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

(12/4/20 Version)

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Agenda

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- **Background and Purpose of the Proposed Regulation**
- **Components of the Proposed Regulation**
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  - Provider Appointment Availability Survey (PAAS) Manual and Survey Tool
  - Timely Access and Annual Network Submission Instruction Manual
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About QMetrics

- We are an independent audit and consultancy organization founded in 2006 by Chief Executive Officer Suzan Mora Dalen.
- We place a high emphasis on diversity, quality, accuracy, efficiency, and innovation. We are unique in our ability to tailor our solutions to the needs of our clients, trusted partners and stakeholders while allowing us to build long standing relationships.
- We do not just check a box for completion, we “think outside the box” and go above and beyond the scope of work to provide maximum value.
- Our team has over three decades of experience working in health care, including leadership positions in managed care, working for and consulting with large multi-state Payor and Provider organizations, overseeing and auditing health plans, providers, and health information exchange (HIE) organizations.
- 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.

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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

- Out 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.

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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 regulations
    - 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).

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.

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 (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 Changes to Current Requirements

Patterns of Non-Compliance

- 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 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 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 had an appointment within the time elapsed standards as calculated during the PAAS for the applicable Measurement Year • 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 to satisfy the EES requirement. • Plans will be required to field a separate ESS. • Plans will be required to translate the ESS.

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 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 which are not clearly captured in current law
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 (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 • Allow for plan CAP process • 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: *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 • Allow for plan CAP process • 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
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	• 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 so, 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
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: 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 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	• Newly required information

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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 effective date (unclear if this refers to the date the regulation is adopted by the OAL or the 1/1/2022 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	Regulation effective date (generally)
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

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.

Upcoming QMetrics Activities

March 2021

- Sponsor for CAHP Timely Access Webinar

April 2021

- QMetrics Virtual PAAS Summit

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