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MEASUREMENT YEAR 2018

PROVIDER APPOINTMENT AVAILABILITY SURVEY METHODOLOGY

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The Provider Appointment Availability Survey ("PAAS") Methodology was developed by the Department of Managed Health Care ("Department"), pursuant to the Knox-Keene Health Care Service Plan Act of 1975.[1] The PAAS Methodology, published under authority granted in Section 1367.03, subd. (f)(3), is a regulation in accordance with Government Code section 11342.600. For measurement year 2018 ("MY 2018"), all reporting health plans must adhere to the PAAS Methodology when developing and reporting rates of compliance for timely access appointment standards, pursuant to Rule 1300.67.2.2, subd. (g).

All health plans that are required to submit an annual *Timely Access Compliance Report* must maintain the administrative capacity necessary to gather compliance data in accordance with this mandatory methodology, validate compliance data, and identify and rectify compliance data errors, so that all documents submitted to the Department in connection with *Timely Access Compliance Reports* are accurate and present data regarding the Plan's in-network providers.

Step-by-step instructions for using the MY 2018 PAAS Methodology are set forth below. The PAAS Templates include:

- *Results Template*;
- *Raw Data Template*; and
- *Provider Contact List Template (the complete list, before de-duplication)*.

The PAAS Templates and template instructions are available on the Department's public Timely Access web page. The health plan's MY 2018 *Timely Access Compliance Report,* including the completed PAAS Templates, must be submitted through the Timely Access web portal no later than March 31, 2019, pursuant to Rule 1300.67.2.2, subd. (g)(2). Populated samples of the PAAS Templates are available on the Department's Timely Access web page.

Step 1: Determine Which Networks to Survey

[1] California Health and Safety Code sections 1340 et seq. (the "Act"). References herein to "Section" are to Sections of the Act. References to "Rule" refer to the regulations promulgated by the Department at California Code of Regulations, title 28.

Health plans must report a separate rate of compliance with the time elapsed standards for each county in each network ("County/Network") for each Provider Survey Type.[2] A network is a unique combination of providers that has been reviewed and approved by the DMHC for use with one or more lines-of-business.

Health plans are not currently required report a rate of compliance for networks serving exclusively Medicare Advantage or Cal-MediConnect enrollees. Health plans are required to submit rates of compliance for networks associated with a Medicare or Cal-MediConnect line-of-business, if that network also serves lines-of-businesses other than Medicare Advantage and Cal-MediConnect and these lines-of-business are subject to timely access reporting requirements.

Plan-to-Plan Agreements

Health plans must report a rate of compliance that is representative of all providers who are a part of the health plan's network, whether the providers are contracted with the health plan directly, via a plan-to-plan agreement, or through another arrangement.

Health plans that contract with another full service or mental health Knox-Keene Act licensed plan ("Secondary Health Plan") are required to include this information in the health plan's *Timely Access Compliance Report* by incorporating by reference the relevant sections of the Secondary Health Plan's *Timely Access Compliance Report*. Incorporation occurs in the health plan's Profile in the Timely Access Portal. (The Annual Provider Network Submission Instruction Manual contains additional information about reporting plan-to-plan arrangements in the health plan's profile.)

Prior to incorporating the Secondary Health Plan's data into its *Timely Access Compliance Report*, the data should be carefully reviewed so that the health plan can complete the required affirmation regarding accuracy and completeness.[3]

In addition, health plans must include a narrative in the *Timely Access Compliance Report* that identifies (1) the name of the Secondary Health Plan that delivers health services, (2) the type and scope of services delivered (e.g., full service or mental health services, including both psychiatric and non-physician mental health provider services), (3) the counties in which the Secondary Health Plan delivers health care services, and (4) the names of the health plan's networks that are served through the plan-to-plan arrangement.

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[2] This Methodology requires timely access rates of compliance be reported by county and network, rather than provider group. As a result, this methodology supersedes the provider group reporting requirement set forth in Rule 1300.67.2.2, subd. (g)(2)(B). (Section 1367.03, subd. (f)(3).) Accordingly, this subdivision is amended to require health plans to report "The rate of compliance, during the reporting period, with the time elapsed standards set forth in subsection (c)(5), separately reported for each county of the plan's service area."

[3] Under Section 1395, health plans are required to affirm (at the time of submission) to the Department that its *Timely Access Compliance Report* is true, complete, and accurate. This includes portions of the health plan's *timely Access Compliance Report* that have been incorporated by reference.

Step 2: Create Provider Contact List

The *Provider Contact List* is used to calculate the required target sample size and select a random sample of the health plan's network providers to survey for each County/Network. The *Provider Contact List* must include all providers in the health plan's network(s) as of December 31, 2017[4] who furnish health care service through enrollee appointments for the following Provider Survey Types:

(1) Primary Care Physicians and Primary Care Providers (collectively "PCPs")[5]
(2) Specialists: Cardiologists, Endocrinologists, and Gastroenterologists[6]
(3) Psychiatrists[7]
(4) Non-Physician Mental Health Providers: Master Degree Providers, PhD and above, including Psychologists[8]
(5) Ancillary Providers: entities or facilities providing Physical Therapy Appointments, MRI Appointments, and Mammogram Appointments

Use the P*rovider Contact List Template* Instructions to create at least five separate *Provider Contact List Templates* that identify each of the five Provider Survey Types set forth above.

[4] Health plans may use the data in the Annual Provider Network Review ("G Data") Templates, required to be submitted on March 31, 2018, by Section 1367.035 and Rule 1300.67.2.2, subd. (g)(2)(G), to populate the *Provider Contact List* if all requirements of the PAAS Methodology and Template Instructions are met. If the health plan did not have a DMHC-approved network on December 31, 2018, the health plan must contact the DMHC for further guidance.

[5] Primary Care Physicians may include Family Practice, General Practice, Pediatrics, OB/GYN, or Internal Medicine Physicians. For other specialty types, health plans must include only those providers that have agreed to serve as a PCP for the health plan. Primary Care Providers include physician assistants performing services under the supervision of a primary care physician in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code and/or nurse practitioners performing services in collaboration with a physician pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code.

[6] Include only those physicians with the following specialty/subspecialty certification: Internal Medicine-Cardiovascular Disease, Internal Medicine-Endocrinology, Diabetes and Metabolism, and Internal Medicine-Gastroenterology.

[7] Although Psychiatrists are included in the Specialists Physicians PAAS Templates, a separate Psychiatrists sample, distinct from the Specialist Physician sample, must be taken to report a rate of compliance for Psychiatrists in each County/Network.

[8] Non-Physician Mental Health Providers with a Master's Degree or Ph.D. that provide appointments may include Associate Clinical Social Worker, Clinical Nurse Specialist, Certificate of Clinical Competence for Speech-Language Pathology, Board Certified Assistant Behavior Analyst (BCBA), Board Certified Assistant Behavior Analyst Doctoral (BCBA-D), Licensed Clinical Social Worker/Master of Social Work, Marriage and Family Therapist Intern, Marriage and Family Therapist/Licensed Marriage and Family Therapist, Nurse Practitioner/Physician, Assistant/Advanced/Masters RN, Professional Clinical Counselor (LPCC), Psychologist, and School Psychologist (Certified School Psychology, National Certified School Psychologist).

Specialties, counties, and other look-up codes are available on the Department Timely Access web portal. Any provider or Provider Group/IPA that is no longer in network as of March 31, 2018 may be omitted from the Provider Contact List.[9] A copy of each *Provider Contact List* (the complete list, before de-duplication) must be retained to be submitted to the Department in the health plan's *Timely Access Compliance Report*.

De-duplicating the Provider Contact List

The goal of de-duplicating the *Provider Contact List* is to ensure that each provider in each county has an equal chance of being selected to be surveyed during the random sample selection process.

Review each *Provider Contact List* to remove all duplicate entries. Duplicate entries are rows where the same provider appears more than once in a single county for a single network. Any manual corrections that affect the de-duplication, such as slight name corrections, must be incorporated into the PAAS Templates submitted to the Department.

- De-duplicate each *Provider Contact List* (except Federally Qualified Health Center and Ancillary Providers) by the following fields: Provider Survey Type, Name of Network, County, NPI[10], First Name, and Last Name.
- De-duplicate the Ancillary *Provider Contact List* using the following fields: Name of Network, County, NPI, and Other Contracted Provider Facility Name.

Federally Qualified Health Center

The goal of the FQHC de-duplication is to ensure that during the random selection process that an FQHC has an equal chance of being selected to be surveyed as compared to any individual provider in the county for each network. FQHCs must be surveyed without regard to the availability of any individual provider or physical site.[11] The Survey Tool requires that the health plan inquire about the next available appointment at the FQHC. Only the name of the FQHC may be used in administering the survey.

The telephone, fax and email address associated with the FQHCs should be listed in association with only the FQHC, not in association with individual providers who may practice at the FQHC. When creating the Provider Contact List, plans should not include provider's telephone numbers, fax numbers and email addresses associated with individual providers practicing at FQHCs to avoid contacting an individual provider at the FQHC.

[9] Providers identified as not in network during the administration of the survey must be identified as ineligible and replaced with a provider from the oversample.
[10] Health plans must use the unique National Provider Identification (NPI) number assigned to the individual provider (except for Ancillary Providers, health plans may not use an institutional NPI).
[11] Welfare and Institutions Code section 4087.325, subd. (b) requires that enrollees be "assigned directly to the federally qualified health center … and not to any individual provider performing services on behalf of the federally qualified health center…."

- De-duplicate FQHCs by Provider Survey Type, Name of Network, FQHC (set forth in the Provider Group/IPA field), and County.

Step 3: Determine Sample and Oversample Size

Determine the Sample Size for Each Provider Survey Type in each County/Network

This Methodology ensures that an appropriate number of providers for each County/Network are surveyed to produce statistically reliable and comparable results across all health plans, in accordance with Section 1367.03, subd. (f)(2) and Rule 1300.67.2.2, subd. (g)(2)(B). The number of providers to be surveyed for each County/Network is determined separately for each of the five Provider Survey Types.[12] (Section 1367.03, subd. (f)(3) and Rule 1300.67.2.2, subd. (g)(2)(B).)
For each Provider Survey Type in each Network/County, the health plan must either survey:

- A sample of providers; or
- All providers in the County/Network (Census).

When selecting a sample, determine the number of providers for each Provider Survey Type in each County/Network, as set forth in the de-duplicated *Provider Contact List*. Use either the Multi-County Network Sample Size Chart in Appendix 2 or the Single County Health Plans Sample Size Chart in Appendix 3 to determine the appropriate sample size. (To determine which sample size chart to use, the health plan must ascertain whether there is a single county or multiple counties within each network.)

- **Example:** Health Plan 1 has multiple counties in Network A. In San Francisco County, the de-duplicated *Provider Contact List* includes 84 PCPs[13] in Network A. As a result Health Plan 1 refers to Appendix 2 to determine that a sample size of 41 PCPs is required for San Francisco County in Network A. While only 41 PCPs will be surveyed, the health plan elected to include the remaining 43 PCPs in the oversample for replacements. (The health plan could have selected 21 providers for the oversample based on the oversample options set forth below.)

- **Example:** Health Plan 2 has a single county in Network B. In San Francisco County the de-duplicated *Provider Contact List* includes 84 PCPs in Network B. As a result, Health Plan 2 uses the Appendix 3 to determine that a sample size of

[12] Combine Cardiologists, Endocrinologists, and Gastroenterologists to determine the sample size for the Specialist Physicians sample for each County/Network. Combine the entities or facilities providing Physical Therapy Appointments, MRI Appointments, and Mammogram Appointments to determine the sample size for the Ancillary Provider sample for each County/Network.
[13] All Provider Survey Types should be sampled and surveyed in the same manner. For explanatory purposes, PCPs are used as examples throughout this Methodology.

60 PCPs is required. While only 60 PCPs will be surveyed, the remaining 24 PCPs are also selected for the oversample for replacements.

A health plan may survey a sample larger than what is set forth in the sample size charts (e.g., for internal quality assurance purposes), but it must only include results in its *Raw Data and Results Templates* for either all PCPs in the County/Network (Census) or the number of PCPs identified by the appropriate sample size chart. Where Census is used, all providers for the Provider Survey Type in the Network/County will be surveyed and no oversample selection is necessary.

Determine the Oversample Size for Replacements

Ineligible or non-responding providers must be replaced with another provider, if available in the County/Network, in order to meet the required target sample size and ensure that the health plan's reported rates of compliance are statistically reliable and comparable, as required by Section 1367.03, subd. (f)(3) and Rule 1300.67.2.2, subd. (g)(2)(B). (*See* Replacements in Step 7 to ascertain whether a provider may be replaced.)

To allow for the replacement of providers, the health plan must select an oversample of each Provider Survey Type for the County/Network using the random sample selection process below in Step 4: Select Random Samples. The size of the oversample must be either (1) no less than 50% of the required target sample size or (2) all remaining providers in the County/Network.

Providers in the oversample must be surveyed and included on the *Raw Data Template*, only if replacements are needed. If the oversample is exhausted, but additional providers that were not selected as part of that Provider Survey Type sample or oversample remain in the County/Network, use this same process to add additional providers of that same Provider Survey Type to the oversample.

Step 4: Select Random Samples

Once the appropriate sample and oversample size for each Provider Survey Type in each County/Network has been determined, use the random sample selection process described below to select those providers that will be surveyed.

- Assign a random number to each provider in the health plan's working copy of the de-duplicated *Provider Contact List.* (*See* Appendix 1 - Random Number Generation for further instructions.)
- Sort each de-duplicated *Provider Contact List* by the random number within each County/Network by each Provider Survey Type.
- From the randomly sorted *Provider Contact List*, select the required number of providers in the sample and oversample for the largest network in each county. (*See* Step 3: Determine Sample and Oversample Size for instructions.)
- If there is only one plan network in the county, move to Step 5.

Counties with Multiple Networks

The process used to sample multiple networks is designed to sample the smallest number of providers needed to produce results for all networks. For health plans with multiple networks in a single county, use the process described above to select a random sample from the network in the county with the largest number of providers. Once the first sample is selected, use the first name, last name, NPI, and county fields to identify whether the provider participates in the other networks in that county. (For Ancillary Providers, use the Other Contracted Provider Facility Name, NPI, and county fields.) Apply the providers sampled from the larger network to all of the smaller networks in which the sampled provider participates. (The Provider will be surveyed only once in a single county, the response will be applied to all networks the provider was selected to be surveyed in that county.)

Review each network by size to determine whether additional providers need to be sampled to meet the required target sample size. If so, select additional providers from that network in the randomly sorted de-duplicated *Provider Contact List* and apply these providers to all smaller networks in the county. This process will continue until a sufficient sample is identified for each Provider Survey Type in all Counties/Networks. (The oversample for replacement is selected following this same process.)

The following page contains examples for selecting the sample size for networks that include a single county and for networks that include multiple counties.

- **Example:** The Plan has four networks in Sacramento County: Network A has 500 PCPs, Networks B and C use an identical set of 300 PCPs, and Network D has 100 PCPs.[14]

    - The Plan first randomly selects 67 PCPs to be surveyed from Network A, the largest network. Of those randomly selected PCPs from Network A, 55 are in Networks B and C, and 40 are in Network D.

    - Networks B and C have 300 PCPs and require a sample of 62 providers. The 55 PCPs selected from Network A's sample are used for these networks. The first unique 7 providers from the randomly sorted list from Network B are also selected to meet the required target sample size of 62. Because Networks B and C use the exact same set of providers, no additional steps are required for these networks. Of the 7 PCPs selected for Networks C and D, 6 were also in Network D.

[14] The required target sample sizes for each network in the example below are determined using Appendix 2: Multi-County Network Sample Size Chart because the health plan has multiple counties in each network.

- Network D has 100 PCPs and requires a sample of 44. Because 40 PCPs from Network D were selected in Network A's sample, Network D only needs an additional 4 PCPs to meet the required target sample size for this county. The first 4 of the 6 unique providers are selected from the second random sample taken from Networks B and C to meet the required target sample size of 44.

Table 1 – Example of a Health Plan with Four Networks in a Single County

	Network A	Networks B and C (uses same providers)	Network D
Size of PCP Network (Required Sample Size)	500 (67)	300 (62)	100 (44)
First Sample From Network A	67	55 (all 55 providers previously identified in Network A)	40 (all 40 providers previously identified in Network A)
Second Sample From Networks B and C	0	7 (first 7 randomly selected providers from Network B)	4 (first 4 of the 6 providers previously identified in Networks B and C)
Total Number of Providers Sampled	**67**	**62**	**44**

Provide surveyors the *Raw Data Template* with the providers that were randomly selected to be surveyed as part of the sample and oversample.

Step 5: Engage in Provider Outreach

In order to accurately report network performance across the time elapsed standards, health plans must obtain survey responses from a meaningful number of providers. Simple, strategic communications with health plan-contracted providers can yield a significant increase in response rates, putting the health plan (and its contracted providers) in the best position to demonstrate compliance with Timely Access appointment availability standards. Special focus for provider groups and provider types that had high non-response rates in prior measurement years is recommended.

Health plans may consider outreach communications that:

- Inform providers about the importance of participating in the survey;
- Help the provider or provider group understand what the survey is, why it is being done, how its administered, and the types of questions that will be asked;
- Identify the date range during which the survey is likely to occur;
- Inform providers that rates of compliance and response rates will be part of publicly available information;
- Offer information on how the provider or provider group may provide this information through Extraction to avoid providing this information through another survey mode; and
- Remind providers about any contractual obligations indicating that they must provide appointment availability information to the health plan. (See Section 1367.03, subd. (f)(1).)

In situations where the volume of non-responding providers does not allow for completion of the survey in accordance with this Methodology's required target sample sizes, the health plan may be required to institute a corrective action plan that includes steps necessary to secure responses from the number of providers necessary to fully complete the PAAS survey in future years. Inability by a health plan to reach the required target sample sizes and complete the PAAS survey may result in referral to the Department's Office of Enforcement.

Step 6: Prepare Survey Questions

The Department developed a Telephone Survey Tool and an Online/Email and Fax Survey Tool, to be used with the MY 2018 Methodology. Health plans are permitted to make minor adjustments to the Online/Email and Fax Survey Tool introductory language and add language that allows confirmations of the provider's identifying information. All Survey Tools may be amended to indicate that the provider is contractually required to provide this information, if applicable.

In addition, health plans may incorporate additional survey questions and required provider contacts and/or notifications into the Department's Survey Tools, if all of the following conditions are met:

- All of the Department's PAAS Methodology is followed.
- The Department's questions, set forth in the Survey Tool, are included as a block at beginning of the survey. No modifications are made to Survey Tool's individual items or the item order.
- The resulting survey is not too exhaustive (which may decrease willingness to respond or may frustrate providers responding to the survey).
- The data and responses for the Department's PAAS questions are transferred to the Department's PAAS *Raw Data Template* and *Results Template*.
- The contact and/or notification complies with all other requirements of the Act.
- The redlined revisions are filed as an Exhibit J-13 in eFile within 30 days of the amendment, pursuant to Section 1352, subd. (a) and Rule 1300.52, subd. (e).
- In prior years, the DMHC's Survey Tool included a follow-up question: "Is there another practitioner in the same physical office who could see the patient sooner? (If yes) On what date and time is the earliest appointment?" This question is no longer allowed to be used in connection with the MY 2018 PAAS Survey Tool.
- All Survey Tools used in the administration of the survey must also be submitted as part of the *Timely Access Compliance Report.* The health plan must include revisions to the Survey Tools in redline. This may be accomplished by linking the eFiling Number of the Exhibit J-13 in section A Policy and Procedures of *Timely Access Compliance Report* submission.

Health plans may use software or a computer program for capturing survey results, if the following requirements are met:

- The survey questions are identical to the survey questions in the Survey Tool.
- The health plan captures the same data fields included in the Survey Tool.
- The health plan populates the *Provider Contact List, Raw Data* and *Results Templates* in accordance with the template instructions and submits these documents in its *Timely Access Compliance Report* submission.

Step 7: Administer Survey

Timeframe and Waves

All surveys must occur between April 1, 2018 and December 31, 2018. The surveys must be conducted in two waves. For each county, approximately 50% (and no more than 60%) of the providers will be surveyed in each wave. The two survey waves may be of any duration necessary to complete the survey of all providers included in the wave, unless Electronic Extraction is used. (See Option 1 in Survey Administration Modalities, below, for further details related to Electronic Extraction waves duration.) Waves must be spaced at least three weeks apart. Health plans may sequence the survey administration so that the waves are staggered by Provider Survey Type to avoid periods in which surveys are not being administered.

Survey Administration Modality

All surveys must be administered using either Extraction (Option 1) or the Three Step Protocol (Option 2), set forth below. Where Extraction is available for only a subset of providers in a County/Network, health plans may use a combination of Options 1 and 2. Once the health plan has a response (or has identified the provider as being ineligible or non-responsive), apply that response or outcome to that provider for all networks within the county.

Option 1: Manual or Electronic Extraction

Health plans may extract the next available urgent and non-urgent appointments for providers that were selected to be surveyed from the provider's practice management software. The extraction process may be done manually (e.g., individual urgent and non-urgent appointment queries manually ran for each provider) or electronically (e.g., the next available urgent and non-urgent appointments are downloaded), if all of the following requirements are met:

- Prior to administering the survey, a reliable method is in place to identify the providers that are able and willing to allow the health plan to access the next available urgent and non-urgent appointment via Extraction.
- The method for extracting appointment data from a provider or provider group/IPA's practice management software is reliable.

- The method for extracting appointment data from a provider or provider group/IPA's allows the health plan to distinguish ineligible and non-responding providers.
- The date and time the extraction of the appointment data occurred (e.g., the date the practice management software is queried or downloaded) is captured and used to populate the "Date Survey Completed" and the "Time Survey Completed" field on the *Raw Data Template*.
- The extraction method used by the health plan captures the date and time of the next available urgent and non-urgent appointment for the individual provider sampled. The health plan must populate this information in the appropriate survey question field on the *Raw Data Template*.
- The date and time of the extraction and the first available urgent and non-urgent appointment must accurately represent what would be available to an enrollee if an appointment was requested by an enrollee on the date of extraction.
- The Department's Methodology and administration procedures are followed, including selection of the random sample of providers. The sample may not be selected based on whether providers' scheduling data can be accessed via Extraction.
- Unless surveying a Census in a County/Network, the health plan must include only those providers who were randomly selected to be sampled on the *Raw Data* and *Results Template*, even if Electronic Extraction is available for all providers in a provider group/IPA.
- The health plan completes the *Provider Contact List, Raw Data and Results Templates* in accordance with the instructions set forth in each template and submits these documents as part of its *Timely Access Compliance Report* submission.

For Electronic Extraction, the health plan must randomly assign extraction dates to provider groups/IPAs with accessible practice management software over a three-week period during each of the survey waves. If the total number of providers in any provider group/IPA selected for Extraction does not exceed 50%-60% of the entire sample for the county, the health plan may include all providers in the provider group/IPA that will provide appointment data by Extraction in Wave 1 or Wave 2. (This may allow the health plan to access the provider group/IPA's practice management software only once.) If a single provider group/IPA constitutes more than half of the sample, the health plan must extract data from the provider group/IPA across both waves.

Option 2: The Three Step Protocol

The Three Step Protocol sets forth a sequence all health plans using Option 2 must follow in administering the survey. The sequence is ordered to reduce disruption to providers.

1. Initiate the Survey via Email or Fax: The health plan must initiate the survey by sending a survey invitation either by email or fax. (If an email or fax contact is not available, the health plan must skip to Step 3: Conduct a Phone Survey.) The invitation may be addressed to one or more providers at the same email or fax contact; however, the survey must require each provider to provide individual responses to the survey questions. The survey invitation must:
    - Either include the survey or direct the provider to take the survey through an online portal.
    - Indicate that the provider has five business days to respond, otherwise the provider will be contacted by phone to take the survey.

2. Send a Survey Reminder: If the provider has not responded within two business days of sending the initial survey invitation, a reminder notice may be sent. If the plan elects to send a reminder notice, it must notify providers who have not responded of the remaining time to respond to the survey. Email or fax responses received after five business days of sending the survey invitation shall not be counted as responsive to the email or fax survey and a phone survey must be initiated.

3. Conduct a Phone Survey: If the provider does not respond to the email or fax survey invitation within five business days, the health plan must initiate the survey via telephone, using the Telephone Survey Tool, within ten business days of the expiration of the initial survey attempt conducted via email or fax.

    - Health plans may conduct the survey of several providers during a single phone call, but the provider's must respond to the survey questions individually.
    - If a provider's office does not answer the initial call, the surveyor must call the provider back on or before the next business day to initiate the phone survey. If possible, the surveyor may also leave a message requesting that the provider complete the survey via a call-back number within two business days of the message.
    - If a provider declines to respond to the survey, the surveyor must offer the provider's office the option to respond at a later time. If the provider is willing to participate later, the health plan must offer the provider the option to receive a (scheduled or unscheduled) follow-up call within the next two business days.

If the provider does not complete the telephone survey within two business days of the initial phone call, the provider must be recorded as a non-responder and replaced with a provider from the oversample.

Replacements of Non-Responding and Ineligible Providers

Whether using Extraction or the Three Step Protocol, an ineligible or non-responding provider (defined below) must be replaced if another provider from the oversample of the same Provider Survey Type and within the same County/Network is available. If a replacement of a provider is needed, the surveyor will use the next available provider as a replacement until the required sample size is reached. The health plan will continue to replace providers until either the required sample size is reached or all of the providers of that same Provider Survey Type in the County/Network have been exhausted. (This may require the health plan to select additional oversample providers, as set forth in Step 4 above.)

Non-Responding Providers

A non-responding provider is a provider that does not respond to one or more applicable items within two business days of the phone call attempt or that declines to participate in the survey.

Ineligible Providers

A provider is ineligible if he/she:

- No longer participates in the health plan's network at the time the survey is administered or did not participate in the health plan's network when the *Provider Contact List* was created;
- Does not practice in the county at the time the survey is administered or when the *Provider Contact List* was created;
- Retired or for other reasons is no longer practicing;
- Was included in the *Provider Contact List* under an incorrect Provider Survey Type;
- Was unable to be surveyed because he/she is listed in the database with incorrect contact information that could not be corrected; or
- Does not offer enrollees appointments (e.g., provides only hospital-based services or peer-to-peer consultation services).

The health plan's discovery that a provider is ineligible may inform the health plan of a change of information requiring an update of the health plan's online provider directory, in accordance with the requirements set forth in Section 1367.27, subd. (e). In addition, health plans must use the information obtained in administering the survey to update health plan records to improve the *Provider Contact List* for the following measurement year (e.g., update contact information and exclude all ineligible providers that are retired from future *Provider Contact Lists*).

Survey Administration Notes

- If the provider reports that the date and time of the next available appointment depends upon whether the patient is a new or existing patient, request the dates for both and use the earlier date (the shorter duration time).
- If the provider reports that patients are served on a walk-in or same day basis, ask the provider to confirm that walk-in slots are available later that same day and, if so, enter the date and approximate time that a patient walking in at the time of the call would be seen. A confirmed slot for later that day is compliant.[15]
- Referral of a patient to a different provider in a different office (e.g. a separate urgent care center) cannot be recorded as the initially surveyed provider providing an appointment. An appointment offered at a different office in the same county with the same provider can be recorded as an available appointment with the initially surveyed provider. (For FQHCs, availability at a separate site within the same FQHC qualifies as an available appointment.)
- If a provider's office indicates that urgent appointments are not offered, record "NA" on the *Raw Data Template* in the applicable urgent appointment and compliance determination fields.
- All survey calls must be conducted during normal business hours.

Step 8: Calculate Compliance Rates

Health plans must calculate a compliance rate and the percentage of providers that were ineligible or did not respond. These figures must be calculated for each County/Network using the responses to the survey questions for each Provider Survey Type. Use the *Results Template* Instructions, the Plan's *Raw Data Template*, and the calculation instructions set forth below to complete these calculations and enter this information on the *Results Template*.

Calculating Timeframes

For consistency, timeframes must be calculated in accordance with the following instructions:

- When calculating timeframes to make a compliance determination use the date and time the provider responded to the survey or extracted the appointment from the provider's practice management software as the date of the request for the appointment. Do not use the date of the initial contact for this calculation (e.g., where email is used or a follow-up survey is necessary use the date the provider responded, not the date the communication was sent).
- Urgent appointments are measured in hours and include weekends and holidays. As a result, health plans must capture the date and time the provider responded to the questions and the date and time of the first available appointment identified by the provider's office.

[15] See Rule 1300.67.2.2, subd. (b)(1).

- Non-urgent appointment standards are set forth in the Timely Access regulation in business days. For consistency, all health plans must use the following rules in calculating timeframes:

    - Count 14 calendar days (including weekends and holidays) to calculate the 10 business day standard.
    - Count 21 calendar days (including weekends and holidays) to calculate the 15 business day standard.
    - When calculating calendar days, exclude the first day (e.g., the day of the request) and include the last day.

- Example: If a PCP responds with an appointment date and time on Tuesday the 15th, then the appointment identified must be on or before Tuesday the 29th in order to meet the 10 business day standard (calculated by counting forward 14 calendar days) for non-urgent primary care appointments.[16]

Compliance Determinations

For each response to the question related to the next available appointment (whether obtained through the Three Step Protocol or through Extraction), a compliance determination must be recorded on the *Raw Data Template* in accordance with the following instructions:

- Record the date and time of the next available urgent care appointment provided in response to Question 1 and the next available non-urgent care appointment provided in response to Question 2[17].

Urgent Appointments

- If the response to Question 1 indicates that: "Yes, there is an available appointment within [48 hours for PCPs or 96 hours for Specialist and NPMH]" (as applicable), the provider is counted as compliant for urgent care appointments in Calculation 1.
- If the provider's response to Question 1 indicates: "No, there is no available appointment within [48 hours for PCPs or 96 hours for Specialist and NPMH]" (as applicable), the provider is counted as non-compliant in Calculation 1.

[16] In this example, days would be counted as follows: Tuesday the 15th is not counted (because, as the day of the request, it is excluded), Day 1: Wednesday the 16th, Day 2: Thursday the 17th, Day 3: Friday the 18th, Day 4: Saturday the 19th, Day 5: Sunday the 20th, Day 6: Monday the 21st, Day 7: Tuesday the 22nd, Day 8: Wednesday the 23rd, Day 9: Thursday the 24th, Day 10: Friday the 25th, Day 11: Saturday the 26th, Day 12: Sunday the 27th, Day 13: Monday the 28th, Day 14: Tuesday the 29th.

[17] For Ancillary Providers the question related to the next available non-urgent care appointment is Question 1. For all other provider types, the question related to the next available non-urgent care appointment is Question 2. For Ancillary Providers, conduct the compliance calculations using the same instructions but replace "Question 1" with "Question 2" in these instructions.

Non-Urgent Appointments

- If the response to Question 2 indicates that: “Yes, there is an available appointment within [10 business days for PCPs and NPMH or 15 business days for Specialist and Ancillary providers]” (as applicable), the provider is counted as compliant in Calculation 2.
- If the provider’s response to Question 2 indicates: “No, there is no available appointment within [10 business days for PCPs and NPMH or 15 business days for Specialist and Ancillary providers]” (as applicable), the provider is counted as non-compliant in Calculation 2.

Rate of Compliance

The *Results Template* includes a formula that divides the total number of compliant providers (the numerator) by the total number of providers that responded (the denominator) and records the rate of compliance as a percentage (e.g., 89%) on the *Results Template*. If more providers are surveyed than required to meet the required target sample size for a County/Network, use only the first providers randomly selected for that network to meet the target sample size and calculate the information on the *Results Template*. Using the compliance determinations set forth on the *Raw Data Template*, the health plan must record a numerator and denominator for each of the appointment standards. The numerator and denominator must be calculated and recorded on the *Results Template* for each County/Network for each Provider Survey Type to develop the rate of compliance, in accordance with the following instructions:

Urgent Appointments

- Add together the total number of compliant providers based on Calculation 1. Record this number (the numerator) in either the “Number of Providers with an Urgent Care Appointment with no Prior Auth within 48 Hours” field or the “Number of Providers with an Urgent Care Appointment with Prior Auth within 96 Hours” field (as applicable).
- Calculate the total number of responding providers, which includes compliant and non-compliant providers. Do not count “NA” responses in the denominator or numerator for the 48 or 96 hour urgent care appointment standards. Record this number (the denominator) in the “Number of Providers Responded to an Urgent Care Appointment with no Prior Auth within 48 Hours” field or the “Number of Providers Responded to an Urgent Care Appointment with Prior Auth within 96 Hours” field (as applicable).

Non-Urgent Appointments

- Add the total number of compliant providers from Calculation 2. Record this number (the numerator) in either the “Number of Providers with a Non-Urgent Care Appointment within 10 Days” field or the “Number of Providers with a Non-Urgent Care Appointment within 15 Days” field (as applicable).

- Calculate the total number of responding providers, which includes compliant and non-compliant providers. Record this number (the denominator) in the "Number of Providers Responded to a Non-Urgent Care Appointment within 10 Days" field or the "Number of Providers Responded to a Non-Urgent Care Appointment within 15 Days" field (as applicable).

Calculating the Percentage of Ineligible and Non-Responding Providers

The health plan must separately report the percentage of providers that are ineligible and those who do not respond or declined to respond to one or more survey question for each Provider Survey Type in each County/Network on the *Results Template*.[18] The *Results Template* includes a formula to calculate both percentages. To use this formula, the health plan must record on the *Results Template* the numerator for each Provider Survey Type in each County/Network, in accordance with the following instructions:

Ineligible Providers (See Table 2)

For each County/Network for each Provider Survey Type:

- Count the number of ineligible providers from the sample and any oversample (the numerator) on the *Raw Data Template*. Record this number on the *Results Template* in the "Number of Ineligible Providers" field.
- The *Results Template* adds the "Number of Providers Responded via Survey," the "Number of Providers Responded via Extraction," the "Number of Non-Responding Providers," and the "Number of Ineligible Providers" to calculate the denominator.
- The *Results Template* formula then divides the numerator by the denominator to calculate and record the percentage of ineligible providers on the *Results Template* in the "Percentage of Ineligible Providers" field.

Non-Responding Providers (See Table 2)

For each County/Network for each Provider Survey Type:

- Count the number of non-responding providers in the sample and in the oversample (the numerator) from the *Raw Data Template*. Record this number on the *Results Template* in the "Number of Non-Responding Providers" field.
- The *Results Template* adds the "Number of Providers Responded via Survey," the "Number of Providers Responded via Extraction," and the "Number of Non-Responding Providers" to calculate the denominator.
- The *Results Template* formula then divides the numerator by the denominator to calculate and record the percentage of non-responding providers on the *Results Template* in the "Percentage of Non-Responding Providers" field.

[18] Ineligible and non-responders may be identified through the Three Step Protocol or through Extraction.

Table 2 – Example of How to Calculate the Percentage of Ineligible and Non-Responding PCPs

Number of PCPs in County/Network (using Appendix A)	37
Target Sample Size	27
Initial Sample of 27:	
PCPs that responded to all survey questions or through Extraction in County/Network	21
PCPs that declined to respond or did not respond to all survey questions or through Extraction in County/Network	4
PCPs that were ineligible (e.g., retired) in County/Network	2
Oversample: (PCPs used as replacements for ineligible and non-responding PCPs)	
PCPs from oversample that responded to survey questions or provided data through Extraction in County/Network	6
PCPs from oversample that were ineligible or declined to respond in County/Network	0
Total for PCPs in County/Network (includes Initial Sample and Oversample)	
Number of Non-Responding PCPs in County/Network	4
Number of PCPs Responded via Survey and Extraction in County/Network (21 initial and 6 replacements)	27
Add the Number of PCPs Responded via Survey, the Number of PCPs Responded via Extraction, and the Number of Non-Responding PCPs in County/Network (27+4) (denominator)	31
Percentage of Non-Responding PCPs in County/Network (4/31=.129)	13%
Number of Ineligible PCPs in County/Network	2
Number of PCPs Responded in County/Network (21 initial and 6 replacements)	27
Add the Number of Ineligible PCPs, the Number of Non-Responding PCPs, and the Number of PCPs Responded via Survey and via Extraction in County/Network (2+27+4) (denominator)	33
Percentage of Ineligible PCPs in County/Network (2/33=.061)	6%

Step 9: Create Quality Assurance Report

Each health plan must have a quality assurance process to ensure that it followed the PAAS Methodology and PAAS Template instructions, met all *Timely Access Compliance Report* statutory and regulatory requirements, and that all information in the *Timely Access Compliance Report,* submitted to the Department, is true, complete, and accurate, pursuant to Section 1396.

As part of this quality assurance process, the health plan shall contract with an external vendor to conduct a review to ensure accuracy and completeness of the health plan's MY 2018 PAAS data and processes. This review and the quality assurance process must be completed prior to submission of the *Timely Access Compliance Report* to the Department, on or before March 31, 2019**.** At a minimum, the external vendor's review must ensure all of the following:

- The health plan used the Department-issued PAAS Templates for MY 2018.
- The health plan reported survey results for all Provider Survey Types that were required to be surveyed, as applicable, based on the composition of the health plan's network as of December 31, 2017.
- The *Timely Access Compliance Report* (including the *Provider Contact List Template*, the *Raw Data Template*, and the *Results Template)* accurately reflects and reports compliance for providers who were under contract with and part of the health plan's Department-regulated network(s) at the time the *Provider Contact List* was generated.
- All rates of compliance and compliance determinations recorded on the *Raw Data and Results Template* are accurately calculated, consistent with, and supported by data entered on the health plan's *Raw Data Template* (including those calculations embedded on the *Results Templates*).
- The administration of the survey followed the mandatory Department PAAS Methodology for MY 2018, including, but not limited to, conducting the survey during the appropriate measurement year and ensuring adherence to all target sample sizes and other parameters required under the Methodology and PAAS Template instructions, in accordance with Section 1367.03, subd. (f)(3).

In its Timely Access Compliance Report, the health plan must submit a *Quality Assurance Report,* prepared by an external vendor, outlining the results of the review and includes:

- Details regarding the review of each verification item identified above.
- A summary of the findings from the review, including completion of the DMHC-issued Addendum to the Quality Assurance Report.
- Identification of any changes and/or corrections made as a result of the data and quality assurance review.
- Any explanations for issues identified, including those determined to be compliant with this Methodology.

- For any identified errors or issues that the health plan does not correct or is unable to correct, the health plan must explain why it was unable to comply with the MY 2018 PAAS Methodology and identify steps to be taken by the health plan to ensure compliance during future reporting years. (See Section 1367.03, subd. (f)(3).)

The *Quality Assurance Report* and any accompanying health plan explanations must be submitted in the Comment/Narrative section of the Department Timely Access Web Portal.

Step 10: Submit the Health Plan's Timely Access Compliance Report

On March 31, 2019, as part of its annual *Timely Access Compliance Report*, each health plan must submit the following items to the Department for each of the Provider Survey Types, identified in Step 2 on page 4:

- *Results Template*;
- *Raw Data Template*; and
- *Provider Contact List Template (the complete list, before de-duplication)*.

The health plan's *Timely Access Compliance Report* must be submitted through the Department Timely Access Web Portal. Please refer to the *Timely Access Compliance Report Instructions*, available on the on Department's Timely Access web page, for further details regarding submission of each required element.

Appendix 1: Random Number Generation

Once a health plan has determined the appropriate sample size for each County/Network, it will need to determine which providers to call and survey. The random number identifies which providers to survey and include in the *Raw Data Template* from the health plan's working copy of the de-duplicated *Provider Contact List*. Health plans may use excel, SAS, or other statistical software to assign a random number to each provider for sample selection. Steps to generate a random number using excel and SAS are described below.

Excel Method

1. For each County/Network, place the PCPs, Specialist Physicians, Psychiatrists, Non-Physician Mental Health Providers, and Ancillary Providers in separate workbook tabs. Then perform the sorting steps set forth below by County/Network, Provider Survey Type, and Random Number.
2. Create a new column to the left of "A" on your spreadsheet by highlighting column A and select "insert" then "insert sheet columns."
3. Create a formula to generate the random number by typing "=Rand()" into the newly created column A.
4. Copy and paste the function down column A beside each provider in the table. If done correctly, a list of numbers with decimals in column A will be generated.
5. To convert the formula to a numeric value for sorting purposes, insert a new column A. Highlight Column B (now containing the Random formula), from the "Home" tab select "copy," "paste," and "paste values." (Once this step is complete, delete column B containing the "Rand=()" formula to avoid confusion during the sorting process.)
6. Highlight the entire spreadsheet by clicking on the very top left of the spreadsheet (gray area where A and 1 intersect). Go to Data, select "Sort," and sort by column A (the random number). Check "my data has headers" so that the headers will remain.
7. Starting with the first row, use the number of rows indicated by the required target sample size for the County/Network (plus additional rows for the oversample unless the health plan intends to supply the surveyors with the entire list, in random order) to select the providers to be surveyed and included in the *Raw Data Template*. It may be helpful to add columns to the health plan's working documents to label the primary sample vs. oversample so that the surveyor will not unnecessarily survey providers in oversample beyond those needed as replacements.

SAS Method

A simple random sample may be generated using the SURVEYSELECT procedure in SAS. Using the simple random sample methodology and no stratification in the sample design, the selection probability is the same for all units in the sample.

Appendix 2: Multi-County Network Sample Size Chart[19]

To determine the required target sample size for networks with multiple counties, identify the number of providers in the County/Network in the "Number of Providers in County/Network" column and the corresponding required target sample size.

Number of Providers in County / Network	Required Target Sample Size
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9-10	9
11	10
12	11
13-14	12
15	13
16	14
17-18	15
19	16
20-21	17
22-23	18
24	19
25-26	20
27-28	21
29-30	22
31-32	23

Number of Providers in County / Network	Required Target Sample Size
33-34	24
35	25
36-40	27
41-45	29
46-50	31
51-55	33
56-60	34
61-65	36
66-70	37
71-75	39
76-80	40
81-85	41
86-90	42
91-95	43
96-100	44
101-105	45
106-110	46
111-120	47
121-125	48
126-130	49
131-139	50
140-150	51
151-159	52

[19] Sample sizes were calculated to produce confidence limits of +- 8% for an expected compliance rate of 85% with a 95% confidence level. In other words, we would be 95% sure that the actual County/Network compliance rate is within +-8% given a compliance rate estimate of 85%. This table was created using a sample size calculation with a finite population correction: n = [N*p(1-p)]/[((d^2/(Z^2))*(N-1))+p*(1-p)], where n is the sample size, N represents the number of providers in a County/Network (population size), p is the rate of .85, d is the confidence limit of .08, and Z is the score of 1.96 required for a 95% confidence level. These target sample sizes are expected to produce confidence limits of +- 2% or lower at the health plan level of reporting for most health plan networks.

Multi-County Network Sample Size Chart Continued

Number of Providers in County / Network	Required Target Sample Size
160-170	53
171-179	54
180-189	55
190-204	56
205-220	57
221-232	58
233-250	59
251-269	60
270-293	61
294-318	62
319-349	63
350-385	64
386-412	65
413-460	66
461-529	67
530-598	68
599-680	69
681-794	70
795-912	71
913-1,138	72
1,139-1,435	73
1,436-2,112	74
2,113 – 3,339	75
3,340-10,000	76

Appendix 3: Single County Network Sample Size Chart[20]

To determine the required target sample size for networks with a single county, identify the number of providers in the County/Network in the "Number of Providers in County/Network" column and the corresponding required target sample size.

Number of Providers in County / Network	Required Target Sample Size	Number of Providers in County / Network	Required Target Sample Size
1	1	26	24
2	2	27	24
3	3	28	25
4	4	29	26
5	5	30	27
6	6	31	27
7	7	32	28
8	8	33	29
9	9	34	30
10	10	35	30
11	11	36 - 40	34
12	12	41 - 45	37
13	13	46 - 50	40
14	14	51 - 55	44
15	14	56 - 60	47
16	15	61 - 65	49
17	16	66 - 70	52
18	17	71 - 75	55
19	18	76 - 80	58
20	19	81 - 85	60
21	20	86 - 90	62
22	20	91 - 95	65
23	21	96 - 100	67
24	22	101 - 105	69
25	23	106 - 110	71

[20] Sample sizes were calculated to produce confidence limits of +- 5% for an expected compliance rate of 85% with a 95% confidence level. See footnote 14 for description and formula of sample size calculation with finite population. These target sample sizes are expected to produce maximum confidence limits of +- 5% for single-county networks.

Single County Network Sample Size Chart Continued

Number of Providers in County / Network	Required Target Sample Size
111 - 115	73
116 - 120	75
121 - 125	77
126 - 130	79
131 - 135	81
136 - 140	82
141 - 145	84
146 - 150	86
151 – 155	87
156 – 160	89
161 – 165	90
166 – 170	92
171 – 175	93
176 – 180	95
181 – 185	96
186 – 190	97
191 – 195	98
196 – 200	100
201 – 205	101
206 – 210	102
211 – 215	103
216 – 220	104
221 – 225	105
226 – 230	107
231 – 235	108
236 – 240	109
241 – 245	110
246 – 250	111
251 – 255	112
256 – 265	113
266 – 270	114
271 – 275	115
276 – 280	116
281 – 285	117
286 – 290	118
291 – 300	119
301 – 305	120
306 – 310	121
311 – 315	122
316 - 325	123

Number of Providers in County / Network	Required Target Sample Size
326 - 330	124
331 - 340	125
341 - 345	126
346 - 355	127
356 - 360	128
361 - 370	129
371 - 380	130
381 - 385	131
386 - 395	132
396 - 405	133
406 - 415	134
416 - 425	135
426 - 435	136
436 - 445	137
446 - 455	138
456 - 465	139
466 - 480	140
481 - 490	141
491 - 505	142
506 - 515	143
516 - 530	144
531 - 545	145
546 - 560	146
561 - 575	147
576 - 590	148
591 - 605	149
606 - 620	150
621 - 640	151
641 - 660	152
661 - 675	153
676 - 695	154
696 - 720	155
721 - 740	156
741 - 765	157
766 - 790	158
791 - 815	159
816 - 840	160
841 - 870	161
871 - 900	162
901 - 935	163

Single County Network Sample Size Chart Continued

Number of Providers in County / Network	Required Target Sample Size
936 - 970	164
971 - 1005	165
1006 - 1045	166
1046 - 1085	167
1086 - 1130	168
1131 - 1175	169
1176 - 1225	170
1226 - 1280	171
1281 - 1340	172
1341 - 1405	173
1406 - 1475	174
1476 - 1550	175
1551 - 1635	176
1636 - 1725	177
1726 - 1825	178
1826 - 1940	179
1941 - 2065	180
2066 - 2205	181
2206 - 2370	182
2371 - 2550	183
2551 - 2765	184
2766 - 3015	185
3016 - 3305	186
3306 - 3660	187
3661 - 4090	188
4091 - 4635	189
4636 - 5330	190
5331 - 6265	191
6266 - 7580	192
7581 - 9565	193
9566 - 12920	194
12921 - 41649	195
41650 and above	196

Language Assistance Program Assessment Addendum

Health plans must assess provider perspective and concerns with the health plan's language assistance program regarding:

- The coordination of appointments with an interpreter.
- The availability of an appropriate range of interpreters, and
- The training and competency of available interpreters.

These additional required questions—designed to elicit providers concerns and perspectives—may be posed through one of the following mechanisms:

1. The health plan's existing Annual Provider Satisfaction Survey (*See* Rule 1300.67.2.2, subd. (c)(4) and (d)(2)(C));

2. In a separate provider survey; or

3. At the end of the PAAS Survey Tool, the health plan may include additional questions regarding these topics.

Any redlined revisions to the applicable mechanism and policies and procedures to implement these requirements must be filed as an Exhibit J-13 in eFile within 30 of the amendment, pursuant to Section 1352, subd. (a) and Rule 1300.52, subd. (e).

Results for the current year and a comparison of the prior year's results must be reported with the plan's *Timely Access Compliance Report* in the Comment/Narrative section. In addition, health plans are required to utilize information obtained related to provider perspectives and concerns in this area in connection with the plan's timely access monitoring quality assurance activities and language assistance program compliance monitoring for MY 2018. (*See* Section 1367.01, Rule 1300.67.2.2, subd. (d), and Rules 1300.67.04, subds. (c)(2)(E) and (c)(4)(A).)