    - Within 48 hours of a request for an urgent care appointment for services that do not require prior authorization.
    - Within 96 hours of a request for an urgent appointment for services that do require prior authorization.
    - Within 10 business days of a request for non-urgent primary care appointments.
    - Within 15 business days of a request for an appointment with a specialist.
    - Within 10 business days of a request for an appointment with non-physician mental health care providers.
    - Within 15 business days of a request for a non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness or other health condition.

- The applicable waiting time for an appointment may be shorter or longer as clinically appropriate based on the opinion of a qualified health care professional acting within the scope of his or her practice consistent with professionally recognized standards of practice. If the waiting time is extended, it must be noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.

- In areas with provider shortages, plans must still meet their obligation to arrange for enrollees to receive timely care as necessary for their health condition. If timely

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[2] Health and Safety Code § 1367.03.
[3] Section 1300.67.2.2 of title 28 of the California Code of Regulations.

appointments are not available in a particular area, a plan must refer enrollees to or assist enrollees in locating available and accessible contracted providers in neighboring service areas.

Health plans also are required to:

- Provide or make available telephone triage or screening services 24 hours a day, 7 days a week to determine the urgency of an enrollee's condition. Triage must be performed by qualified health care professionals, and, if needed, a call back must be made to an enrollee within 30 minutes.
- Ensure that during normal business hours, the telephone waiting time for an enrollee to speak with a knowledgeable and competent plan customer service representative does not exceed 10 minutes.
- Monitor network compliance with the standards and investigate and correct deficiencies.

Health care providers must report their compliance with these standards to health care service plans. Health care service plans must report to the Department their performance and that of their contracted providers in complying with the standards during the Measurement Year, by March 31 of each Reporting Year.

B. PROVIDER SURVEYS

In early 2010, the Department and several health plans participated in a Timely Access Implementation Workgroup. The health plans suggested that the Industry Collaboration Effort (ICE) [4] assist in creating standardized provider surveys that plans could use as part of their compliance monitoring. ICE also developed a template for plans to use in developing their timely access policies and procedures. While the goal was to have all plans utilize the ICE survey, some plans used ICE survey, some plans modified the ICE survey, and other plans did not use the ICE survey.

C. PLAN REPORTS FOR MEASUREMENT YEAR 2011

Appendix D contains the Department's 2011 instructions to plans for Reporting Year 2012. The Department did not specify the measurement tools, surveys, methodologies or approaches that plans must use to monitor and report compliance with the Timely Access Regulation. Plans had flexibility to use a variety of tools and approaches to meet their reporting obligations.

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[4] The Industry Collaboration Effort (ICE) works with health plans, regulators and other health care industry stakeholders to develop educational materials, "best practice" materials, standardized reporting mechanisms, policy/procedure templates and other materials to help plans and providers consistently and efficiently comply with regulations. See www.iceforhealth.org for additional information.

The Department retained and utilized the services of an independent contractor with industry experience, Managed Healthcare Unlimited, Inc. ("MHU"), to review the plans' reported data. MHU provided feedback to the Department concerning each plans' reported data.

The plans' first compliance reports, which are the basis for this report, were submitted to the Department in March 2012 based on Measurement Year 2011. Thirty-three (33) full service plans and seven (7) mental health plans submitted reports (see *Appendix E*).

III. FULL SERVICE HEALTH PLANS

For Measurement Year 2011, 33 full service plans and 7 mental health plans submitted reports on their compliance with the Timely Access Regulation to the Department.

Plans submitted the following information:

- **Access and availability policies and procedures**.
- **Rates of compliance**, including methodology, compliance rates and data sources including Grievances and Appeals.
- **Provider and enrollee surveys** of their experiences offering and obtaining timely appointments.
- **Non-compliance data**, including methodology, incidents of non-compliance resulting in substantial harm to an enrollee and patterns of non-compliance.
- **Advanced access** to primary care appointments within the same or next business day.
- **Triage services, telemedicine, and health information technology** utilization.

In addition, each plan submitted data files that contained specific details (e.g., address, county, zip, medical specialties, language spoken) confirming each provider and facility in the plan's network.

A. ACCESS AND AVAILABILITY POLICIES AND PROCEDURES

Plans are required to describe their operations and standards in policies, procedures, program descriptions, and other documents related to the implementation of the Timely Access Regulation. Each plan's quality assurance systems, policies and procedures must ensure that the plan's provider network is sufficient to provide access, availability and continuity of covered health care services. Quality assurance program documents include the following:

- **Standards** for the provision of covered services in a timely manner consistent with the regulation.

- **Methods for monitoring compliance**, including tracking and assessing network capacity and availability, evaluating access information at least quarterly, conducting an annual enrollee experience survey, conducting an annual provider survey, and verifying the advanced access programs reported by providers.

- **Methods for investigating underlying causes of non-compliance and implementing corrective actions** when the plan is not meeting the timely access standards.

In addition, plans must review the quality of care provided to enrollees, identify any problems, take effective action to improve care where deficiencies are identified, and conduct follow-up to determine if deficiencies have been resolved.

1. STANDARDS

Table 1 summarizes the content of health plans' access and availability policies and procedures submitted to the Department. The Table shows the number of plans and percentage of plans that had the required element present or not present in their policies. Time-elapsed standards were present in all plans' policies and procedures. The Department has followed up with specific plans concerning deficiencies in Timely Access Regulation compliance. Compliance issues either have been resolved, or the Department is actively working with plans to address deficiencies.

Table 1
Access and Availability Policies and Procedures
(n=33)

Content Element to be Included/Described	Present	Not Present	N/A
Incorporation of the required time-elapse standards for appointments:	# (%)	# (%)	# (%)
▪ Urgent appointments, no prior authorization required, offered within 48 hours	33 (100%)		
▪ Urgent appointments for services that require prior authorization offered within 96 hours	28 (85%)	1 (3%)	4 (12%)
▪ Non-urgent appointments for primary care offered within 10 business days	33 (100%)		
▪ Non-urgent appointments with specialist physicians, including psychiatrists, within 15 business days	33 (100%)		
▪ Non-urgent appointments with a non-physician mental health provider within 10 business days	31 (94%)		2 (6%)
▪ Non-urgent appointments for ancillary services within 15 business days	32 (97%)	1 [a] (3%)	
Applicable waiting time may be extended if the referring or treating provider or triage/screening service has determined and noted in relevant records that a longer waiting time will not have a detrimental impact on enrollee health	28 (85%)	5 [b] (15%)	
Rescheduling an appointment in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice	31 (94%)	2 [a] (6%)	
Preventive care services and periodic follow-up care can be scheduled in advance consistent with professionally recognized standards	29 (88%)	4 [b] (12%)	
Coordination of interpreter services with scheduled appointments	33 [c] (100%)		
Requirement to provide 24-hour-per-day, 7-days-per-week triage or screening services by telephone	29 (88%)	4 [a] (12%)	
Methodology for providing triage services (e.g., in-house, contracted)	33 (100%)		
Requirement that during normal business hours, the waiting time to speak with a plan customer service representative does not exceed 10 minutes	31 (94%)	2 [a] (6%)	
Requirement to conduct an annual enrollee experience survey	32 (97%)	1 [a] (3%)	
Requirement to conduct an annual provider survey	33 (100%)		
Reviewing and evaluating on not less than a quarterly basis information regarding accessibility, availability and continuity of care, including information obtained through surveys, grievances and appeals, and triage services	32 (97%)	1 [a] (3%)	
How the plan implements prompt investigation and corrective action when monitoring identifies provider network insufficiencies (based on timely access standards)	33[c] (100%)		

[a] The Department has followed up to bring Plans into compliance.
[b] Inclusion of this statement is permitted but not required – plans may elect not to extend wait times beyond those in the regulation.
[c] Although these plans had not addressed these processes in their access policies, the requirement was included in quality management policies.

2. METHODS FOR MONITORING COMPLIANCE

All plans adopted the time-elapsed standards contained in the regulation and incorporated the Timely Access Regulation's time-elapsed timeframes into their internal policies.

a) Timely Access to Appointments

Plans used a variety of tools and methodologies to monitor timely access to appointments. These included the following:

- **Enrollee satisfaction/experience survey**—Plans used various vendor-developed and plan-developed surveys, most commonly NCQA's CAHPS survey. Most were administered annually but some plans drew monthly or quarterly samples of enrollees who received services. Some surveys were targeted to satisfaction with a specific type of service (e.g., mental health, customer service).
- **Provider appointment availability survey**—Plans most often used the Provider Appointment Availability Survey developed by ICE, but several used other vendor-developed or internally developed surveys.
- **Provider satisfaction survey**—Most plans used the Provider Satisfaction Survey about Access Standards developed by ICE.
- **Mystery shopper calls**.
- **Visits to provider offices**, often including a visual review of scheduling systems or appointment books to assess next available appointment wait times.
- **Wait time calculations** from scheduling software.
- **Analysis of referral** frequencies and specialties to which referrals are made.
- **Analysis of claims/encounter data**.
- **Geographic access** reports and/or mapping of provider locations.
- **Provider grievance** monitoring.
- **Review of potential quality issues**.
- **Requests for changes in primary care providers (PCPs)**.
- **Provider turnover**.
- **Enrollee grievances and appeals**.

b) Timely Access to Customer Service and Triage

In general, plans monitor customer service access electronically (i.e., through audit of the telephone system) including call abandonment and time-to-answer rates. Plans monitor wait time for triage services through collection and analysis of time-to-answer rates and enrollee satisfaction surveys.

3. METHODS FOR INVESTIGATING NON-COMPLIANCE

Each plan's quality assurance program must address prompt investigation and corrective action when it identifies provider network insufficiencies that affect timely access. Some plans' policies and procedures contained:

- Detail for monitoring compliance data;
- Methods for assessing the data and identifying patterns and significant incidents of non-compliance;
- Processes for investigating and identifying underlying causes of non-compliance;
- Types of corrective actions that are used to address non-compliance; and
- Processes for notifying and working with non-compliant providers.

Plans often stated that investigation and corrective action would be handled by their quality management departments/committees and may include the involvement of peer review bodies if significant concerns about the quality of care rendered by a provider were raised.

B. RATES OF COMPLIANCE

For each contracted provider group, plans must annually report to the Department the group's compliance with the time elapsed standards by county. A plan may use a statistically reliable sampling methodology, including but not limited to, provider and enrollee surveys. The report should also describe whether the plan, during the Measurement Year, identified: (1) any incidents of non-compliance resulting in substantial harm to an enrollee; or (2) any patterns of non-compliance. If the plan found either of these, the plan must describe the incident or pattern of non-compliance and the plan's responsive investigation, determination and corrective action.

Plans used a variety of tools to develop their rates of compliance with the Timely Access Regulation. The most consistent common tool used by plans was an appointment availability survey administered to providers, although the specific survey varied amongst plans.

In calculating rate of compliance with the Timely Access Regulation, Table 2 shows the following:

- Approximately one-third (13 out of 33) of plans used the results of an enrollee satisfaction survey.
- About 80 percent (27 out of 33) of plans used the results of a provider survey regarding appointment availability.
- One-third (11 out of 33) of plans used the results of a provider satisfaction survey.
- Nearly two-thirds (21 out of 33) of plans incorporated enrollee grievances data.
- Only 3 plans used calculations from the plan's appointment scheduling system.

Table 2
Measurement Tools Used (often in combination) to Develop Annual Rates of Compliance
(n=33)

Timely Access Element	Measurement Tool	# of Plans	Total # of Plans	% of Plans
Satisfaction/experience survey administered to enrollees	CAHPS enrollee survey (standard methodology and items performed by certified vendor)	6	13	39%
	CAHPS-based survey (not performed by a certified vendor, possible variation in items)	3		
	Other enrollee survey (may contain some CAHPS items but largely different items/methodology)	4		
Appointment availability survey administered to providers	ICE Appointment Availability Survey (standard methodology and items)	12	27	82%
	ICE Appointment Availability-based survey (some variations in items and/or methods)	5		
	Other appointment availability survey (may contain some ICE items but largely different items/methodology)	10		
Satisfaction/experience survey administered to providers	ICE Provider Satisfaction Survey (standard methodology and items)	3	11	33%
	ICE Provider Satisfaction-based survey (some variations in items and/or methods)	5		
	Other provider satisfaction survey (may contain some ICE items but largely different items/methodology)	3		
Grievance counts/rates			21	64%
Appointment scheduling system calculations			3	9%
Other (e.g., mystery caller, provider site audits, enrollee/provider ratio, letters of agreement with providers, open panel rate, after hours survey)			8	24%

1. GRIEVANCES AND APPEALS AS AN INDICATOR OF ACCESS

Grievances constitute an important source of information about enrollees' experiences accessing a plan's health delivery system. All plans are required to monitor enrollee grievances and appeals and identify patterns that may adversely affect quality of care and service. Access grievances include dissatisfaction with availability of providers, wait time for appointments, wait time at provider offices, and access to linguistic and cultural services. Plans regularly track and monitor these grievances by provider, provider site or geographic area, specialty, and other elements in order to identify systemic, actual or potential problems and implement corrective actions.

Plans are required to report the number and types of grievances they receive on a quarterly basis, including those that were unresolved beyond 30 days.

As part of their compliance calculations, 21 plans (64%) included grievances about access. However, there was variation in the types of grievances that plans included in their rates – some plans included all access grievances (e.g., geographic access, customer service phone line access, linguistic/cultural issues, referral delays, provider office phone line access, and appointments); others included grievances only related to timely access standards.

2. MEASURING AND REPORTING COMPLIANCE

The Timely Access Regulation requires that each plan develop rates of compliance through statistically reliable methodologies including, but not limited to, provider and enrollee survey processes or through provider reporting.

As noted previously, in this first year, the plans had flexibility to select measurement and reporting methods. In reviewing plan submissions, the Department identified areas that could be improved in measuring and reporting compliance as well as strengths and creative approaches. For example, three plans (9%) used survey items or made wait time calculations based on averages (e.g., the average length of time to obtain a routine appointment). This method does not produce a clear rate of compliance. While calculating average days wait may provide some insight into monitoring the overall monthly trend, this method does not account for enrollees' individual wait times. The intent of the Timely Access Regulation is to ensure that enrollees are consistently offered appointments within a given timeframe. Rather than reporting compliance based on average wait times, an improved measure would be for plans to report on actual individual wait times.

C. PROVIDER AND ENROLLEE SURVEYS

1. PROVIDER APPOINTMENT AVAILABILITY SURVEYS

Each plan must conduct an annual provider survey using valid and reliable survey methodology. The survey should solicit providers' perspectives and concerns regarding compliance with the Timely Access Regulation standards. Plans administered provider appointment availability surveys, provider satisfaction surveys and/or surveys that combined the various types of items. The most frequently used provider appointment availability survey was the Provider Appointment Availability Survey developed by ICE (see *Appendix B*).

Twelve plans (36%) calculated their compliance rate in whole or in part using the ICE Provider Appointment Availability Survey with the approved format and methodology. Five additional plans (15%) used the ICE tool but modified the items or the methodology to tailor them to the needs of the plan.

Ten plans (30%) used a different appointment availability survey rather than the ICE tool. These

plans either developed the survey internally or via a vendor. While some of these surveys contained one or more ICE items, most were largely different in terms of items and methodology.

The Department has concerns about the accuracy of self-reported data when the provider responds generally as to whether or not it can meet the specific time-elapsed standards (e.g., can you provide an urgent appointment that does not require prior authorization within 48 hours of the request?). For the 2013 Measurement Year, the Department has worked with ICE to amend the provider survey questions in order to capture the specific date of next available appointment based on the date of the survey.

2. PROVIDER SATISFACTION SURVEYS

Physicians and their office staff often refer patients to specialists or make arrangements for diagnostic or treatment services. Thus, in addition to providing information about their own appointment availability, providers can provide valuable information about the ease and speed of referrals and, arranging for various services. Of particular relevance to the Timely Access Regulations are survey items by which providers rate their ability to make referrals to other providers and services (e.g., medical specialists, mental health providers, diagnostic imaging).

The provider satisfaction survey most frequently used by plans to meet their annual reporting obligations was the Provider Satisfaction Survey developed by ICE (*See Appendix C*). This six-item survey assessed the referral and/or prior authorization process necessary for the provider's patients to obtain covered services and patients' access to urgent care, non-urgent primary care, non-urgent specialty services, non-urgent ancillary diagnostic and treatment services and non-urgent mental health care. Four plans (12%) used this survey in the ICE-approved format and methodology and included this data in calculating their rates of compliance with the Timely Access Regulation. Several additional plans added the ICE items to existing surveys, either as presented, or with minor format or wording changes.

Three plans (9%) used satisfaction surveys other than the ICE survey. Generally these surveys were more extensive than the ICE survey. They gathered input on provider satisfaction with many aspects of care delivery and plan operations such as, providers' experiences and attitudes regarding reimbursement, the health plans' provider services staff, ease of obtaining eligibility information about enrollees, and processes for obtaining authorization to provide services.

3. ENROLLEE EXPERIENCE SURVEYS

The Timely Access Regulation requires all plans to conduct an annual enrollee experience survey. Thirty of the full service plans (91%) conducted enrollee surveys. Of the remaining three plans, one did not include this information and two plans stated that they had not been in operation long enough to conduct the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The Department is working with these three plans to ensure submission for Measurement Year 2013. Thirteen plans (39%) included their enrollee survey results as part of their rates of compliance.

The most frequently used enrollee survey for reporting compliance was the CAHPS survey, which collects information from consumers about their experiences with health care.[5] The CAHPS survey questionnaire includes several questions pertaining to access to services (see Table 3). The majority of these items are included in the Health Care Quality Report Card results published each year by the Office of the Patient Advocate.

Because the CAHPS surveys are used for assessment and plan-to-plan comparisons nationally, the survey items pertaining to access do not measure against specific timeframes, which may vary from state to state (and which have not been established by many states). Rather, they measure enrollee perception of the appropriateness of their wait times.

Table 3
Primary CAHPS Survey Items Pertaining to Access

<table>
<tr><th>CAHPS Item Number</th><th>CAHPS Survey Question</th><th>OPA Composite Measure (Bars) Reported</th><th>OPA Summary Indicator Star Rating</th></tr>
<tr><td>4</td><td>In the last 12 months, when you needed care right away, how often did you get care as soon as you thought you needed? (never, sometimes, usually, always)</td><td rowspan="2">Getting Appointments and Care Quickly</td><td rowspan="4">Getting Care Easily (New topic added in 2011 Edition of the Report Card)</td></tr>
<tr><td>6</td><td>In the last 12 months, not counting the times you needed health care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? (never, sometimes, usually, always)</td></tr>
<tr><td>23</td><td>In the last 12 months, how often was it easy to get appointments with specialists? (never, sometimes, usually, always)</td><td rowspan="2">Getting Doctors and Care Easily</td></tr>
<tr><td>27</td><td>In the last 12 months, how often was it easy to get the care, tests or treatment you thought you needed through your health plan? (never, sometimes, usually, always)</td></tr>
</table>

Six plans (18%) included the standard CAHPS survey results as part of their compliance calculations and three plans (9%) included a modified version of CAHPS. Fourteen plans (42%) administer the standard CAHPS or a modified/shortened version as part of their ongoing monitoring but did not include the results in their rates of compliance.

Four plans (12%) used enrollee surveys either of their own design or developed by a vendor. Seven plans (21%) mentioned in their policies the use of surveys for ongoing monitoring but did not include those results in their rates of compliance.

[5] The National Committee for Quality Assurance website describes CAHPS surveys as including "a core set of questions, with some questions grouped to form composites, or summary results, of key areas of care and service … NCQA uses survey results in health plan performance reports to inform accreditation decisions and to create national benchmarks for care. Health plans might also collect HEDIS survey data for internal quality improvement purposes." NCQA offers four versions of CAHPS covering HMO, POS and PPO products:

1. CAHPS Health Plan Survey 5.0H Adult Version, Commercial
2. CAHPS Health Plan Survey 5.0H Adult Version, Medicaid
3. CAHPS Health Plan Survey 5.0H Child Version, Children With Chronic Conditions (Commercial and Medicaid)
4. CAHPS Health Plan Survey 5.0H Child Version, Children Without Chronic Conditions (Commercial and Medicaid)

See www.ncqa.org for additional information.

D. NON-COMPLIANCE DATA

1. PATTERNS OF NON-COMPLIANCE

Health plans were instructed to report whether they identified any patterns of non-compliance with the Timely Access Regulation. If they found a pattern, plans were to provide a description of the non-compliance and the plan's investigation, determination, and corrective action.

Out of 33 plans, 25 plans (76%) reported no patterns of non-compliance. Eight plans (24%) identified and reported patterns of non-compliance.

The plans described a variety of methods they used to identify these patterns and reported implementing corrective actions to address the identified concerns. For example:

- A provider appointment availability survey was used to determine non-compliance within its contracted provider network and an audit/survey as the primary data source for identifying patterns. Responses to the provider survey for each selected contracted provider were logged into the audit tool and the compliance rate for each time-elapsed standard was calculated using a simple numerator/denominator calculation, with the numerator equaling all providers with an appointment within the required timeframe and the denominator equaling all providers for that standard. Using this method, a pattern of non-compliance was identified in wait times for triage services, particularly specialty triage services. The plan intends to review the provider-by-provider survey results in order to determine if the triage issue is a network-wide issue or more specific to a type of provider.

- An enrollee survey administered by a vendor was used to determine non-compliance with access to ancillary services and getting an appointment with a specialist. The plan intends to convene an Access Workgroup to identify causes for poor access and to identify the specific interventions and action plans to address the problem(s).

- Another plan identified patterns of non-compliance based on analysis of all grievances related to timely access problems and use of an enrollee survey to examine the medical center in question. The network has added some appointment slots for primary care and has begun construction of new clinics to increase capacity and availability of appointments.

- Non-compliance for non-urgent primary care visits and preventive/well visits were identified through a plan's appointment availability survey. The plan expects to use an onsite audit of its delegated providers to monitor appointment availability. In addition, the plan intends to follow-up with those providers who did not meet the standard.

- Use of the appointment availability survey to identify pediatric neurology, gastroenterology, and dermatology as the most frequently cited outliers for non-urgent appointments. The survey responses indicated some incidents of non-compliance with these specialties in certain parts of the service area, some of which are rural and/or

geographically isolated. The plan addressed the pediatric neurology and gastroenterology access issue by referring patients to specialists in neighboring counties; it addressed the dermatology access issue by contracting with two new dermatologists.

- Utilizing the results of the enrollee survey and complaints from enrollees to identify a pattern of untimely access with pediatric gastroenterologists. The plan has actively addressed this issue by reviewing all Treatment Authorization Requests for pediatric gastroenterologists and having the Utilization Review nurses call the gastroenterologists to find out their appointment availability waiting times. The nurse then calls the referring PCP to ensure that the appointment waiting time is acceptable without risking harm to the enrollee's health. If the wait time is unacceptable to the PCP, the plan goes outside of the contracted provider network and obtains a case agreement with a non-contracted provider.

2. INCIDENTS OF NON-COMPLIANCE

In addition to identifying patterns of non-compliance, plans reported whether they identified any incidents of non-compliance that resulted in substantial harm to an enrollee. If there were such incidents, the plan was directed to describe the identified non-compliance, and the plan's investigation, determination, and corrective action.

No full service plan reported an incident of non-compliance resulting in substantial harm to an enrollee. Plan policies and procedures generally stated that these incidents, should they occur, would be handled through the plan's peer review or quality management processes.

E. ADVANCED ACCESS

When a provider, medical group, or independent practice association provides an assigned enrollee an appointment with a primary care provider within the same or next business day from the time an appointment is requested, this practice is known as "advanced access." A plan may demonstrate a provider's compliance with the primary care time-elapsed standards through advanced access programs.

However, to consider a provider compliant based on advanced access, the plan must establish systems to verify these advanced access programs, (i.e., monitoring to confirm that appointments can be scheduled consistent with the definition of advanced access). The Department asked plans to provide a listing of all provider groups and individual providers in their network utilizing advanced access appointment scheduling.

Ten of the 33 full service plans (30%) provided lists of individual providers and/or provider groups that offer advanced access appointment scheduling. Amongst those plans, the lists of providers ranged in size from three physician groups (for a single-county plan) to nearly 2,000 individual physicians (for a large, statewide plan). Six of those plans (60%) were single or joint county plans. Two of the five largest plans in California (40%) reported advanced access

providers. Most often providers reported as having advanced access appointment scheduling were large provider groups or clinics.

The 10 plans that identified providers offering advanced access confirmed that those providers were in fact able to offer appointments within the same or next business day through two primary methods:

- Annual Provider Appointment Availability Surveys – Six of the ten plans collected self-reported data through surveys such as the ICE Provider Appointment Availability Survey. Some plans supplemented the annual surveys with quarterly verification or spot checks during site visits. Two additional plans administered an appointment availability survey that collects information on wait times that would allow verification of advanced access status, but did not submit details on their methods for identifying and monitoring the providers on their lists.

- Individual Verification – Two plans monitored advanced access as part of their onsite surveys and periodic visits to providers. One of these plans also did some monitoring via phone surveys.

Twenty-three plans (70%) did not report having providers offering advanced access. Several of these plans noted that, although some providers in their networks operate advanced access scheduling systems, the plan did not formally track and monitor for advanced access systems and, therefore, could not rely upon providers' statements to count the providers as compliant.

F. TRIAGE SERVICES, TELEMEDICINE, AND HEALTH INFORMATION TECHNOLOGY

1. TRIAGE SERVICES

The Timely Access Regulation requires plans to provide or arrange for the provision of telephone triage or screening services 24 hours a day, seven days per week. The regulation defines *triage* or *screening* as "the assessment of an enrollee's health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care, for the purpose of determining the urgency of the enrollee's need for care."
Plans must ensure that wait time to speak with a qualified health professional for triage or screening does not exceed 30 minutes. Plans must monitor wait times, call abandonment rates, and other meaningful statistics that assist to determine the impact of the triage and screening services on timely access to care.

Health plans generally view *triage* as a process of determining the priority of an enrollee's treatment based on the severity of his/her condition and *screening* as a strategy used to detect a disease. Health plans generally provide a combination of triage and screening services via a toll-free telephone number often listed on the back of the enrollee's insurance card.

Triage and screening services may be provided in-house, through contracted vendors, or by provider groups in the network. All triage service providers employ licensed clinical professionals to take calls from enrollees.

Twelve health plans (36%) contract with external organizations to provide triage and screening services. Larger health plans tend to establish triage and screening units in-house. Ten plans (30%) provide in-house triage and screening services and one plan contracts with a subsidiary. Six health plans (18%) rely on triage and screening services provided by contracted providers, which is required by the providers' contracts with the plans. The four remaining plans did not specifically indicate how triage and screening services are provided.

There is wide variation in plans' monitoring of triage and screening services for timely access issues. Three plans (9%) measure the impact of triage and screening services on timely access. One plan collects extensive triage usage data—broken down according to age, gender, region, day of the week, and specific triage issues—and analyzes this data to assess impact on timely access. The majority of plans collect basic triage utilization data, such as number of calls received, speed in answering calls, and call abandonment rates, but do not necessarily analyze the data to assess impact on timely access.

Due to the varying descriptions of triage programs and utilization data collection and analysis submitted by the plans, it is difficult to compare programs to determine if some are more comprehensive and effective than others. Monitoring mechanisms also vary and differ in robustness. However, a number of service features were innovative and responsive in providing triage and screening services:

- Comprehensive written description of the triage and screening program, including responsibilities of clinical and non-clinical staff, guidelines/algorithms and call scripts, data collection, and oversight.
- Provision of combined in-house or vendor-based triage and screening plus provider-based services— plan contracts with providers/provider groups require triage services 24/7.
- Structured communication of triage and screening services with case management and disease management divisions.
- Structured communication of triage and screening services with primary care providers, e.g., triage/screening services shares information on the triage call with PCPs.
- Documentation of issues, triage actions and follow-up.
- Follow-up by clinical staff with PCPs to coordinate care.
- Regular collection and analysis of comprehensive triage utilization data, including issue description, disposition, and conclusion broken down by region, age, gender, days of the week, and specific issues.
- Documented analysis of triage data and how triage services impact timely access to care and emergency room utilization.
- Regular monitoring of triage usage data regardless of who provides triage services.

- Oversight committees that review and analyze triage data on a regular basis and document such activities.

2. TELEMEDICINE

Health plans may provide health care services via telemedicine as appropriate. [6] Telemedicine includes delivering health care services "via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site." [7] Telemedicine may be conducted via a variety of technologies. Videoconference, transmission of images, e-health, patient portals, store and forward technologies (which transfer information such as documents, images and videos between providers for consultation), remote monitoring of vital signs, and nursing call centers are all considered part of telemedicine.

The Timely Access Regulation requires plans to describe their implementation and use of telemedicine to provide timely access to care. [8] Seventeen full service plans (52%) reported using one or more forms of telemedicine. Thirteen plans of those seventeen plans provided detailed descriptions of their use of telemedicine services, the monitoring of these services and the impact on timely access. Nine plans (27%) reported that they do not currently utilize any form of telemedicine, and the remaining seven plans (21%) did not provide any information about the use of telemedicine.

Telemedicine can include e-Consultations, telephone consulting, and tele-imaging.

- **e-Consultation—**Can take several forms including securely exchanging clinical information between primary care providers and enrollees or electronic consultation between enrollee/PCPs and specialists. For example, one large urban hospital using telemedicine to improve timely access to its enrollees in rural areas. This provider partners with community hospitals and clinics to provide patients and PCPs access to specialty medical services and education. This system uses high speed data links and video at the hospital and local hospitals and clinics to provide interactive live consultation with specialists. The specialists are available to enrollees through a referral program and when there are transportation challenges or a particular condition where time is of the essence, telemedicine may facilitate access to a specialist who can assist in the diagnosis and treatment plan.

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[6] Health and Safety Code § 1367(e)(2).

[7] Health and Safety Code § 1367(e)(2) defines "telemedicine" as it is defined in Section 2290.5 of the Business and Professions Code. Note: in 2012, legislative amendment sought to change the term "telemedicine" to "telehealth" in state statutes, but the term "telemedicine" still remains in some statutes and regulations.

[8] California Code of Regulations section 1300.67.2.2(g)(2)(E).

- **Telephone consulting** – Two plans described the availability of telephone appointment visits which provide enrollees the option to consult with a physician over the telephone.

- **Tele-imaging** – The most common form of telemedicine plans reported using was diagnostic imaging and other specialized imaging services. For example, in one plan, some of its provider networks have the capability to share radiologic studies. Plans that implement various forms of telemedicine report being pleased with their results. One plan noted that patients do not necessarily call for an *appointment* but rather for help with a *problem*. The plan has found that telemedicine, telephone visits, e-consults, and instant messages used appropriately can often address enrollee problems promptly and effectively.

3. HEALTH INFORMATION TECHNOLOGY

The Timely Access Regulation requires plans to describe their implementation and use of health information technology to provide timely access to care. [9] Health plans reported using a wide variety of health technologies to improve access to health care services.

Certified electronic health record systems were the most commonly reported description of health information technology. These electronic health record systems enable providers to quickly and efficiently exchange information between primary care providers, specialists, laboratories, pharmacies and other ancillary services. Most of these systems also enable electronic referral and authorizations, ordering lab tests and recording lab results, provider access to laboratory and other diagnostic results as well as clinical notes of other practitioners, and receiving preventive and chronic care reminders.

Several plans indicated they have assisted their provider groups in implementing certified electronic health records systems. For example, one plan provides support to its contracted medical groups and IPAs to use electronic health records to facilitate e-consultation, e-prescribing, e-referrals, e-appointments, on-line personal health record, and/or smart cards containing enrollee health or benefits information.

Many electronic medical record systems have the ability to measure the waiting times between enrollees' appointment requests and actual visits. This data can be used to identify specific services with access issues.

Other forms of health information technology that plans indicated using include:

- **Patient Web Portals** allow enrollees to manage their health online. Through these portals enrollees can book and cancel appointments, email their providers, view lab test results, refill prescriptions, view information from past visits and act for family members.

[9] California Code of Regulations section 1300.67.2.2(g)(2)(E).

- **E-prescribing** enables physicians to electronically access the prescription drug formulary, check for drug interactions, print a prescription and in some cases, send a prescription directly to a pharmacy.

- **E-referrals** enable PCPs to send a referral to both the health plan and the physician electronically.

- **Smart cards** contain enrollee health or benefits information that can be read electronically by providers.

- **Mobile Apps** enable enrollees to access the features of patient web portals through smart phones. Plans have developed mobile applications that enable enrollees to locate and get directions to the plans' facilities.

- **Electronic Grievance and Complaint Management Systems** enable plans to process complaints and grievances in a timely manner and generate reports. Plans can use these data to analyze geographical areas or specific services with high counts of complaints and grievances.

The information reported in the annual reports demonstrated that few plans have made extensive use of health information technology to improve timely access, such as using appointment data generated through an electronic appointment system to monitor compliance and to identify issues and problems with timely access to care.

IV. MENTAL HEALTH PLANS

The Timely Access Regulation requires mental health services to be offered:

- Within 15 business days of a request for an appointment with a specialist (e.g., psychiatrist), and

- Within 10 business days of a request for an appointment with a non-physician mental health care provider.

Full service health plans generally provide mental health services through one of the following arrangements:

- **Integrated Staff Model** – Utilizes a group of mental health providers co-located or closely linked with the medical providers within the delivery setting. Both the medical and mental health providers belong to a multi-specialty group either employed by or contracted with the health plan.

- **Single Plan Model** –Creates its mental health network through direct contracts with mental health providers.

- **Subsidiary Model** – Contracts with a subsidiary that specializes in mental health services.

- **Carve-Out Model** – Contracts with a Managed Mental Healthcare Organization, also known as a mental health plan which recruits and maintains its own network of providers, including both psychiatrists and non-M.D. providers (e.g., psychologists, marriage and family therapists, licensed clinical social workers). The mental health plan is responsible for managing and monitoring access to that network of services, credentialing, utilization management, case management and quality management.

Plans responsible for arranging mental health services must:

- Provide telephone triage or screening services 24 hours a day, seven days a week and a callback time of not more than 30 minutes.

- Ensure that during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns does not exceed 10 minutes.

- Monitor network compliance with the Timely Access Regulation standards and investigate and correct deficiencies.

Seven mental health plans submitted reports on their compliance with the Timely Access Regulation for Measurement Year 2011. This Report evaluates the following timely access factors:

- Access and Availability Policies and Procedures.
- Rates of Compliance.
- Provider and Enrollee Surveys.
- Non-compliance Data.
- Advanced Access.
- Triage Services, Telemedicine, and Health Information Technology.

A. ACCESS AND AVAILABILITY POLICIES AND PROCEDURES

Mental health plans must describe their operations and standards in policies, procedures, program descriptions, and other documents related to the implementation of the Timely Access Regulation. Each plan's quality assurance systems, policies and procedures must ensure that the plan's provider network is sufficient to provide access, availability and continuity of covered mental health care services. Quality assurance program documents must include the following:

- Standards for the provision of covered services in a timely manner consistent with the regulation.

- Methods for monitoring compliance, including tracking and assessing network capacity and availability, evaluating access information at least quarterly, conducting an annual enrollee experience survey, conducting an annual provider survey, and verifying any advanced access programs reported by providers.

- Methods for investigating underlying causes of non-compliance and implementing corrective actions when the plan is not meeting the timely access standards.

In addition, plans must review the quality of care provided to enrollees, identify any problems, take effective action to improve care where deficiencies are identified, and conduct follow-up to determine if deficiencies have been resolved.

Table 5 summarizes the content of mental health plans' policies and procedures as reported to the Department. Time-elapsed standards (e.g., for urgent appointments, no prior authorization required) were present in all plans' policies and procedures.

Table 5
Mental Health Plan Policies and Procedures
Implementing the Timely Access Regulation
(n=7)

Content Element to be Included/Described	Present	Not Present	N/A
Incorporation of the required time-elapse standards for appointments:			
▪ Urgent appointments, no prior authorization required, offered within 48 hours	7 (100%)		
▪ Urgent appointments for services that require prior authorization offered within 96 hours	4 (57%)		3 (43%)
▪ Non-urgent appointments with specialist physicians, including psychiatrists, within 15 business days	7 [a] (100%)		
▪ Non-urgent appointments with a non-physician mental health provider within 10 business days	7 [b] (100%)		
Applicable waiting time may be extended if the referring or treating provider or triage/screening service has determined and noted in relevant records that a longer waiting time will not have a detrimental impact on enrollee health	6 [c] (86%)	1 [d] (14%)	
Rescheduling an appointment in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice	4 (57%)	3 [e] (43%)	
Periodic follow-up care can be scheduled in advance consistent with professionally recognized standards	2 (29%)	5 [d] (71%)	
Coordination of interpreter services with scheduled appointments	7 [f] (100%)		
Provide 24-hour-per-day, 7-days-per-week triage or screening services by telephone	7 (100%)		
Methodology for providing triage services (e.g., in-house, contracted)	6 (86%)	1 [e] (14%)	
Methodology for monitoring and reporting on triage services	6 (86%)	1 [e] (14%)	
During normal business hours, the waiting time to speak with a plan customer service representative does not exceed 10 minutes	7 (100%)		
Conduct an annual enrollee experience survey	7 (100%)		
Conduct an annual provider survey	7 (100%)		
Monitoring of individual provider groups	1 (14%)		6 [g] (86%)
Reviewing and evaluating, not less than quarterly, information regarding accessibility, availability and continuity of care, including information obtained through surveys, grievances and appeals, and triage services	7 (100%)		
Verifying the advanced access reported by contracted providers			7 (100%)
How the plan implements prompt investigation and corrective action when monitoring identifies provider network insufficiencies (based on timely access standards)	7 [h] (100%)		

[a] Five of the plans held themselves to a shorter standard; four required non-urgent appointments within 10 days and one within 5 days.
[b] One plan held itself to a shorter standard of 5 days.
[c] One policy was revised during the timeframe of this review.
[d] Inclusion of this statement is permitted but not required – plans may elect not to extend wait times beyond those in the regulation.
[e] The Department has followed up to ensure plans comply with the regulation.
[f] Two plans included this requirement in its language assistance program policies.
[g] These plans reported contracting with individual providers rather than groups.
[h] Three plans included this requirement in its quality management policies.

B. RATES OF COMPLIANCE

Most plans listed a range of tools and methodologies they used for ongoing monitoring of timely access to appointments. Many tools and methodologies were used at least quarterly to assess access. Some plans incorporated parts of these tools and methodologies into their annual reporting to the Department in addition to using them for internal monitoring purposes. Tools and methodologies utilized by the plans include:

- Enrollee satisfaction/experience surveys – All seven mental health plans conducted enrollee surveys. Mental health plans often administered these surveys throughout the year (unlike full service plans which generally administer them annually) – often after an initial appointment or episode of care.
- Provider appointment availability survey.
- Call center statistics.
- Triage monitoring.
- Provider satisfaction survey.
- Visits to provider offices, often including a visual review of scheduling systems or appointment books to assess next available appointment wait times.
- Wait time calculations from scheduling software.
- Analysis of claims/encounter data.
- Geographic access reports and/or mapping of provider locations.
- Review of potential quality issues.
- Enrollee grievances and appeals monitoring. All seven plans reported tracking access-related grievances as part of their access monitoring. Most policies evidenced a further breakdown of access grievances by subcategories (e.g., after-hours access, PCP access, ancillary service access).

Mental health plans used a variety of tools to develop their rates of compliance with the timely access regulation. All mental health plans used an enrollee satisfaction survey and a provider satisfaction survey in their calculations, although neither survey was standard across all plans.

In addition, Table 6 shows the following:

- About half of the mental health plans (3 out of 7) used an appointment availability survey administered to providers.
- Four out of 7 mental health plans included grievance rates in their compliance calculations.
- About half of the mental health plans (4 out of 7) used appointment scheduling system calculations to determine compliance.

Table 6
Measurement Tools Used to Develop Mental Health Plans' Annual Rates of Compliance
(n=7)

<table>
<tr><th>Timely Access Element</th><th>Measurement Tool</th><th># of Plans</th><th>Total # of Plans</th><th>% of Plans</th></tr>
<tr><td rowspan="2">Satisfaction/experience survey administered to enrollees</td><td>ECHO (NCQA-sponsored survey similar to CAHPS survey but designed for managed mental health organizations)</td><td>1</td><td rowspan="2">7</td><td rowspan="2">100%</td></tr>
<tr><td>Vendor or plan-designed survey(s)</td><td>6</td></tr>
<tr><td rowspan="2">Appointment availability survey administered to providers</td><td>ICE-based survey</td><td>1</td><td rowspan="2">3</td><td rowspan="2">43%</td></tr>
<tr><td>Vendor or plan-designed survey</td><td>2</td></tr>
<tr><td rowspan="2">Satisfaction/experience survey administered to providers</td><td>ICE-based survey or some ICE items contained in broader survey</td><td>2</td><td rowspan="2">7</td><td rowspan="2">100%</td></tr>
<tr><td>Vendor or plan-designed survey</td><td>5</td></tr>
<tr><td>Grievance counts/rates</td><td colspan="2" rowspan="3"></td><td>4</td><td>57%</td></tr>
<tr><td>Plan call center/ appointment scheduling system calculations</td><td>4</td><td>57%</td></tr>
<tr><td>Other (e.g., triage data, after hours survey, provider site visits, claims data)</td><td>4</td><td>57%</td></tr>
</table>

In contrast to full service plans, mental health plans may administer their enrollee surveys throughout the year—generally shortly after or during an episode of treatment—and compile statistics quarterly. Four of the enrollee surveys specifically asked about the number of days wait time (rather than simply satisfactions with wait times).

Mental health plans generally operate call centers where enrollees can request a listing of mental health providers. Enrollees may then call providers to set up the initial appointment or, in cases of urgent or emergent need, plan staff may set up the appointment. Plans often maintain computerized records of the date the enrollee called and the date the appointment was set. This information was used by four plans (57%) to report timeliness of urgent and/or routine appointments; other plans use this approach for internal monitoring.

Use of data collected by plan call centers regarding the time elapsed from the initial call for service/authorization to the date of the appointment allows plans to calculate precise wait times for all appointments, not just a sample. An advantage of this system is that the data is verified by the plan, rather than relying solely on self-reporting by providers.

C. PROVIDER AND ENROLLEE SURVEYS

The mental health plans used a variety of survey tools; survey administration methods; survey administrators; thresholds for determining compliance; and non-survey measures to assess compliance with the Timely Access Regulation. Mental health plans relied on proprietary, vendor enrollee and appointment availability surveys; a few plans used the ECHO enrollee survey (the equivalent of CAHPS for mental health) or ICE items. As with the full service plans, mental health plans used a variety of tools and methodologies for calculating timely access.

D. NON-COMPLIANCE DATA

Two of the seven mental health plans identified and reported patterns of non-compliance; the remaining five plans reported no patterns. One reported difficulties in access to psychiatrists in rural areas and another reported provider non-compliance with after-hours telephone messaging and responding to enrollee messages in a timely manner.

No mental health plans reported any incidents of non-compliance resulting in substantial harm to an enrollee.

E. ADVANCED ACCESS

Although mental health plans often noted that same day appointments were available when needed, none of the mental health plans reported relying on providers' reporting of advanced access scheduling to assess compliance with timely access timeframes. None submitted lists of providers offering advanced access scheduling.

F. TRIAGE SERVICES, TELEMEDICINE, AND HEALTH INFORMATION TECHNOLOGY

1. TRIAGE SERVICES

Mental health plans use triage services so that a qualified, licensed clinician can assess the nature and urgency of an enrollee's condition and determine the most appropriate service response. Triage ensures that enrollees who need urgent or emergent services are able to receive them quickly. Referrals to the appropriate provider, help in securing provider appointments, calling 911, and crisis intervention are the most common tasks of clinicians staffing triage units.

The Timely Access Regulation requires plans to describe their implementation and use of triage to provide timely access to care. [10] Six of the seven mental health plans (86%) reported

[10] California Code of Regulations section 1300.67.2.2(g)(2)(E).

providing in-house triage and screening services 24 hours a day, 7 days a week. In-house triage services means that the plan employs both clinical and non-clinical staff for the triage unit. The seventh plan contracts with an independent vendor to provide triage and screening services 24 hours a day, 7 days a week. All mental health plans that reported using non-clinicians have policies and procedures for proper handling of calls by non-clinical staff.

Only two of seven mental health plans (28%) mentioned that they monitor compliance of their triage services through call audits. Others reported that they measure compliance but did not specify how triage services are monitored or compliance is measured.

One mental health plan reported a multi-system approach to triage services—enrollees may call the plan's triage unit (24 hours a day, 7 days a week), the Health Information Line, or the Crisis Stabilization Network. The Plan's Crisis Stabilization Network connects individuals to network professionals who can provide immediate crisis intervention and avert a potential inpatient admission. The use of various avenues to screen enrollees who may need mental health services could be beneficial to both enrollees and the plan by providing timely intervention and reduction of avoidable hospitalization.

Plans reported a number of service features that are innovative and responsive in providing triage and screening services:

- Comprehensive written description of the triage and screening program, including responsibilities of clinical and non-clinical staff, guidelines/algorithms and call scripts, data collection, and oversight.
- Provision of triage and screening services through a multi-system approach.
- Structured communication sharing with case management and/or primary care providers.
- Documentation of issues, triage actions and follow-up.
- Follow-up by clinical staff to coordinate care.
- Regular collection and analysis of comprehensive triage utilization data, including issue description, disposition, and conclusion broken down by region, age, gender, days of the week, and specific issues.
- Documented analysis of how triage services impact timely access and emergency room utilization.
- Regular monitoring of triage usage data.
- Oversight committees that review, analyze, and document triage data on a regular basis.

2. TELEMEDICINE

The Timely Access regulation requires plans to describe their implementation and use of telemedicine to provide timely access to care. [11] Overall, plans differ in how or if they offer services via telemedicine techniques. While some plans extend telemedicine services to all

[11] California Code of Regulations section 1300.67.2.2(g)(2)(E).

enrollees, others require enrollees to elect to receive services ahead of time. One plan limits telemedicine arrangements only to selected counties. The plans offering telemedicine cover and reimburse services according to standard coverage structures.

3. HEALTH INFORMATION TECHNOLOGY

The Timely Access Regulation requires plans to describe their implementation and use of health information technology to provide timely access to care. [12] The use of health information technology by mental health plans appears to be limited. Two plans did not provide any information related to health information technology. Two other plans reported that they did not use health information technology to promote timely access to care.

Three plans reported using health information technology. One plan allows providers to obtain authorization information instantly through the provider network online. Another plan utilizes health information technology to exchange data with the enrollees' medical providers to improve accuracy of authorizations. A third plan utilizes an electronic system to provide access to information and resources for enrollees and providers.

Several plans provide educational information and newsletters as accessible tools for providers.

[12] California Code of Regulations section 1300.67.2.2(g)(2)(E).

V. CONCLUSION

The various methods used by plans to demonstrate compliance with the Timely Access Regulation make it difficult for the Department to analyze and compare the data amongst plans. The Department is working with the plans to improve methods for reporting timely access compliance data that would allow for comparison. The approach includes working with health plans, association groups, and other stakeholders to make revisions and encourage all plans to use a standardized process.

While the data cannot yet be used for making comparisons amongst plans, it has been valuable for the Department's ongoing oversight of each individual plan. The Department has already followed up with plans concerning any deficiencies noted in their Timely Access reports submitted for the 2011 Measurement Year.

Based on the lessons learned from the data submitted by plans for the 2011 Measurement Year, The Department plans to take the following next steps:

1. **Encourage the use of standardized methodologies** – Many plans used standardized survey items and methodologies (e.g., the CAHPS enrollee survey; provider satisfaction surveys from ICE; and, appointment availability surveys from various vendors) to measure enrollee satisfaction, provider satisfaction and appointment availability. However, unless plans use identical survey items that are administered using the same methodology, comparing the survey results from plan to plan is difficult. A single survey used by all plans would greatly improve the comparability and usefulness of the data.

2. **Explore using an experienced survey vendor** – A number of plans use experienced vendors to administer CAHPS survey items, and/or other enrollee, provider satisfaction and appointment availability surveys. Using the same reliable vendor to administer a standardized survey for all plans promotes consistency and, therefore, comparability. When plans choose to administer their own surveys rather than using a professional survey vendor, it is difficult to ensure consistency in the processes used and comparability of results.

3. **Coordinate collection of data** – If all plans used the ICE surveys for appointment availability or provider satisfaction without modifications, the plans could collect data on a specified number of IPAs/providers and share data on these providers. This process would promote consistency, minimize calls to providers, and reduce cost amongst plans.

4. **Improve reporting of timely access grievances** – Work with plans, in consultation with other stakeholders, to adopt common categories and definitions of grievances relating to timely access (e.g., appointment availability, customer service wait time) and define a standard ratio that would allow comparison amongst plans (e.g., grievances per 1000 enrollee months).

APPENDICES

Appendix A: Timely Access Regulation

1300.67.2.2. Timely Access to Non-Emergency Health Care Services

(a) Application

1. All health care service plans that provide or arrange for the provision of hospital or physician services, including specialized mental health plans that provide physician or hospital services, or that provide mental health services pursuant to a contract with a full service plan, shall comply with the requirements of this section.

2. Dental, vision, chiropractic, and acupuncture plans shall comply with subsections (c)(1), (3), (4), (7), (9) and (10), and subsections (d)(1) and (g)(1). Dental plans shall also comply with subsection (c)(6).

3. The obligation of a plan to comply with this section shall not be waived when the plan delegates to its medical groups, independent practice associations, or other contracting entities any services or activities that the plan is required to perform. A plan's implementation of this section shall be consistent with the requirements of the Health Care Providers' Bill of Rights, and a material change in the obligations of a plan's contracting providers shall be considered a material change to the provider contract, within the meaning of subsections (b) and (g)(2) of Section 1375.7 of the Act.

4. This section confirms requirements for plans to provide or arrange for the provision of access to health care services in a timely manner, and establishes additional metrics for measuring and monitoring the adequacy of a plan's contracted provider network to provide enrollees with timely access to needed health care services. This section does not:

(A) Establish professional standards of practice for health care providers;

(B) Establish requirements for the provision of emergency services; or

(C) Create a new cause of action or a new defense to liability for any person.

(b) Definitions. For purposes of this section, the following definitions apply.

1. "Advanced access" means the provision, by an individual provider, or by the medical group or independent practice association to which an enrollee is assigned, of appointments with a primary care physician, or other qualified primary care provider such as a nurse practitioner or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the enrollee prefers not to accept the appointment offered within the same or next business day.

2. "Appointment waiting time" means the time from the initial request for health care services by an enrollee or the enrollee's treating provider to the earliest date offered for the appointment for

services inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its contracting providers.

3. “Preventive care” means health care provided for prevention and early detection of disease, illness, injury or other health condition and, in the case of a full service plan includes but is not limited to all of the basic health care services required by subsection (b)(5) of Section 1345 of the Act, and Section 1300.67(f) of Title 28.

4. “Provider group” has the meaning set forth in subsection (g) of Section 1373.65 of the Act.

5. “Triage” or “screening” means the assessment of an enrollee’s health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care, for the purpose of determining the urgency of the enrollee’s need for care.

6. “Triage or screening waiting time” means the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care.

7. “Urgent care” means health care for a condition which requires prompt attention, consistent with subsection (h)(2) of Section 1367.01 of the Act.

(c) Standards for Timely Access to Care.

(1) Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee’s condition consistent with good professional practice. Plans shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.

(2) Plans shall ensure that all plan and provider processes necessary to obtain covered health care services, including but not limited to prior authorization processes, are completed in a manner that assures the provision of covered health care services to enrollees in a timely manner appropriate for the enrollee’s condition and in compliance with the requirements of this section.

(3) When it is necessary for a provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee’s health care needs, and ensures continuity of care consistent with good professional practice, and consistent with the objectives of Section 1367.03 of the Act and the requirements of this section.

(4) Interpreter services required by Section 1367.04 of the Act and Section 1300.67.04 of Title 28 shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. This subsection does not modify the requirements established in Section 1300.67.04, or approved by the Department pursuant to Section 1300.67.04 for a plan’s language assistance program.

(5) In addition to ensuring compliance with the clinical appropriateness standard set forth at subsection (c)(1), each plan shall ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the following timeframes:

(A) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in (G);

(B) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in (G);

(C) Non-urgent appointments for primary care: within ten business days of the request for appointment, except as provided in (G) and (H);

(D) Non-urgent appointments with specialist physicians: within fifteen business days of the request for appointment, except as provided in (G) and (H);

(E) Non-urgent appointments with a non-physician mental health care provider: within ten business days of the request for appointment, except as provided in (G) and (H);

(F) Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within fifteen business days of the request for appointment, except as provided in (G) and (H);

(G) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee;

(H) Preventive care services, as defined at subsection (b)(3), and periodic follow up care, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice; and

(I) A plan may demonstrate compliance with the primary care time-elapsed standards established by this subsection through implementation of standards, processes and systems providing advanced access to primary care appointments, as defined at subsection (b)(1).

(6) In addition to ensuring compliance with the clinical appropriateness standard set forth at subsection (c)(1), each dental plan, and each full service plan offering coverage for dental services, shall ensure that contracted dental provider networks have adequate capacity and availability of licensed health care providers to offer enrollees appointments for covered dental services in accordance with the following

(A) Urgent appointments within the dental plan network shall be offered within 72 hours of the time of request for appointment, when consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice;

(B) Non-urgent appointments shall be offered within 36 business days of the request for appointment, except as provided in subsection (c)(6)(C); and

(C) Preventive dental care appointments shall be offered within 40 business days of the request for appointment.

(7) Plans shall ensure they have sufficient numbers of contracted providers to maintain compliance with the standards established by this section.

(A) This section does not modify the requirements regarding provider-to-enrollee ratio or geographic accessibility established by Sections 1300.51, 1300.67.2 or 1300.67.2.1 of Title 28.

(B) A plan operating in a service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring enrollees to, or, in the case of a preferred provider network, by assisting enrollees to locate, available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. Plans shall arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network, when medically necessary for the enrollee's condition. Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider.

(8) Plans shall provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone as defined at subsection (b)(5).

(A) Plans shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the enrollee's condition, and that the triage or screening waiting time does not exceed 30 minutes.

(B) A plan may provide or arrange for the provision of telephone triage or screening services through one or more of the following means: plan-operated telephone triage or screening services consistent with subsection (b)(5); telephone medical advice services pursuant to Section 1348.8 of the Act; the plan's contracted primary care and mental health care provider network; or other method that provides triage or screening services consistent with the requirements of this subsection.

1. A plan that arranges for the provision of telephone triage or screening services through contracted primary care and mental health care providers shall require those providers to

maintain a procedure for triaging or screening enrollee telephone calls, which, at a minimum, shall include the employment, during and after business hours, of a telephone answering machine and/or an answering service and/or office staff, that will inform the caller:

a. Regarding the length of wait for a return call from the provider; and

b. How the caller may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

2. A plan that arranges for the provision of triage or screening services through contracted primary care and mental health care providers who are unable to meet the time-elapsed standards established in paragraph (8)(A) shall also provide or arrange for the provision of plan-contracted or operated triage or screening services, which shall, at a minimum, be made available to enrollees affected by that portion of the plan's network.

3. Unlicensed staff persons handling enrollee calls may ask questions on behalf of a licensed staff person in order to help ascertain the condition of an enrollee so that the enrollee can be referred to licensed staff. However, under no circumstances shall unlicensed staff persons use the answers to those questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of an enrollee or determine when an enrollee needs to be seen by a licensed medical professional.

(9) Dental, vision, chiropractic, and acupuncture plans shall ensure that contracted providers employ an answering service or a telephone answering machine during non-business hours, which provide instructions regarding how enrollees may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

(10) Plans shall ensure that, during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed ten minutes.

(d) Quality Assurance Processes. Each plan shall have written quality assurance systems, policies and procedures designed to ensure that the plan's provider network is sufficient to provide accessibility, availability and continuity of covered health care services as required by the Act and this section. In addition to the requirements established by Section 1300.70 of Title 28, a plan's quality assurance program shall address:

(1) Standards for the provision of covered services in a timely manner consistent with the requirements of this section.

(2) Compliance monitoring policies and procedures, filed for the Department's review and approval, designed to accurately measure the accessibility and availability of contracted providers, which shall include:

(A) Tracking and documenting network capacity and availability with respect to the standards set forth in subsection (c);

(B) Conducting an annual enrollee experience survey, which shall be conducted in accordance with valid and reliable survey methodology and designed to ascertain compliance with the standards set forth at subsection (c);

(C) Conducting an annual provider survey, which shall be conducted in accordance with valid and reliable survey methodology and designed to solicit, from physicians and non-physician mental health providers, perspective and concerns regarding compliance with the standards set forth at subsection (c);

(D) Reviewing and evaluating, on not less than a quarterly basis, the information available to the plan regarding accessibility, availability and continuity of care, including but not limited to information obtained through enrollee and provider surveys, enrollee grievances and appeals, and triage or screening services; and

(E) Verifying the advanced access programs reported by contracted providers, medical groups and independent practice associations to confirm that appointments are scheduled consistent with the definition of advanced access in subsection (b)(1).

(F) A plan that provides services through a preferred provider organization network may, for that portion of its network, demonstrate compliance with subsections (d)(2)(A) and (D) by monitoring, on not less than an annual basis: the number of PPO primary care and specialty physicians under contract with the plan in each county of the plan's service area; enrollee grievances and appeals regarding timely access; and the rates of compliance with the time-elapsed standards established in subsection (c)(5).

(3) A plan shall implement prompt investigation and corrective action when compliance monitoring discloses that the plan's provider network is not sufficient to ensure timely access as required by this section, including but not limited to taking all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance. Plans shall give advance written notice to all contracted providers affected by a corrective action, and shall include: a description of the identified deficiencies, the rationale for the corrective action, and the name and telephone number of the person authorized to respond to provider concerns regarding the plan's corrective action.

(e) Enrollee Disclosure and Education

(1) Plans shall disclose in all evidences of coverage the availability of triage or screening services and how to obtain those services. Plans shall disclose annually, in plan newsletters or comparable enrollee communications, the plan's standards for timely access.

(2) The telephone number at which enrollees can access triage and screening services shall be included on enrollee membership cards. A plan or its delegated provider group may comply with this requirement through an additional selection in its automated customer service telephone

answering system, where applicable, so long as the customer service number is included on the enrollee's membership card.

(f) Plans may file, by notice of material modification, a request for the Department's approval of alternative time-elapsed standards or alternatives to time-elapsed standards. A request for an alternative standard shall include:

(1) An explanation of the plan's clinical and operational reasons for requesting the alternative standard, together with information and documentation, including scientifically valid evidence (based on reliable and verifiable data), demonstrating that the proposed alternative standard is consistent with professionally recognized standards of practice and a description of the expected impact of the alternative standard on clinical outcomes, on access for enrollees, and on contracted health care providers;

(2) The burden shall be on the plan to demonstrate and substantiate why a proposed alternative standard is more appropriate than time elapsed standards. Plans that have received approval for an alternative standard shall file, on an annual basis, an amendment requesting approval for continued use of the alternative standard, and providing updated information and documentation to substantiate the continued need for the alternative standard; and

(3) In approving or disapproving a plan's proposed alternative standards the Department may consider all relevant factors, including but not limited to the factors set forth in subsections (d) and (e) of Section 1367.03 of the Act and subsection (c) of Section 1300.67.2.1 of Title 28.

(g) Filing, Implementation and Reporting Requirements.

(1) Not later than twelve months after the effective date of this section, plans shall implement the policies, procedures and systems necessary for compliance with the requirements of Section 1367.03 of the Act and this section. Not later than nine months after the effective date of this section, each plan shall file an amendment pursuant to Section 1352 of the Act disclosing how it will achieve compliance with the requirements of this section, which shall include substantiating documentation, including but not limited to, quality assurance policies and procedures, survey forms, subscriber and enrollee disclosures, and amendments to provider contracts. The amendment shall also include documentation sufficient to confirm the plan's compliance, as of the date of filing, with existing requirements regarding physician-to-enrollee ratios, including but not limited to updated Exhibits I-1 and I-4 to the plan's license application. If a plan asserts prior Department approval of alternative physician-to-enrollee ratios or an alternative method of demonstrating network adequacy, the filing shall contain confirming documentation. A plan may concurrently request approval of alternative physician-to-enrollee ratios or an alternative method of demonstrating network adequacy by filing a notice of material modification pursuant to section 1300.67.2.1 of Title 28.

(2) By March 31, 2012, and by March 31 of each year thereafter, plans shall file with the Department a report, pursuant to subsection (f)(2) of Section 1367.03 of the Act, regarding compliance during the immediately preceding year. The first reporting period shall be the calendar year ending December 31, 2011. The reports shall document the following information:

(A) The timely access standards set forth in the plan's policies and procedures including, as may be applicable, any alternative time-elapsed standards and alternatives to time-elapsed standards for which the plan obtained the Department's prior approval by Order;

(B) The rate of compliance, during the reporting period, with the time elapsed standards set forth in subsection (c)(5), separately reported for each of the plan's contracted provider groups located in each county of the plan's service area. A plan may develop data regarding rates of compliance through statistically reliable sampling methodology, including but not limited to provider and enrollee survey processes, or through provider reporting required pursuant to subsection (f)(2) of Section 1367.03 of the Act;

(C) Whether the plan identified, during the reporting period, (1) any incidents of non-compliance resulting in substantial harm to an enrollee or (2) any patterns of non-compliance and, if so, a description of the identified non-compliance and the plan's responsive investigation, determination and corrective action;

(D) A list of all provider groups and individual providers utilizing advanced access appointment scheduling;

(E) A description of the implementation and use by the plan and its contracting providers of triage, telemedicine, and health information technology to provide timely access to care;

(F) The results of the most recent annual enrollee and provider surveys and a comparison with the results of the prior year's survey, including a discussion of the relative change in survey results; and

(G) Information confirming the status of the plan's provider network and enrollment at the time of the report, which shall include, on a county-by-county basis, in a format approved by the Department:

1. The plan's enrollment in each product line; and

2. A complete list of the plan's contracted physicians, hospitals, and other contracted providers, including location, specialty and subspecialty qualifications, California license number and National Provider Identification Number, as applicable. Physician specialty designation shall specify board certification or eligibility consistent with the specialty designations recognized by the American Board of Medical Specialties.

3. The information required by paragraphs (g)(2)(G)(1) and (2) shall be included with the annual report until the Department implements a web-based application that provides for electronic submission via a web portal designated for the collection of plan network data. Upon the Department's implementation of the designated network data collection web portal, the information required by paragraphs (G) (1) and (2), shall be submitted directly to the web portal.

(3) In determining a plan's compliance or non-compliance with the requirements of this section, the Department will focus more upon patterns of non-compliance than isolated episodes of non-compliance and may consider all relevant factors, including but not limited to:

(A) The efforts by a plan to evade the standards, such as referring enrollees to providers who are not appropriate for an enrollee's condition;

(B) The nature and extent of a plan's efforts to avoid or correct non-compliance, including whether a plan has taken all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance;

(C) The nature of physician practices, including group and individual practices, the nature of a plan's network, and the nature of the health care services offered;

(D) The nature and extent to which a single instance of non-compliance results in, or contributes to, serious injury or damages to an enrollee; and

(E) Other factors established in relevant provisions of law, and other factors that the Director deems appropriate in the public interest and consistent with the intent and purpose of the Act as applied to specific facts or circumstances.

Appendix B: ICE Appointment Availability Survey

ICE Appointment Availability Survey

* Required

Date Survey Completed (MM/DD/YYYY) *

Provider First Name *

Provider Last Name *

Person Spoke to *

Name of Plan creating survey data * Aetna

Source: *

- Fax
- Call
- Vendor
- IPA / PMG

Provider Type: *

- PCP
- Specialist

County of this Office Location: * Alameda

IPA/Medical Group Affiliation: *

Access IPA

Hello. My Name is [Say Name] and I'm calling from [Say Plan or Entity Name]. We're conducting a phone survey to assess patient access to health care providers in California. We are conducting this survey as required by California law. This is not a telemarketing call. Are you able to respond to survey questions regarding the scheduling of appointments in your office? If yes, caller validates office information above. If No,

May I speak to someone in the office who is able to respond to survey questions regarding the scheduling of appointments in your office? If no one is available, end call, delete all demographic information above and go on to next provider.

1. Is your office (the doctor, nurse practitioner or physician's assistant, as applicable) able to offer all appointment types (urgent, routine, sick, etc.) to patients on the same or next business day from the time an appointment is requested?

- If yes, go to number 6

- If no, skip to number 2

2. Urgent services means health care for a condition which requires prompt attention and poses an imminent and serious threat to someone's health, including loss of life, limb or other major bodily function. Does your IPA/Medical Group require prior authorization for any urgent services provided by your office?

- If Yes, go to number 3
- If no, skip to number 4

3. For urgent services appointments provided in your office that DO require prior authorization from your IPA/Medical Group, is your office able to offer patients an appointment within 4 calendar days of the appointment request?

- YES - go to number 5
- NO - follow-up with questions 3a and 3b to see if any are applicable

3a. If your office cannot offer a patient an urgent services appointment within 4 calendar days of the appointment request, can the patient be offered an appointment with another physician or urgent care clinic in the network within 4 calendar days of the appointment request?

- If yes, mark number 3 as "YES"
- If no, continue to 3b

3b. If your office cannot offer a patient an urgent services appointment within 4 calendar days of the appointment request, does your office have a process in place for physician to: 1) assess the patient's condition to determine whether a longer waiting time will not be detrimental to the patient and 2) notate this decision in the patient's record?

- If yes, mark number 3 as "YES"
- If no, mark number 3 as "NO" and skip to number 5

4. For urgent services appointments provided in your office that DO NOT require prior authorization from your IPA/Medical Group, is your office able to offer patients an appointment within 2 calendar days of the appointment request?

- YES - go to number 5
- NO - follow-up with questions 4a and 4b to see if any are applicable

4a. If your office cannot offer a patient an urgent services appointment within 2 calendar days of the appointment request, can the patient be offered an appointment with another physician or urgent care clinic in the network within 2 calendar days of the appointment request?

- If yes, mark number 4 as "YES"
- If No, continue to 4b

4b. If your office cannot offer a patient an urgent services appointment within 2 calendar days of the appointment request, does your office have a process in place for the physician to: 1) assess the patient's condition to determine whether a longer waiting time will not be detrimental to the patient and 2) notate this decision in the patient's record?

- If yes, mark number 4 as "YES"
- If no, mark number 4 as "NO"

5. For non-urgent appointments, is your office able to offer patients an appointment within [10 business days - PCPs; 15 business days - specialists] of the appointment request? This question does not apply to preventive care services and periodic follow-up care, including, but not limited to, standing referrals to specialists for

chronic conditions, office visits for pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease.

- YES - go to number 6
- NO - follow-up with questions 5a and 5b to see if any are applicable

5a. If your office cannot offer a patient a non-urgent appointment within [10 business days - PCPs; 15 business days - specialists] of the appointment request, can the patient be offered an appointment with another physician in the network within [10 business days - PCPs; 15 business days - specialists] of the appointment requested?

- If yes, mark number 5 as "YES"
- If no, continue to 5b

5b. If your office cannot offer a patient a non-urgent appointment within [10 business days - PCPs; 15 business days - specialists] of the appointment request, does your office have a process in place for the physician to: 1) assess the patient's condition to determine whether a longer waiting time will not be detrimental to the patient and 2) notate this decision in the patient's record?

- If yes, mark number 5 as "YES"
- If no, go to number 6

This concludes our survey. Thank you very much for your time. Have a nice day.

END SURVEY

Submit

Appendix C: ICE Provider Satisfaction Survey

ICE Provider Satisfaction Survey

Dear Provider The California Timely Access to Non-Emergency Health Care Services Regulation (Access Standards also known as Section 1300.67.2.2 Title 28, California Code of Regulations) requires health plans to maintain an adequate provider network to ensure patients receive timely care as appropriate for their condition and conduct quality assurance processes to evaluate compliance. Based on this regulation, please respond to the following questions. Your responses will be anonymous.

---

* Required

a) Your Provider Type *

- PCP
- Specialist
- Mental Health (BH)

b) The county of your Primary office location * Alameda

c) For BH Providers Select "BH Provider". For PCPs and Specialists select the IPA / Medical Group affiliation that represents the majority of your time (your responses below should reflect your experience with the IPA / Medical Group Selected). *

Access IPA

In your experience with the IPA/MG named above (or general experience for BH providers), since the implementation of the Access Standards (January 17, 2011), how satisfied are you with the following:

1. The referral and/or prior authorization process necessary for your patients to obtain covered services *

- Very Satisfied
- Satisfied
- Dissatisfied
- Very Dissatisfied
- Not Applicable/Unknown

2. Your patients' access to urgent care *

- Very Satisfied

- Satisfied
- Dissatisfied
- Very Dissatisfied
- Not Applicable/Unknown

3. Your patients' access to non-urgent primary care *

- Very Satisfied
- Satisfied
- Dissatisfied
- Very Dissatisfied
- Not Applicable/Unknown

4. Your patients' access to non-urgent specialty services *

- Very Satisfied
- Satisfied
- Dissatisfied
- Very Dissatisfied
- Not Applicable/Unknown

5. Your patients' access to non-urgent ancillary diagnostic and treatment services *

- Very Satisfied
- Satisfied
- Dissatisfied
- Very Dissatisfied
- Not Applicable/Unknown

6. Your patients' access to mental health non-urgent care *

- Very Satisfied
- Satisfied
- Dissatisfied

- Very Dissatisfied
- Not Applicable/Unknown

Appendix D: Timely Access Annual Compliance Report Instructions

TIMELY ACCESS ANNUAL COMPLIANCE REPORT INSTRUCTIONS	
A. POLICIES AND PROCEDURES*	
1. Timely Access Time-Elapsed Standards	Please upload as separate documents the timely access standards set forth in the plan's policies and procedures including, as may be applicable, any alternative time-elapsed standards and alternatives to time-elapsed standards for which the plan obtained the Department's prior approval by Order. *>Please note that submission of a document in the annual report does not imply approval by the Department. This report portal may not be used to request approval for an amendment or material modification to the Plan license.*
B. RATE OF COMPLIANCE*	
1. Methodology	Include a narrative description of the Plan's methodology for determining the rate of compliance. The description should include all pertinent information, including but not limited to: a. Identify data sources and describe the methodology for each; b. Describe the statistically valid sampling methodology for each source; c. Describe how the Plan will use the data to arrive at the rate of compliance, including calculations and formulae used. d. Describe the processes for compiling the information including quality assurance. If the Plan utilized in whole or in part the ICE methodology, survey tools or processes, please clearly indicate that in the description.
2. Compliance Rates	Please file the rate of compliance with the time-elapsed standards set forth in rule 1300.67.2.2(c)(5) in separately uploaded documents for each county (or equivalent area defined by zip code). Within each document, please report separately for each contracted provider group, broken down by the six categories of time-elapsed standards in §1300.67.2.2(c)(5) (A)-(F). For each survey or data collection tool or method used, please provide the supporting or raw data under this section, except for enrollee and provider surveys, which are to be filed under F.
3. Data Source: Appointment Availability Audit/Survey	For each contracted provider group, the report should include data regarding the appointment availability audit. If the ICE Appointment Availability Survey data was submitted as part of the compliance rate (above in 2), it does not need to be re-submitted, but rather reference that

TIMELY ACCESS ANNUAL COMPLIANCE REPORT INSTRUCTIONS	
	the Appointment Availability was submitted above.
4. Rate of Compliance: Provider Reporting	If the Plan is utilizing provider reporting that is in addition to the reporting related to the annual provider survey pursuant to 1300.67.2.2(d)(2)(c) (which is reported in section F) to develop data regarding rates of compliance, please provide the data resulting from this measurement. If the Plan did not use additional provider reporting, please indicate N/A.
5. Rate of Compliance: Grievance & Appeals	If the Plan is utilizing grievance and appeal information to develop data regarding rates of compliance, please provide the data resulting from this measurement
6. Rate of Compliance: Other	If the Plan is utilizing other information to develop data regarding rates of compliance, provide the data resulting from these measurements. Please file separate documents for each other method.
C. NON-COMPLIANCE DATA*	
1. Methodology	Please provide a description of the methodology for identifying and gathering and compiling non-compliance information. Include the following information: definitions; data sources and methodology for data gathering; processes and procedures for compiling the information; how the Plan used the data to identify patterns of non-compliance; etc.
2. Incidents of non-compliance with Rule 1300.67.2.2	Please provide a report with the following information: Whether the plan identified, during the reporting period, any incidents of non-compliance resulting in substantial harm to an enrollee and if so, a description of the identified non-compliance and the Plan's responsive investigation, determination and corrective action. If this report contains protected health information, the Plan may identify this report as confidential if a redacted document is simultaneously filed.
3. Patterns of non-compliance with Rule 1300.67.2.2	Please provide a report with the following information: Whether the Plan identified, during the reporting period, any patterns of non-compliance, and if so, a description of the identified non-compliance and Plan's responsive investigation, determination and corrective action.

TIMELY ACCESS ANNUAL COMPLIANCE REPORT INSTRUCTIONS	
D. ADVANCED ACCESS	
	Provide a list of all provider groups and individual providers utilizing advanced access appointment scheduling. (D Advance Access.xls may be used to report provider groups)
E. PLAN AND CONTRACTOR USE OF TRIAGE, TELEMEDICINE HEALTH I.T.*	
1. Triage	Provide a description of the implementation and use by the Plan and its contracting providers of triage services to provide timely access to care.
2. Telemedicine	Provide a description of the implementation and use by the Plan and its contracting providers of telemedicine services to provide timely access to care.
3. Health I.T.	Provide a description of the implementation and use by the Plan and its contracting providers of health information technology to provide timely access to care.
F. PROVIDER AND ENROLLEE SURVEYS	
1. Provider Surveys 2. Enrollee Surveys	Please provide the most recent results of both Provider and Enrollee surveys and a copy of the survey tool utilized. Please provide a comparison with results from prior year's survey(s), including a discussion of the relative change in survey results.[13]

* Please upload multiple documents and label. System will accept Word, Excel and PDF formats.

13 2012 will be the first submission of the Plan's Satisfaction Survey Results, representing results from 2011; therefore, there is no comparison from any previous results. 2013 Survey results will reflect results from 2012 and will be compared to 2011.

Appendix E: List of Reporting Health Plans

FULL SERVICE PLANS
Aetna Health of California, Inc.
Alameda Alliance for Health with Alameda Alliance Joint Powers Authority (QIF)
Blue Cross of California
Blue Cross of California Partnership Plan (QIF)
California Physicians' Service
Care 1st Health Plan with Care 1st Health Plan Partner (QIF)
Chinese Community Health Plan
Cigna HealthCare of California, Inc.
Community Health Group with CHG Foundation (QIF)
Contra Costa County Medical Services with Contra Costa County Medical Services (QIF)
County of Los Angeles-Department of Health Services
County of Ventura
Fresno-Kings-Madera Regional Health Authority
GEMCare Health Plan, Inc.
Health Net of California, Inc. with Health Net Community Solutions, Inc. (QIF)
Inland Empire Health Plan with IEHP Health Access (QIF)
Kaiser Foundation Health Plan, Inc. – North with KP Cal, LLC
Kaiser Foundation Health Plan, Inc. – South with KP Cal, LLC
Kern Health Systems with Kern Health Systems Group Health Plan
Local Initiative Health Authority for L.A. County
Molina Healthcare of CA Partner Plan, Inc. (QIF) with Molina Healthcare of California
Orange County Health Authority
Partnership Health Plan of California
San Francisco Community Health Authority with San Francisco Health Authority (QIF)
San Joaquin County Health Commission with Health Plan of San Joaquin Joint Powers Authority
San Mateo Health Commission with San Mateo Community Health Plan (QIF)
Santa Barbara San Luis Obispo Regional Health Authority
Santa Clara County
Santa Clara County Health Authority with Santa Clara Community Health Authority (QIF)
Santa Cruz-Monterey-Merced Managed Medical Care Community
Sharp Health Plan
UHC of California
Western Health Advantage with Western Health Advantage Community Health Plan (QIF)

MANAGED MENTAL HEALTH PLANS
Avante Mental Health Plan
Cigna Mental Health of California, Inc.
Holman Professional Counseling Centers
Human Affairs International of California
Managed Health Network
U. S. Mental Health Plan, California
ValueOptions of California, Inc.