

DEPARTMENT OF MANAGED HEALTH CARE PROVIDER APPOINTMENT AUDIT METHODOLOGY

Rule 1300.67.2.2(g)(2)(B) requires health plans to report a rate of compliance with the following appointment wait time standards:

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

Pursuant to SB 964 and Section 1367.03(f)(3), the Department has adopted two standardized methodologies that plans may use to report compliance with the above standards for Measurement Year 2016 (“MY2016”). Plans may use the DMHC MY2016 Standardized Provider Appointment Availability Survey & Methodology (“PAAS”) or the DMHC MY2016 Provider Appointment Audit Methodology (the “Audit”).

The Audit is based on the premise that plans will coordinate with providers and/or provider groups to track and measure appointment wait time for enrollees using providers’ appointment scheduling systems; this can be performed as a computerized systems audit or as a manual audit. Plans that opt to use Audit for MY2016 may also use the PAAS for those provider groups or counties where providers/provider groups are not able to provide appointment data necessary to complete the Audit. However, results for each provider group in each county must be reported using only one methodology (i.e., the provider group may not report data for some providers using the audit methodology and others using the telephone survey). Individually contracted providers should be grouped together for each county within the plan’s service area and treated like a single provider group for each county.

Definitions

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

Booked Date: Many appointment systems do not currently store a record of the date and time of the patient’s request. For these systems, the booked date may be used as a proxy. Booked date is defined as the date and time the appointment was scheduled/booked (i.e., the date and time the appointment data was entered into the appointment system, often indicated by the date and time one or more fields were entered or a screen was updated). In most cases the Booked Date and the Request Date are the same.

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

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

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

Non-urgent appointment: Often referred to as a “routine appointment.”

STEP 1: Determine which networks to audit.

SB 964 requires plans to report separately the rate of compliance with the time elapsed standards for their commercial, Medi-Cal and/or individual/family plan products. If a plan uses the same network for all products, it may be able to audit its network only once and use the audit results to create rates for all products. If, however, a plan has separate Medi-Cal networks or separate individual/family product networks, the plan will need to conduct separate audits for (1) each of its Medi-Cal provider networks and/or (2) each of its individual/family plan provider networks.

If a plan uses the same provider network for all products, but the provider/provider group verifies an enrollee’s plan and product type at the time an appointment is made, the plan will be required to report separate rates of compliance for each product. See below for more details.

Medi-Cal Networks:

A separate Medi-Cal network means a provider network that is different from the plan’s commercial network and serves Medi-Cal enrollees. If a plan contracts with another plan to provide Medi-Cal services, the plan will need to separately report each of the contracted networks. For example, if a plan contracts with three other plans to provide Medi-Cal services, the reporting plan will need to separately report all three contracted networks. For MY2016, plans are not required to report Cal-Medi Connect as a separate Medi-Cal network.

Individual/Family Plans:

To the extent that a plan has separate networks for its individual/family products, each network will need to be separately reported. For example, if a plan has an individual HMO product and

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

an individual EPO product that both have separate networks from the plan's larger commercial network, the plan will need to separately report three separate rates of compliance for each network (HMO, EPO, and greater commercial network) for each provider group in each applicable county in the plan's network.

Plans with a Single Network:

As explained above, plans that have a single network for all products may still have to calculate separate rates of compliance for enrollees in Medi-Cal and individual/family products. If the plan's contracted provider and/or provider group verifies an enrollee's enrollment in a specific plan and product at the time an appointment is made, then the plan must calculate separate rates of compliance for each applicable provider/provider group (whether or not the question should be posed to an individual provider or provider group depends on whether appointments are scheduled by the provider's office or the provider group's office). If, however, a provider/provider group does not verify an enrollee's plan and product type at the time an appointment is made, the Plan may report the same rate of compliance for all products types for that particular provider group. If a plan is unable to confirm whether a provider/ provider group verifies an enrollee's plan and product type at the time an appointment is made, then the plan must calculate separate rates of compliance for enrollees in Medi-Cal, individual/family plan products and its remaining commercial market enrollees. For example, if Provider Group A is unable to confirm whether it verifies the name of the plan and product in which an individual is enrolled at the time an appointment is made, the plan will need to report separate rates of compliance for Provider Group A - a separate rate of compliance for plan's Medi-Cal enrollees, enrollees in the plan's individual/family plan products, and for individuals enrolled in the plan's remaining commercial products.

STEP 2: Identify Participating Provider Groups and Individually Contracted Providers

A participating provider group (PG) is defined as a "medical group, independent practice association, or any other similar organization²" that contracts with a plan. (*See Health & Safety Code section 1367(g).*) A plan will need to identify all PGs participating within in each county of the plan's service area.

Individually Contracted Primary Care Physicians

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

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

STEP 3: Create the Provider List

To begin, a plan will need to create at least three separate data sets that identify the physicians, non-physician mental health providers and ancillary providers within the plan’s network³. For most plans, the simplest approach is to begin by entering the data in an Excel spreadsheet similar to the Excel data templates required for the Timely Access Network Data reports. As such, the remainder of these instructions will assume that plans are using Excel and including the data fields listed below.

Table 1 – Provider List Data Fields

Physicians	Non Physician Mental Health Providers	Ancillary Providers
Last Name	Last Name	DBA
First Name	First Name	
NPI	NPI	NPI
Office phone number	Phone Number	Phone Number
CA License	CA License/Certificate (title of the license or certificate the provider holds. For example, Marriage and Family Therapist, Licensed Clinical Social Worker, Nurse, Nurse Practitioner/Physician Assistant, Professional Clinical Counselor (LPCC), Psychologist - PHD-Level.)	CA License
Type of Licensure		
Board Certified (Y/N)		
Participating Network	Participating Network	Participating Network
Name of Network (The name used by the Plan to describe its Participating Network)	Name of Network (The name used by the Plan to describe its Participating Network)	Name of Network (The name used by the Plan to describe its Participating Network)
Address	Address	Address
City	City	City
County	County	County
State	State	State
Zip Code	Zip Code	Zip Code
Specialty Type	Specialty/Area of Expertise	Ancillary Provider Category (i.e., Physical Therapy, Diagnostic Imaging, MRI, Mammogram, Infusion, etc.)
Medical Group / IPA	Medical Group/IPA	Medical Group/IPA

³ This is the same process as creating a provider contact list for the PAAS. Although plans will not be calling providers, plans must still confirm the provider names and specialties within their networks in order to verify that the plan has audited all appropriate providers.

To simplify this process, the Department selected the same (or very similar) database fields as those required by the Department for the submission of provider network data to the Timely Access Web Portal. Also, specialties, counties and other look-up codes are available on the DMHC website in the provider network submission templates. Plans are encouraged to use these existing look up-codes and may include in their Provider Lists additional contact information, including but not limited to, provider email addresses.

Providers who are members of multiple PGs should have an entry for each PG. Providers who are members of a PG(s) as well as individually contracting with the plan should only be included under their PG(s). Once the Provider Lists are complete, the datasets should be reviewed and duplicate entries removed. Duplicate entries are rows where the same provider name, provider group, address and phone number appear more than once. (Providers that appear in multiple provider groups are not duplicate entries.)

Plans will need to submit the Provider List when submitting their annual reports. Plans make a single Provider List or make multiple Provider Lists for each provider group.

In order to create a Provider List for individually contracted providers, the plan may either:

- (a) include individually contracted providers in the same Provider List as the one described above with “Individually Contracted Provider” in the provider organization name field for these providers or;
- (b) create a separate Provider List for individually contracted providers. Individually contacted provider that are also in a PG should only be counted in the PG.

STEP 4: Determine Which Appointments to Include

Before appointment data can be exported or manually recorded in Excel, the Plan must determine which appointments to measure. There are two types of audits that a plan may conduct for MY2016. The first is a computerized audit that requires a provider/provider group to export data from its scheduling system and use that data to compute appointment wait times. The second audit option is a manual option that requires plans or providers/provider groups on behalf of the plan, to look at specific appointment types and dates and record the appointment wait times manually rather than exporting the data via Excel.

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

➤ **First Episode of Care**

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

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

For appointments for adults:

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

If any of the above are “yes” include this appointment.

For appointments for children:

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

If “yes” include this appointment.

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

➤ **Time Periods**

Computerized Systems Audit

To allow sufficient time for all requested appointments to occur and to give providers sufficient time to develop, run and verify programming and to report results, include ALL appropriate appointments requested/booked January 1, 2016 – September 30, 2016.

Manual Audit

The Plan will measure a sample of appointments occurring on four days in the measurement year. Near the end of the first, second, third and fourth quarters of 2016, the Department will post on its website a notification of the date for which data shall be collected for MY2016. Data should be collected for each date soon after it is posted on the Department's website to allow plans to use the data for ongoing monitoring and to ensure that data systems are not purged before collection is accomplished.

➤ **Appointment types**

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

➤ **Networks**

Plans should include only commercial, Medi-Cal and Individual/Family product appointments. Do not include self-pay appointments.

Appointments for Separate Medi-Cal Networks:

Providers in a plan's Medi-Cal network will likely serve more than just Medi-cal enrollees and will have appointments for enrollees in multiple plans and product types. When conducting the audit, plans may include appointments, regardless of an enrollee's enrollment in a specific plan or product, if the plan can verify that at the time an appointment is made, the provider does NOT verify an enrollee's enrollment in a specific plan and product. If a provider does verify this information or if a plan is unable to confirm whether a provider/ provider group verifies an enrollee's plan and product type at the time an appointment is made, then the plan may only include appointments with Medi-Cal enrollees in its audit. This does not need to be plan-specific, but only those appointments with Medi-Cal enrollees may be included.

For example, assume a plan has a separate network for its Medi-Cal product and Provider Group A contracts to be in the plan's Medi-Cal network. If Provider Group A is unable to confirm whether it verifies the name of the plan and product in which an individual is enrolled at the time an appointment is made, the plan will need to report a separate rate of compliance for Provider Group A that contains only appointments for Medi-Cal enrollees.

Appointments for Individual/ Family Plan Products with Separate Networks:

Providers in a plan's Individual/Family plan products with separate networks will likely serve more than just enrollees in the plan's Individual/Family plan products and will have appointments for enrollees in multiple plans and product types. When conducting the audit, plans may include all appointments, regardless of an enrollee's enrollment in a specific plan

or product, if the plan can verify that at the time an appointment is made, the provider does NOT verify an enrollee's enrollment in a specific plan and product. If a provider does verify this information or if a plan is unable to confirm whether a provider/ provider group verifies an enrollee's plan and product type at the time an appointment is made, then the plan may only include appointments for enrollees in the specific individual/family plan product network that is being audited.

Appointments for Commercial Network:

Plans that have separate networks for Medi-cal products and individual/family plan products will need to report a separate rate of compliance for the remaining licensed commercial products. As explained above, when conducting the audit, plans may include appointments, regardless of an enrollee's enrollment in a specific plan or product, if the plan can verify that at the time an appointment is made, the provider does NOT verify an enrollee's enrollment in a specific plan and product. If a provider does verify this information or if a plan is unable to confirm whether a provider/ provider group verifies an enrollee's plan and product type at the time an appointment is made, then the plan should exclude appointments with Medi-Cal enrollees and appointments for individuals enrolled in individual/family plan products with separate networks. Appointments included in the audit do not need to be limited to plan enrollees, but should exclude enrollees in separate product types that are described above.

Appointments for Plans with a Single Network:

As described above in Step 1, if the plan's contracted provider and/or provider group verifies an enrollee's enrollment in a specific plan and product at the time an appointment is made, then the plan must calculate separate rates of compliance for each applicable plan and product. If, however, a provider/provider group does not verify an enrollee's plan and product type at the time an appointment is made, the Plan may report the same rate of compliance for all products types for that particular provider group. If a plan is unable to confirm whether a provider/ provider group verifies an enrollee's plan and product type at the time an appointment is made, then the plan must calculate separate rates of compliance for enrollees in Medi-Cal, individual/family plan products and its remaining commercial market enrollees using the instructions provided above.

➤ **Providers**

For each PG/County that will be reported using the audit methodology, plans should include ALL providers that fall into the following categories:

Primary Care

- Primary Care Physicians

Specialist Physicians

- Allergists
- Dermatologists
- Cardiologists
- Psychiatrists (except for Child & Adolescent Psychiatrists, who will need to reported separately)
- Child & Adolescent Psychiatrists

Non-Physician Mental Health Providers

- Non-physician mental health providers – PhD Level
- Non-physician mental health providers – Masters Level

Ancillary Appointments

- Physical Therapy Appointments
- MRI Appointments
- Mammogram Appointments

Plans must audit ALL applicable providers in a provider group. For individually contracted providers, plans must audit all individually contracted providers in a county. There is no sampling of providers within a provider group permitted in this methodology.

STEP 5: Conduct Audit

Computerized Systems Audit

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

Manual Audit

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

For both the computerized systems audit and the manual audit methods, plans should submit the compliance rates found via the audit, but not the audit or audit data, to the Department of Managed Health Care. The plan should, however, maintain the audit and audit data in a format accessible to the Department of Managed Health Care's survey team. The Department will provide further instructions regarding the format for reporting compliance results to plans.

STEP 6: Calculating Compliance Rates

Plans may calculate a rate of compliance for each provider group in each county using one of the methods outlined below. As explained previously, plans with separate networks will need to calculate a separate rate of compliance for each PG in each county for each network. Plans with a single network that applies to all products may report the same rate of compliance for all products types for a particular provider/ provider group if the provider/provider group does not verify an enrollee's plan and product type at the time an appointment is made. If the plan is unable to confirm whether a provider/ provider group verifies an enrollee's plan and product type at the time an appointment is made, then the plan must calculate separate rates of compliance for enrollees in Medi-Cal, individual/family plan products and its remaining commercial market enrollees.

Option 1 - Request Date to First Offered Date:

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

Note: Compliance for urgent appointments must be measured using hours. For example, an appointment for urgent care not requiring prior authorization would be compliant if it was requested on a Monday at 10:00am and was offered for Wednesday at 8:00am. It

would not be compliant if it was offered for Wednesday at 11:00am. Compliance for routine appointments may be measured using days without regard to the time of day the appointment was requested/scheduled/occurred.

3. For each provider, add the total number of compliant appointments for each standard and divide that number by the total number of appointments for that standard. Report the result as a percent with one decimal. For example, if 85 out of 100 non-urgent appointments for a specialist were offered (occurred) within 15 business days, this provider would be scored at 85.0%.
4. For each provider group sum up all providers within each provider group who are compliant and divide this by the number of providers to establish a provider group compliance estimate. For example, if 30 providers are included and 25 reach the compliance threshold then the provider groups' compliance rate is 25/30 or 83.3%.

Option 2 - Booked Date to First Offered Date:

Follow instructions for *Request Date to First Offered Date*, replacing *Request Date* with *Booked Date*.

Option 3 - Request Date to Occurred Date:

Follow instructions for *Request Date to First Offered Date*, replacing *First Offered Date* with *Occurred Date*.

Option 4 - Booked Date to Occurred Date:

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

Please account for the following factors:

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

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

STEP 7: Reporting Compliance Rates

For both the computerized systems audit and the manual audit methods, plans should submit the compliance rates found via the audit, but not the audit or audit data, to the Department of Managed Health Care. The plan should, however, maintain the audit and audit data in a format accessible to the Department of Managed Health Care's survey team.

The Department will provide further instructions regarding the format for reporting compliance results to plans. The results for the providers in each PG/County must be reported using the Department's **Provider Appointment Audit Methodology Results Template (which will be provided prior to March 31, 2016)**.