DMHC Timely Access to Non-Emergency Health Care Services Proposed Regulation

(12/4/20 Version)

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Kelly Huffman

QMetrics Sr. Director Strategy & PMO

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Today's Presenter

Stacy Baker, JD

Chief Compliance Officer &
SVP Regulatory Affairs

- Stacy has worked in Regulatory Compliance for over 20 years
- Previously was Director of Legislative & Regulatory Affairs and the Medicare Compliance Officer at a California Health Plan for 10 years
- Has served as the primary Health Plan liaison to regulatory bodies including DMHC, Covered California, & CMS
- Originally from Rhode Island and now resides in San Diego, CA

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About QMetrics

- Founded by Suzan 15 years ago and is a woman and minority owned business
- We strive to help our partners stay in full compliance with State, NCQA, and other regulatory agency requirements while leveraging these activities to improve services and care provided to members and patients.
- QMetrics is a California Association of Health Plans (CAHP) affiliate member and is a California Certified Small Business (#2009743). We are proud to have had a presence in the State of California since 2006.
- Team of over 15 highly experienced health care industry consultants

Suzan Dalen, MPA, CHCA

Chief Executive Officer

& HEDIS® Auditor

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QMetrics Services

- Advanced Analytics
- Appointment & Experience Surveys
- Data Aggregator Validation
- Encounter Data Completeness
- Organizational Effectiveness
- Quality Improvement
- Regulatory Compliance

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QMetrics Services

Data Aggregator Validation & Audits

- QMetrics is the only organization currently performing NCQA Data Aggregator Validation audits.

Advanced Analytics

- 10+ years experience analyzing Risk & Quality Scores along with developing predictive models for their improvement.

Encounter Data Completeness

- We can evaluate and improve your encounter data completeness improving your risk and quality scores.

Quality Measure & Value Based Reporting

- Our expertise in quality score reporting goes back 20+ years & we have been auditing quality measures for 15+ years.

Appointment & Experience Surveys

- We have been a PAAS Validator since 2016, and have administered PAAS, After Hours, Provider Satisfaction, Telehealth and other custom surveys since 2017.

Organizational Effectiveness

- Our team has extensive experience in organizational design, change management and developing company strategy.

Quality Improvement

- QMetrics has extensive experience developing and implementing successful quality improvement teams & programs.

Regulatory Compliance

- Our team has 15+ years working in the regulatory compliance space. QMetrics can assist you with interpreting and implementing state & federal statutory, regulatory provisions, and sub-regulatory guidance, and to prepare for audits.

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QMetrics Webinar: Proposed Timely Access Regulation

Presented by: Stacy Baker, JD

Chief Compliance Officer & SVP Regulatory Compliance

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Agenda

- **About QMetrics**
- **Webinar Objective**
- **Background and Purpose of the Proposed Regulation**
- **Components of the Proposed Regulation**
  - Regulation (Amended Rule 1300.67.2.2 & New Rule 1300.67.2.3)
  - Provider Appointment Availability Survey (PAAS) Manual and Survey Tool
  - Timely Access and Annual Network Submission Instruction Manual
  - Timely Access and Annual Network Form Templates and Instructions
- **Significant Proposed Changes to Current Requirements**
- **Timelines and Implementation Timeframes**
- **CAHP Comments**
- **Upcoming QMetrics Activities**

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Webinar Objective

Orientation to current status of proposed regulation as of 12/4/2020

Assistance with review of lengthy documents and need to compare to and identify differences from current requirements

- 1st version of Proposed Regulation (6/12/20): 553 pages
- Initial Statement of Reasons (6/12/20): 221 pages
- 2nd version of Proposed Regulation (12/4/20): 620 pages
- Comparison against the following current and following guidance documents
  - PAAS Methodology, PAAS Survey Templates
  - PAAS Contact List/Raw Data/Results Data Template Instructions
  - Timely Access Compliance Report Web Portal Instructions
  - Checklist for Health Care Service Plan Vendor Agreements for Quality Assurance Reports
  - ANR Instruction Manual
  - ANR Template Reporting Forms Instructions

Review Next Steps and Potential Operational Impacts

Background and Purpose of Proposed Regulation

2010 Effective Date of the DMHC's timely access regulation: Rule 1300.67.2.2

2012 First Timely Access Report due by March 31, 2012

2014 The California Legislature granted the DMHC the authority to develop standardized reporting methodologies for the annual Timely Access Report, subject to a five-year exemption from the Administrative Procedures Act (APA) rulemaking requirements.

2017 The DMHC required plans to obtain an external validator and file a validator quality assurance report (for Measurement Year 2016 data and prospectively) as part of the annual Timely Access Report, per APL 2017-007.
The DMHC prohibited plans from using ICE to administer the Provider Appointment Availably Survey.

2018-2020 The PAAS Methodology changed each year for Measurement Year's 2017, 2018, and 2019.
For MY 2020, Plans were permitted to utilize the same Methodology as that from MY 2019.

2020 The APA exemption granted by the Legislature in 2014 expired on January 1, 2021.

Therefore, the DMHC initiated the rulemaking process to amend Rule 1300.67.2.2 and adopt new Rule 1300.67.2.3 to formally codify the reporting methodologies that the DMHC developed over the years and make specified changes to existing requirements.

Background and Purpose of Proposed Regulation

Initial Proposed Regulation

- Issued: June 12, 2020
- Comment Period Deadline: July 27, 2020

Revised Text of Proposed Regulation

- Issued: December 4, 2020
- Comment Period Deadline: January 21, 2021

Next Steps

- The DMHC states that it will be amending the proposed regulation during a third comment period.
- The DMHC anticipates submitting the final rulemaking package to the Office of Administrative Law (OAL) during the second quarter of 2021.
- Once received, the OAL has 30 business days to approve or disapprove.

Components of the Proposed Regulation

Amended Rule 1300.67.2.2 [26 pages]

- Timely Access to Non-Emergency Health Care Services and Annual Timely Access and Network Reporting Requirements

New Rule 1300.67.2.3 [2 pages]

- Timely Access Quality Assurance for Measurement Year 2021

Annual Network Review and Timely Access Reporting Form Templates [363 pages]

- Template Forms without Instructions

Timely Access and Annual Network Submission Instruction Manual [171 pages]

- Definitions
- Annual Network Submission Instructions
- Timely Access Compliance Report Instructions
- Enrollee Satisfaction Survey & Provider Satisfaction Survey Instructions
- Template Instructions

Provider Appointment Availability Survey Manual [48 pages]

- Replaces the PAAS Methodology Document
- Sample Size Chart
- Survey Tool

General Overview

The proposed Rule is largely consistent with the overall existing reporting methodologies used by health plans for the annual Timely Access Report (TAR) and Annual Network Review (ANR) Filing.

- MY 2019 PAAS Methodology, Three-Step Protocol, Templates, Survey Tool (steps, process, timeframes, structure, scripting, external validation vendor requirements, etc.)
- Timely Access Report filing instructions
- Annual Network Review Filing (process, templates, etc.)

The proposed Rule codifies the various DMHC TAR and ANR methodologies, templates, FAQs, and guidance documents into law and provides further specificity and detail.

- Defines key terms
- Specifies how health plans must conduct surveys of providers and enrollees and gather data for the TAR and ANR
- Specifies requirements for health plan quality assurance processes and reporting requirements
- Incorporates key documents such as report forms and manuals into law
- Includes other clarifying amendments
- Goal: codifying standardized process to ensure health plans report comparable timely access data year-to-year

Significant Proposed MY2022 Changes to Current Requirements

Patterns of Non-Compliance

- The term is specifically defined and measured at the plan network level (fewer than 70% of providers in the plan network had an appointment within the time-elapsed standards)
- Provides factors for the DMHC to consider to determine whether instances of non-compliance can be considered as a Pattern of Non-Compliance

Enrollee Experience Survey

- Additional questions, disclosures, and translation requirements

Provider Satisfaction Survey

- Additional questions related to language assistance services

Provider Survey Types

- Expands the specialty provider types to be surveyed from 3 specialty types to 10 specialty types.

Applicable Dates

- Network Capture Date: January 15th (rather than December 31st)
- PAAS Fielding Dates: June 1st – December 31st (rather than starting in April)
- Filing Date: May 1st (rather than March 31st)

Significant Proposed MY2022 Changes to Current Requirements

Plan-to-Plan Agreements

- Changes the filing responsibilities for primary and subcontracted plans

Requests for Alternative Access Standards

- Provides a process for plans to request alternative time-elapsed standards or an alternative standard for the threshold rate of compliance

Specialized Plans

- Requires specialized plans (dental, vision, chiropractic, acupuncture) to complete the Network Access Profile portion of the annual filing (previously exempt)

Determining Compliance and Non-Compliance

- Adds specific language describing the process and elements which will be used by the DMHC to determine plan non-compliance.

Proposed Changes: *Regulatory Language*

Section	Area	Amended Provision	Impact
1300.67.2.2 (b)	Definitions	Added new defined terms: • "Measurement Year", "Network", "Network adequacy", "Network capture date", "Network identifier", "Network name", "Network provider", "Network service area", "Patterns of non-compliance", "Plan-to-plan contract", "Product line", "Provider Survey Types", "Reporting plan", "Reporting year"	• Generally, codifies terminology from existing documents or cross-references to statutory provisions. • Specific changes noted below
1300.67.2.2 (b)(7)	Network Capture Date	Annual Network Report • January 15th of reporting year Timely Access Compliance Report • January 15th of prior year	• Change from December 31st • Change made because contracts are typically in flux at the end of each calendar year

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Proposed Changes: *Regulatory Language*

Section	Area	Amended Provision	Impact
1300.67.2.2 (b)(10)	Network Provider	Specifies criteria for a provider to be considered a "Network Provider" • Available to provide covered services to all plan enrollees in all product lines using the designated network • An employee, directly contracted with the plan, contracted through a delegated agreement, a provider available via a plan-to-plan agreement, and/or a provider required by the DMHC (block transfer, CAP, etc.) • Accessible to enrollees of the network without limitations (other than referrals, prior-authorization, etc.) • Not one of the following provider types: single case agreements, OON cost-share level tier provider	• Includes specific reference to the statutory definition of "provider" • Specifies that health plans must ensure reasonable access to care at the *network level*. • Designed to ensure that only the providers truly available to enrollees are included in the network analysis

Proposed Changes: *Regulatory Language*

Section	Area	Amended Provision	Impact
1300.67.2.2 (b)(12)	Patterns of Non-Compliance	• Fewer than 70% of network providers (all provider types) had an appointment within the time elapsed standards for urgent or non-urgent appointments as calculated during the PAAS for the applicable Measurement Year; or • The DMHC receives information of instances of non-compliance to establish that each instance is reasonably related to constitute a pattern by considering various factors (same standard, network, provider group, provider type, network provider, or region; number of providers available in the region; number of enrollees in the network as compared to the total number of instances; whether each instance occurred within the same 12-month period)	• Current law does not specify a standardized methodology plans must use to measure its rate of compliance • Will enable the DMHC to assess compliance at the plan network level rather than the aggregate health plan level

Proposed Changes: *Regulatory Language*

Section	Area	Amended Provision	Impact
1300.67.2.2 (b)(13)	Plan-to-Plan Contract	• Primary Plan: a licensed plan that holds the contract with subscribers to arrange for the provision of health care services • Subcontracted Plan: a licensed plan or specialized plan that is contracted to allow a primary plan's enrollees access to the subcontracted plan's network providers. The contract may be between the primary plan and the subcontracted plan or between two subcontracted plans.	• Specifically defines the term "plan-to-plan contract" • Goal: the primary health plan remains ultimately responsible for complying with network adequacy laws under the law.
1300.67.2.2 (b)(17)	Reporting Plan	• A licensed full-service or behavioral health plan that holds the contract with subscribers to arrange for the provision of health care services and has one or more networks approved by the DMHC. • The reporting plan is the entity required to submit the TAR and ANR reports on behalf of itself and/or on behalf of a subcontracted plan through a plan-to-plan contract.	• Changes the structure as to the responsibilities for submitting the TAR and ANR filings under plan-to-plan agreements

Proposed Changes: *Regulatory Language*

Section	Area	Amended Provision	Impact
1300.67.2.2 (d)(2)(B)	Enrollee Experience Survey (ESS)	• Conducted in accordance with a *statistically* valid and reliable survey methodology. • Obtain enrollees' perspectives and concerns regarding their experience obtaining timely appointments for health care services within, and designed to ascertain compliance with, the timely access standards • Inform enrollees of their right to obtain an appointment within each of the time-elapsed standards and their right to receive interpreter services at that appointment • Evaluate the experience of limited English proficient enrollees in obtaining interpreter services by obtaining the enrollee's perspectives and concerns regarding language assistance services • Be translated into the enrollee's preferred language (if one of the 15 California LEP designated languages)	• Plans will no longer be able to use the CAHPS survey alone to satisfy the EES requirement. • Plans will be required to field a separate ESS. • Plans will be required to translate the ESS. • Methodology must be statistically valid.

Proposed Changes: *Regulatory Language*

Section	Area	Amended Provision	Impact
1300.67.2.2 (d)(2)(C)	Provider Satisfaction Survey (PSS)	• Added the following elements to the PSS: • The PSS must evaluate provider perspectives and concerns with the plan's language assistance program in a *statistically* valid method regarding: • (i) Coordination of appointments with an interpreter; • (ii) Availability of an interpreter, based on the needs of the enrollee; and • (iii) The ability of the interpreter to effectively communicate with the provider on behalf of the enrollee.	• Clarifies the additional language assistance provider survey requirements from the PAAS LAP Addendum which are not clearly captured in current law. • Methodology must be statistically valid.
1300.67.2.2 (g)	Requests for Alternative Time-Elapsed Access Standards	• Establishes a process for plans to request alternative time-elapsed or compliance threshold standards • Requires plans to submit a description of steps to bring network into compliance with the request	• A specified process for such requests does not currently exist

Proposed Changes: *Regulatory Language*

Section	Area	Amended Provision	Impact
1300.67.2.2 (d)(2)(D)	Quarterly Network Review	• Adds further detail to clarify to the specific elements related to access to services that plans are expected to review on a quarterly basis. • The amendment adds requirements for a health plan to review *network capacity, timely access, and network adequacy* requirements set forth in the Knox-Keene Act, to clarify the existing review requirement. The quarterly review applies to *advanced access* providers as well, if applicable.	• Current law does require plans to conduct a quarterly review of *accessibility, availability, and continuity of care* but is a general requirement. • The amendment adds specificity and additional components.
1300.67.2.2 (d)(2)(E)	PCP Advanced Access Programs	• Adds language to require plans to verify its advanced access programs at least once every three (3) years. • Adds provision for plans to require network providers written notice to the plan 30 calendar days following the date which the provider no longer provides advanced access appointments.	• Current law is silent as to the required interval for verification. • New notice requirement

Proposed Changes: *Regulatory Language*

Section	Area	Amended Provision	Impact
1300.67.2.2 (i)	Determining Compliance & Non-Compliance	• Sets forth factors for the DMHC to evaluate to determine whether a plan is non-compliant • Specifies that a plan's failure to report timely, accurate, or complete information in its TAR or ANR report could be a factor to demonstrate non-compliance • Allows for plans to implement a CAP prior to enforcement • Sets forth the types of non-compliant findings where enforcement action may be taken	• Current law does not specify the exact parameters for determining compliance & non-compliance or plan response options
1300.67.2.3	Timely Access Quality Assurance for MY 2021	• Specifies the quality assurance policies and procedures plans must have in place for Measurement Year 2021 • Tracking network capacity, conducting the annual ESS and PSS surveys, quarterly review and evaluation of accessibility, availability, and continuity of care, verifying advanced access programs, and PPO monitoring process.	• New provision applicable to MY 2021 only.

Proposed Changes: *Timely Access and Annual Network Submission Instruction Manual*

Page #	Area	Amended Provision	Impact
4-9	Definitions	• Adds a "Definitions" section to define key terms used in the Manual. • Goal: to ensure that health plans use consistent terminology while reporting required information and data to the DMHC, resulting in comparable reports.	• Generally, codifies terminology from existing documents or cross-references to statutory provisions.
4	Definitions: "Accepting New Patients"	• "Accepting new patients" means the network provider's practice is open to establish patient care with enrollees who are not currently patients • The definition includes four (4) criteria elements which must *all apply* to classify the provider as meeting the definition: (1) open in all product lines using the network; (2) open to new patient appointments within the same appointment timeframes as existing patients; (3) provider notified plan he/she is accepting new patients and is listed in the directory; (4) practice does not limit accessibility through a waitlist for new patients only.	• Adds more detail to the current definition to provide further clarification for this field on the ANR forms.

Proposed Changes: *Timely Access and Annual Network Submission Instruction Manual*

Page #	Area	Amended Provision	Impact
8	"Network Tier"	• "Network tier" means a set of network providers made available at the same cost-share level, within a tiered network. A network tier does not include providers accessible to enrollees through an out-of-network benefit. • A "tiered network" means a network in which network providers in the same practice area of specialty or expertise are available to enrollees at different cost share levels.	• Provides further specificity for this required field in the ANR forms.
9	"Tertiary Services"	• "Tertiary services" means highly specialized or complex medical care performed by specialists and subspecialists, often using advanced technology in state-of-the-art facilities, including intensive care facilities, for patients with unusually severe, complex or uncommon health problems.	• Provides further specificity for this required field in the ANR forms.

Proposed Changes: *Timely Access and Annual Network Submission Instruction Manual*

Page #	Area	Amended Provision	Impact
9	"Unscheduled Urgent Services"	• "Unscheduled urgent services" means services available to enrollees on a same day, in-person unscheduled "walk-in basis" to diagnose and treat illnesses and injuries that, in accordance with clinical appropriateness requirements require care earlier than the scheduled appointment timeframes, or earlier than the actual appointment timeframes available to enrollees within the network. • Unscheduled urgent services shall include physician or non-physician providers who: (1) Provide urgent services which can reasonably be performed on an outpatient basis in a practitioner's office, urgent care facility or otherwise outside of the emergency room setting; (2) Have basic diagnostic services onsite, for use during the hours of operation; (3) Provide the unscheduled urgent services through expanded hours, or at a location with hours of operation outside of the traditional business hours of 89:00 a.m. to 5:00 p.m., Monday through Friday.	• Provides further specificity for this required field in the ANR forms.

Proposed Changes: *Timely Access and Annual Network Submission Instruction Manual*

Page #	Area	Amended Provision	Impact
5	Definitions: Grievance Complaint Categories	• Geographic Access • Language Assistance Plan • Language Assistance Provider • Office Wait Time • Provider Directory Error • Provider Not Taking New Patients • Telephone Access Plan • Telephone Access Provider • Timely Access • Timely Authorization	• Same categories but consolidated • No “other” option
23	Oversight of Plan-to-Plan Contracts	• Plans will be required to submit the filing number for the filing containing the health plan's policies and procedures setting forth the health plan’s oversight procedures for ensuring all subcontracted plans and other delegated entities comply with Rule 1300.67.2.2(c).	• New requirement

Proposed Changes: *Timely Access and Annual Network Submission Instruction Manual*

Page #	Area	Amended Provision	Impact
25	Prior Incidents or Patterns of Non-Compliance Not Previously Submitted	• Plans will be required to submit a description indicating whether the plan identified any incidents of noncompliance with the standards resulting in substantial harm to an enrollee, or patterns of non-compliance that occurred *in a prior measurement year* that were not previously submitted to the DMHC. • If identified, the plan will need to provide a description of the identified non-compliance, the health plan's responsive investigation, determination, and corrective action.	• New requirement to submit previously identified patterns and incidences of non-compliance • Tracking system will need to be implemented

Proposed Changes: *PAAS Manual*

Page #	Area	Amended Provision	Impact
5	Plan-to-Plan Contracts	a. <u>The Primary Plan Surveys Subcontracted Plan's Providers</u>: The Primary Plan surveys all providers and reports all data. b. <u>The Subcontracted Plan Surveys its Providers, and the Primary Plan Incorporates that Data into its Submission</u>: The Primary Plan submits separate Contact Lists and Raw Date Forms completed by the subcontracted plan and must ensure the accuracy of the subcontracted Plan's data. The Primary Plan shall include the results for the subcontracted Plan's providers on its own Results Report Form that includes results from all of the Primary Plan's other networks.	• Current methodology allows a primary plan to delegate TAR and ANR reporting responsibilities to its subcontracted plan(s) (and incorporate by reference) • Here, the primary plan is the reporting health plan and is responsible for submitting all TAR and ANR data, including information from its subcontracted plan.

Proposed Changes: *PAAS Manual*

Page #	Area	Amended Provision	Impact
6	Provider Survey Types: SCP	• Cardiovascular Disease: Cardiovascular Disease and Pediatric Cardiology • **Dermatology: Dermatology and Pediatric Dermatology** • Endocrinology: Endocrinology and Pediatric Endocrinology • Gastroenterology: Gastroenterology and Pediatric Gastroenterology • **Neurology: Epilepsy, Neurology, and Pediatric Neurology** • **Oncology: Oncology and Pediatric Hematology/Oncology** • **Ophthalmology: Ophthalmology** • **Otolaryngology [ENT]: Otolaryngology and Pediatric Otolaryngology** • **Pulmonology: Pediatric Pulmonology and Pulmonology** • **Urology: Urology and Pediatric Urology**	• 7 new specialty provider types added to the providers to be surveyed during the PAAS • These provider types have never been part of the PAAS before so substantial provider education will be required.

Proposed Changes: *PAAS Manual*

Page #	Area	Amended Provision	Impact
9	Deduplication: FQHC/RHC	• FHQC/RHC Deduplication Fields: 1. FQHC/RHC Name 2. County 3. Network Name	• Removed NPI as deduplication field for FQHC/RHCs
12	Centralized Survey Administration	• Specifies the process to use if a single survey administrator is used by multiple health plans to apply the survey response across all applicable health plan networks. • Requires participating plans to ensure certain elements have been met in the process.	• Previously addressed in the FAQs only but not in the Methodology.

Proposed Changes: *PAAS Manual*

Page #	Area	Amended Provision	Impact
13	Engage in Provider Outreach	• Adds required notice elements to be included in the PAAS provider outreach if a Plan decides to send this optional outreach communication prior to administering the PAAS survey. • Elements are similar to the current permissive elements; but now all are required if a plan chooses to send the communication.	• Current Methodology states that plans "may" include various factors in the outreach communication.
19	Non-Responding Provider Timeframe	• If the plan was unable to initiate a telephonic survey of the provider within *business days 6-15* after sending the survey invitation via email, electronic communication, or fax, the provider shall be recorded on the Raw Data Report Form as a non-responder and replaced with a provider from the oversample.	• Current Methodology uses a 10-business-day time frame. • This change is beneficial to compliance rates.

Proposed Changes: *PAAS Manual*

Page #	Area	Amended Provision	Impact
20	Non-Qualified Advanced Access Providers	• Provides a structure for plans to verify its advanced access program. • If the health plan uses the PAAS to conduct the verification of an advanced access program, the health plan shall not identify these providers as qualified advanced access providers in the "Qualified Advanced Access Providers" field on its PAAS Report Forms, and the health plan shall not automatically deem those advanced access Primary Care Providers compliant. • Plans may use the PAAS data in two (2) years following the PAAS to verify advanced access, if the plan has independently assessed compliance previously.	• Specifies that plans may not use the PAAS to verify advanced access providers until 2 years after independent assessment. • Sets forth the steps for plans to assess advanced access providers.
22	Outgoing Survey Call Times	• Specifies that outgoing survey calls shall be conducted from 8:00am – 5:00pm, Pacific Time.	• Current law states that calls should be conducted during "normal business hours"

Proposed Changes: *PAAS Manual*

Page #	Area	Amended Provision	Impact
24	Calculating Appointment Wait Times: Urgent Care	• Where an urgent care appointment wait time standard expires on a weekend or holiday, the provider shall be recorded as compliant on the Raw Date Report form if the provider has an appointment available during the next business day.	• Current Methodology is silent regarding this nuance. This is a beneficial change.
25	Calculating Appointment Wait Times: Non-Urgent Care	• The proposed Methodology mirrors the business day timeframes from the law. • Example: 10 business days (rather than 14 calendar days) for PCP appointment wait times.	• Current Methodology requires plans to use calendar days to calculate rates of compliance.
31	Results Data: Patterns of Non-Compliance	• Plans must review the rates of compliance in the Summary of Rates of Compliance Tab to identify any patterns of non-compliance (PNC). If a PNC is identified, the plan must submit in its annual TAR information on the steps the plan intends to take to correct.	• Current Methodology does not include a specific requirement to review the ROC Tab to identify PNCs.

Proposed Changes: *PAAS Manual*

Page #	Area	Amended Provision	Impact
41	PAAS Survey Tool: Electronic Script	• Removes the following language in the initial contact information validation portion: "The provider does not provide ~~[insert type of provider being surveyed]~~ appointments."	• Beneficial change. This level of detail has caused provider confusion in the past and may help to reduce the "Ineligible Provider" count.
41	Telehealth	• Adds the following instruction: "If appointment wait times depend upon whether the appointment is in-person or telehealth, use the earlier appointment date and time (shorter duration time).	• Beneficial change. Allows for a telehealth appointment to meet the time-elapsed standards even if a provider is not officially designated as a "telehealth provider".

Proposed Changes: *PAAS Template Instructions*

Template	Field	Amended Provision	Impact
Contact List	Subcontracted Plan Information	• Subcontracted Plan License Number • Subcontracted Plan Network ID	• Newly required information
Contact List	Displayed in Provider Directory	• Y/N	• Newly required information
Contact List	Telehealth	• Y/N	• No longer included

Proposed Changes: *PAAS Template Instructions*

Template	Field	Amended Provision	Impact
Raw Data Template	Wave	• Identify whether the provider was included in the survey as part of the first or second wave using the following values: "Wave One" and "Wave Two."	• Newly required information
Raw Data Template	Date Survey Initiated	• Enter the date the survey was initiated	• Newly required information • Will allow the DMHC and validators to assess compliance with fielding timeframes.

Timelines and Implementation Timeframes

Calendar Year	Date(s)	Activity Type	Activity
2021	March 31, 2021	TAR & ANR	Filings Due (using current process/templates): • MY 2020 Timely Access Report • 2021 Annual Network Review Report
2021	April 1 – December 31, 2021	PAAS, ESS, PSS	Field MY 2021 Surveys (using current process/templates): • Provider Appointment Availability Survey (PAAS) • Enrollee Satisfaction Survey (ESS) • Provider Satisfaction Survey (PSS)
2021	Measurement Year 2021	TAR & ANR	Quality Assurance Process for MY 2021 • Develop and maintain policies specified under section 1300.67.3
2021	3 months following the regulation effective date	TAR & ANR	Amendment Filing • File an amendment disclosing how the plan will achieve compliance with the requirements of the new regulation, including revised policies & procedures

Timelines and Implementation Timeframes

Calendar Year	Date(s)	Activity Type	Activity
2022	January 1, 2022	TAR & ANR	Effective date of many of the provisions in the regulation
2022	January 15, 2022	ANR	Network Capture Date for May 1, 2022 ANR Filing
2022	May 1, 2022	TAR & ANR	Filings Due: • MY 2021 Timely Access Report (using the December 31, 2020 Network Capture Date and 2021 process/templates) • 2022 Annual Network Review Report (using the January 15, 2022 Network Capture Date and new process/templates)
2022	June 1 – December 31, 2022	PAAS, ESS, PSS	Field MY 2022 Surveys (using new process/templates and January 15, 2021 Network Capture Date): • Provider Appointment Availability Survey (PAAS) • Enrollee Satisfaction Survey (ESS) • Provider Satisfaction Survey (PSS)

Timelines and Implementation Timeframes

Calendar Year	Date(s)	Activity Type	Activity
2023	May 1, 2023	TAR & ANR	Filings Due: • MY 2022 Timely Access Report (using the January 15, 2021 Network Capture Date and new process/templates) • 2023 Annual Network Review Report (using the January 15, 2023 Network Capture Date and new process/templates)
2023	June 1 – December 31, 2023	PAAS, ESS, PSS	Field MY 2023 Surveys (using new process/template and January 15, 2022 Network Capture Date): • Provider Appointment Availability Survey (PAAS) • Enrollee Satisfaction Survey (ESS) • Provider Satisfaction Survey (PSS)

CAHP Comments

The California Association of Health Plans (CAHP) submitted hundreds of very detailed comments to the DMHC on behalf of its partner plans in both the First and Second Comment Periods.

The CAHP comments are segmented by:

- Regulation
- Instruction Manual
- PAAS Manual
- Templates

The next slide captures the points highlighted as significant issues in the Cover Letter accompanying CAHP's Second set of Comments.

CAHP Comments

Revised Definition of Pattern of Non-Compliance

- CAHP recommended that a pattern of non-compliance should be only established by measuring against a threshold standard at a network level, as described in 1300.67.2.2.(b)(12)(A) and commented that consideration of individual “instances” sets an ambiguous and arbitrary standard for compliance.
- The DMHC had previously shared with the plans that the rate of compliance for urgent appointments would be 60% and 70% for non-urgent appointments based upon binomial modeling. The proposed regulation applies the 70% threshold to both appointment types rather than to just the non-urgent appointment type.

American Board of Medical Specialties (ABMS)

- CAHP recommended that the DMHC add clarifying language in this section to clearly indicate that the ABMS designations are not an exhaustive list of board certifications for the specialty types and are only provided as an example.

Enrollee Experience Survey

- CAHP recommended revising this provision to allow an option to provide oral interpretation or to inform the member of the availability and access of these services by the Plan rather than proactively translating the ESS into the member’s preferred language.

Telehealth

- CAHP recommended the Telehealth Report Form should be limited to only those providers who provide services solely via telehealth to reduce provider abrasion from duplicative surveying.

Conclusion and Next Steps

Reminder:

- The DMHC states that it will be amending the proposed regulation during a third comment period. *This presentation is based on the version of the proposed regulation issued on December 4, 2020.*
- The DMHC anticipates submitting the final rulemaking package to the Office of Administrative Law (OAL) during the second quarter of 2021 (by June 2021).

Resources

- Timely Access to Non-Emergency Services - Proposed Regulation

Upcoming QMetrics Activities

- **FREE Consultation on how QMetrics can assist your organization in implementing the new Regulation @ Sbaker@qmetrics.us**
- **NEW! Subscribe to our Regulatory Compliance Newsletter!**
  - Email Sbaker@qmetrics.us to receive Stacy's bi-annual Newsletter or click here to sign up!

March 2021

- Sponsor for CAHP Timely Access Webinar

April 2021

- QMetrics Virtual PAAS Summit – April 2021
  - The State of Access
  - Improving Response and Compliance Rates
  - Strategies to Improve Provider Engagement and Reduce Abrasion

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THANK YOU

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