

**CHECKLIST FOR HEALTH CARE SERVICE PLAN  
 VENDOR AGREEMENTS TIMELY ACCESS COMPLIANCE REPORTS**

*This checklist is not intended to be all-inclusive and only represents those issues that must, at a minimum, be addressed by a health care service plan in connection with the filing of a new or revised Vendor Agreements related to the Timely Access Compliance Process and Report Forms. This checklist also provides information regarding validations that must be included in External Vendor Validation Reports. Additional information may be requested by the Department of Managed Health Care (“the Department”) during review of submitted filings and reports.*

Exhibit E-1

- ❑ Describe the background and purpose of the Vendor Agreement.
- ❑ Specify any sections that are the same/similar to another Vendor Agreement previously filed and approved by the DMHC, and include the filing number.
- ❑ Explain whether the Plan (or the vendor) intends to further delegate or subcontract functions to be performed under the agreement.
  - If a subcontractor is *not* a party to (or acknowledged in) the vendor agreement submitted as Exhibit J-13, provide details regarding the subcontractor and role(s) to be played by the subcontractor.

Exhibit J-13

- ❑ Submit copies of each contract that the Plan has entered into (or intends to enter into) for vendor services.
- ❑ Terms of the Vendor Agreement should address the following wherever applicable:
  - Introduction of all parties to the contract and, other than the Plan, the relationship of those parties to the Plan; this must include any third parties or subcontractors performing work on behalf of one of the primary entities to the Vendor Agreement, and relationship of the parties. (See also Exhibit E-1.)
  - Background and purpose.
  - If necessary, any definitions.
  - The rights and obligations of each party.
  - The responsibility of the plan to notify, and obtain prior approval from, the Department prior to any *material* revision to the Vendor Agreement or *material*

revision to a subcontract by the contracted service provider under the Vendor Agreement.

- Oversight/monitoring and review procedures, including:
  - ✓ Confidentiality compliance.
- General provisions, including but not necessarily limited to verification that:
  - ✓ The *External Vendor Validation Report* outlining the results of the external vendor's review of the validations required. The external vendor's findings must be summarized and any changes or corrections made by the health plan or the external vendor, as a result of the data validation and quality assurance review, must be identified. This includes issues that are identified but deemed resolved by explanation or clarification.
- Areas the Vendor will review, including but not necessarily limited to:
  - ✓ The health plan used the DMHC required templates for MY 2016 and MY 2017, as applicable. The external vendor must ensure that the *Provider Contact List*, *Raw Data Template* and *Results Templates*, set forth on the DMHC's public Timely Access web page under the "2016 Timely Access Compliance Templates and Tools" section, are used.
  - ✓ The health plan reported survey results for all provider types that were required to be surveyed and reported, as applicable.

If a health plan failed to survey a provider type or a medical group/IPA that is in its network and required to be surveyed and reported, the *External Vendor Validation Report* must include this information. The health plan must explain why it was unable to report data for this provider type, medical group/IPA and identify steps to be taken by the health plan to ensure compliance during future reporting years in its submission.
  - ✓ 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 DMHC-regulated network(s) at the time the *Provider Contact List* was generated. The purpose of this requirement is to ensure that the providers, provider groups, and IPAs (collectively, "Providers") identified in the health plan's *Timely Access Compliance Report* were under contract with the health plan for a DMHC-regulated line of business at the time the *Provider Contact List* was generated and used to administer the PAAS. The external vendor should

ensure that the health plan did not inadvertently include Providers serving solely CDI lines of business (or if utilizing a vendor that serves multiple health plans to administer the survey, the external vendor did not include non-contracted Provider data as a result of surveying other plans' Providers). The vendor is not expected to review plan provider contracts to make this determination. Rather, the vendor should use the plan's *Provider Roster* as a baseline.

The DMHC recommends that, at minimum, the health plan require the external vendor to verify the following information on the plan's annual *Provider Roster* and *Timely Access Compliance Report* to ensure that all providers included in the report were in the health plan's network during the appropriate measurement year:

- \*Name of Provider/Provider Group/IPA
- \*Number of providers in the group by county by product type
- \*Number of Individually Contracted Provider by county by product type
- \*The correct specialty type reported for each provider
- \*Timely Access Compliance Report did not exclude a provider type or group that should have been surveyed

The DMHC has published a Technical Assistance Validation Grid to further inform plans and vendors about the requirements involved in submitting MY 2016 Timely Access Compliance Reports to the DMHC.

- ✓ Information indicating that non-contracted Providers were identified and included or removed from the *Timely Access Compliance Report* should be included in the *External Vendor Validation Report*. (See Page 4 of the All Plan Letter, issued February 13, 2017.) Health plans should provide this information and an explanation for the discrepancies identified between the data sources in narrative form in the *External Vendor Validation Report*. (E.g., "There are 52 PCPs and 41 specialists who appear on the health plan's *Timely Access Compliance Report* Provider Contact List and Raw Data Template, but are not listed on the health plan's Provider Roster (G Data). As part of its work performed for MY 2016, the health plan's external vendor/data validator confirmed that each of the 52 PCPs and the 41 specialists were contracted with and part of the health plan's network at the time the MY 2016 Provider Contact List was generated.")

- ✓ All rates of compliance for the health plan reported on the *Results Template* are accurately calculated, consistent with, and supported by data entered on the health plan's *Raw Data Template*. Each calculation should follow the requirements set forth in the DMHC's mandatory PAAS methodology, including providers surveyed by telephone that were counted as non-compliant for failing to respond to one or more items. Suggested calculation validations are included at the end of this document.
  - ✓ The administration of the survey followed the mandatory DMHC methodology for MY 2016 and MY 2017, as applicable, 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.
- Terms and termination.
  - ✓ Procedures the Plan uses to audit the vendor under the Vendor Agreement, including reports issued and steps to be taken by the Plan takes if it finds noncompliance.
  - ✓ Explain the Plan's process for monitoring subcontractors who are not a party to any Vendor Agreement with the Plan, including time frames in which monitoring will occur and be completed; whether monitoring will occur through direct oversight or delegation to the primary service provider.

### **Calculation Validations**

Based on issues previously identified by the DMHC, the external vendor should ensure the following calculations and/or data items are validated and reported accurately:

- The formula used to report the rate of compliance, including the denominator and numerator, must be correct.
- All results must be mathematically possible (e.g., no rates above 100% should be reported).
- The calculation should be consistent with the survey logic set forth in the PAAS methodology. For example, the compliance determination for a particular standard should account for the response of the provider selected to be surveyed and any other provider in the office who was able to provide an appointment sooner. (*See Step 8 of the MY 2016 PAAS Methodology.*)

- The responses in source data are recorded accurately on the *Raw Data Template* and are set forth in the appropriate column.
- The rate of compliance for each standard reported on the *Results Template* must be derived from the appropriate survey question(s).
- The number of providers reported on the *Raw Data Template* and *Results Templates* must be consistent. (E.g., if responses for 15 providers in a medical group in a particular county were included in the *Raw Data Template*, this number should be consistent with what is set forth on the Results Template. The *Raw Data Templates* should not indicate that a larger or smaller number of providers responded when that information is compared against information set forth on the *Raw Data Template*.)
- No unnecessary duplicate entries are included on the *Raw Data Template* and *Results Templates*. (E.g., no provider group should be reported more than once per county for each provider type).
- If a health plan reports a 0% rate of compliance on the *Results Template*, this calculation must be consistent with information on the *Raw Data Template* and should not be reported as “NA.” (E.g., if listed as 0% this means that none of the providers surveyed reported appointment availability that was compliant with the timely access standard. If “NA” is reported, this means that all of the providers surveyed were ineligible for inclusion in the survey, or that the measurement does not apply to the plan).
- Allocation of non-responding providers, deemed non-compliant with one or more standards pursuant to the PAAS methodology, must be consistent with *the MY 2016 Methodology Clarifications*, issued by the DMHC.