



# **Reporting Year 2024/ Measurement Year 2023 Provider Appointment Availability Survey Manual**

**(Revised December 21, 2022)<sup>1</sup>**

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<sup>1</sup> Revised pursuant to the authority set forth in Health and Safety Code section 1367.03(f)(3).

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

**DEPARTMENT OF MANAGED HEALTH CARE  
PROVIDER APPOINTMENT AVAILABILITY SURVEY MANUAL**

Table of Contents

Introduction to the Provider Appointment Availability Survey ..... 3

    Step 1: Determine the Networks Required to be Surveyed (Rule 1300.67.2.2(f)(1)(A))....4

    Step 2: Complete a Contact List Report Form for Each of the Applicable Provider Survey  
    Types (Rule 1300.67.2.2(f)(1)(B)) .....5

    Step 3: Determine Sample and Oversample Size (Rule 1300.67.2.2(f)(1)(C)-(D)) .....10

    Step 4: Select Random Samples (Rule 1300.67.2.2(f)(1)(D))..... 11

    Step 5: Engage in Provider Outreach ..... 13

    Step 6: Prepare Survey Questions (Rule 1300.67.2.2(f)(1)(E)) .....14

    Step 7: Administer Survey (Rule 1300.67.2.2(f)(1)(F)-(G)) ..... 15

    Step 8: Calculate Appointment Wait Times and the PAAS Results (Rule  
    1300.67.2.2(f)(1)(G)-(H))..... 24

    Step 9: Create Quality Assurance Report (Rule 1300.67.2.2(f)(1)(J) and (f)(3)-(4)) ..... 35

    Step 10: Submit the Health Plan’s Timely Access Compliance Report (Rule  
    1300.67.2.2(f)(1)(K) and (h)).....39

Appendix 1: Sample Size Chart ..... 40

Appendix 2: Survey Tool .....43

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

**Introduction to the Provider Appointment Availability Survey**

1. The Provider Appointment Availability Survey (PAAS) Methodology is set forth in this Manual and in the PAAS Report Form Instructions section of the Timely Access and Annual Network Submission Instruction Manual. The PAAS Methodology was developed by the Department of Managed Health Care (Department) in collaboration with health care service plans (health plans), providers, consumer advocates, and other stakeholders pursuant to Health and Safety Code section 1367.03(f)(3), set forth in the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act).<sup>2</sup>

2. The Knox-Keene Act requires that health plans maintain networks sufficient to meet urgent care and non-urgent appointment availability standards, which include specific appointment wait time standards set forth in section 1367.03(a)(5) and Rule 1300.67.2.2(c)(5) (time-elapsed standards) under which enrollees are able to obtain an appointment. The PAAS Methodology is designed for health plans<sup>3</sup> to measure the ability of health plan networks to deliver timely appointments to enrollees. Using the PAAS Methodology, a health plan contacts either all network providers<sup>4</sup> or a random sample of providers in their network to request the next available appointment. The providers' responses to these survey questions are measured against the appointment time-elapsed standards. The health plan calculates the results of the survey and submits the survey data and results to the Department as part of the health plan's annual Timely Access Compliance Report. The health plan shall include the information set forth in Rule 1300.67.2.2(h)(6)(C) in the health plan's submission if any patterns of non-compliance, as defined in Rule 1300.67.2.2(b)(12)(A), were identified in the results of the PAAS, in the "Rate of Compliance Urgent Care Appointments (All Providers Survey Types)" field and the "Rate of Compliance Non-Urgent Appointments (All Provider Survey Types)" field set forth on the Summary of Rates of Compliance Tab of the Results Report Form.

3. The health plan's Timely Access Compliance Report, including the completed PAAS Report Forms for each of the applicable Provider Survey Types, shall be submitted through the Department's web portal no later than May 1<sup>st</sup> of each year, pursuant to Rule 1300.67.2.2(h)(1)(A). The Department's PAAS Report Forms are listed below:

- a. Primary Care Providers Contact List Report Form (Form No. 40-254);
- b. Non-Physician Mental Health Care Providers Contact List Report Form (Form No. 40-255);
- c. Specialist Physicians Contact List Report Form (Form No. 40-256);
- d. Psychiatrists Contact List Report Form (Form No. 40-257);
- e. Ancillary Service Providers Contact List Report Form (Form No. 40-258);
- f. Primary Care Providers Raw Data Report Form (Form No. 40-259);

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<sup>2</sup> California Health and Safety Code sections 1340 et seq. (the "Knox-Keene Act"). References herein to "section" are to sections of the Knox-Keene Act. References to "Rule" refer to the regulations promulgated by the Department under title 28 of the California Code of Regulations.

<sup>3</sup> All references to health plan(s) in the PAAS Manual shall refer to reporting plan(s), as defined in Rule 1300.67.2.2(b)(17), unless otherwise indicated.

<sup>4</sup> All references to provider(s) in the PAAS Manual shall refer to network provider(s), as defined in Rule 1300.67.2.2(b)(10), unless otherwise indicated.

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

- g. Non-Physician Mental Health Care Providers Raw Data Report Form (Form No. 40-260);
- h. Specialist Physicians Raw Data Report Form (Form No. 40-261);
- i. Psychiatrists Raw Data Report Form (Form No. 40-262);
- j. Ancillary Service Providers Raw Data Report Form (Form No. 40-263); and
- k. Results Report Form (Form No. 40-264), which includes the following:
  - 1. Primary Care Providers Results Tab;
  - 2. Non-Physician Mental Health Care Providers Results Tab;
  - 3. Specialist Physicians Results Tab;
  - 4. Psychiatrists Results Tab;
  - 5. Ancillary Service Providers Results Tab<sup>5</sup>;
  - 6. Summary of Rates of Compliance Tab; and
  - 7. Network by Provider Survey Type Tab.

4. Health plans shall complete these report forms and submit to the Department the Timely Access Compliance Report in accordance with this manual and the PAAS Report Form Instructions set forth in the Timely Access and Annual Network Submission Instruction Manual (Report Form Instructions).

**Adherence to the PAAS Manual**

5. Health plans shall adhere to the PAAS Methodology in administering the PAAS and reporting the information to the Department on the PAAS Report Forms.

**Step 1: Determine the Networks Required to be Surveyed (Rule 1300.67.2.2(f)(1)(A))**

6. Unless otherwise specified, health plans shall survey all networks, as defined in Rule 1300.67.2.2(b)(5). Health plans shall report a percentage of providers with an appointment available within each of the time-elapsd standards for each county in each network (County/Network) for each Provider Survey Type.<sup>6</sup> The percentage of providers with an appointment within each of the time-elapsd standards shall be reported for each county in the health plan's network service area and for all counties adjacent to the health plan's network service area in which providers are located.

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<sup>5</sup> The Primary Care Providers Results Tab, Non-Physician Mental Health Care Providers Results Tab, Specialist Physicians Results Tab, Psychiatrists Results Tab, and Ancillary Service Providers Results Tab are collectively referred to as the "Results Tab" throughout the PAAS Manual.

<sup>6</sup> Health plans shall treat "Telehealth" as a single virtual county for the purpose of this Methodology. Health plans shall survey providers within each network in the telehealth virtual county in the same manner as all other County/Networks. Providers who offer only telehealth appointments shall be included in the telehealth virtual county. Providers who offer both in-person appointments and telehealth appointments for a practice location shall only be included in the physical county they offer in-person appointments. (See paragraph 9 below and the PAAS Report Form instructions in the Timely Access and Annual Network Submission Instruction Manual for additional details regarding reporting the Telehealth virtual county.)

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

7. Health plans are not required to survey or report a rate of compliance for networks exclusively serving Medicare Advantage, Medi-Medi Plans,<sup>7</sup> or Employee Assistance Program enrollees, unless that network also serves other product lines that are subject to Timely Access Compliance Report requirements. Health plans shall report rates of compliance for all other Knox-Keene Act-regulated networks.

**Plan-to-Plan Contracts**

8. When a primary plan's network contains providers that are made available through a plan-to-plan contract with a subcontracted plan, the primary plan shall report all required data for the providers made available through the plan-to-plan contract on the primary plan's PAAS Report Forms, in accordance with the requirements set forth in Rule 1300.67.2.2(h)(3) and the Timely Access and Annual Network Submission Instruction Manual. (See Rule 1300.67.2.2(b)(13).) The primary plan shall report on its PAAS Report Forms data for those providers who are available through a plan-to-plan contract by either:

- a. **The Primary Plan Surveys Subcontracted Plan's Providers:** The primary plan shall determine the required sample size (or conduct a census), select the providers required to be surveyed, and survey all providers selected to be surveyed for each network, including providers available through a plan-to-plan contract. The primary plan shall report data for all providers, including those providers made available through the plan-to-plan contract, in its Contact List Report Forms and Raw Data Report Forms, and report required data for all providers on the Results Report Form; or
- b. **The Subcontracted Plan Surveys its Providers, and the Primary Plan Incorporates that Data into its Submission:** The primary plan shall submit separate Contact List Report Forms and Raw Data Report Forms completed by the subcontracted plan that include only those providers made available through the plan-to-plan contract. The primary plan shall ensure that required sample sizes are calculated separately for those providers included in the primary plan's network through the plan-to-plan contract (i.e., providers available through a plan-to-plan contract shall be treated as a separate network for purposes of calculating required sample sizes). The primary plan shall perform the necessary calculations and include the results for the subcontracted plan's providers on its Results Report Form that includes results for all the primary plan's other networks. The primary plan shall report results from those providers who are available through a plan-to-plan contract by using the "Subcontracted Plan ID" and "Subcontracted Plan Network ID" fields.

**Step 2: Complete a Contact List Report Form for Each of the Applicable Provider Survey Types (Rule 1300.67.2.2(f)(1)(B))**

9. The Contact List Report Form is used as the source to calculate the required sample size and select a random sample of the health plan's providers to survey for each

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<sup>7</sup> On January 1, 2023, the Cal MediConnect program is transitioning to Medi-Medi Plans (MMPs). MMPs is the California-specific program name for Exclusively Aligned Enrollment Dual Eligible Special Needs Plans (EAE D-SNPs).

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

County/Network. The health plan shall include on the Contact List Report Form all providers meeting each of the following requirements:

- a. The provider is a network provider as defined in Rule 1300.67.2.2(b)(10);
- b. The provider participates in the health plan's network as of the network capture date. The network capture date shall be a single date selected by the health plan that occurs on or after January 15 of the measurement year, but no later than the date the health plan begins conducting the survey.<sup>8</sup> A health plan shall select a single network capture date for all Contact Lists Report Forms. The network capture date selected by the health plan shall:
  - i. Allow the health plan to adhere to all requirements in the PAAS Manual;
  - ii. Be a date as close to administration of the survey as practical; and
  - iii. Ensure the Contact List is accurate and representative of the network at the time the survey is administered.<sup>9</sup>
- c. The provider either:
  - i. Offers telehealth services only;<sup>10</sup> or
  - ii. Is located and offers in-person appointments either (1) in any county within the health plan's approved network service area, or (2) in a county next to or adjoining a county in the health plan's network service area.<sup>11</sup> Where the health plan has a partial county as its approved network service area, the health plan shall include all providers located in the county regardless of whether the provider is located outside of the approved network service area;
- d. The provider delivers health care services through enrollee appointments;
- e. The provider delivers health care services within one or more of the five Provider Survey Types set forth below:

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<sup>8</sup> The following example illustrates how the survey is administered during the measurement year and submitted the following year: The health plan shall include on the Contact List Report Forms all network providers meeting the criteria set forth in paragraph 9 that were in the health plan's network on the network capture date. The health plan will use the Contact List Report Forms to identify the providers it will survey from June 1 – December 31 of that same year. The health plan will then record the outcomes of the survey on the Raw Data Report Forms and complete the Results Report Form. The health plan then submits the PAAS Report Forms to the Department by May 1 of the year following administration of the survey (i.e., MY 2023 PAAS Report Forms are submitted May 1, 2024).

<sup>9</sup> For example, if a significant number of providers will no longer be in network when the survey is administered because a provider group or plan-to-plan contract is terminating, the health plan should select a network capture date after the termination of the contract.

<sup>10</sup> The Contact List and Raw Data Report Forms require health plans to create a row for each network provider who exclusively offers telehealth appointments with "NA" in the Address, City, State, and ZIP Code fields. The health plan shall enter "Telehealth" into the County field of a network provider who exclusively offers telehealth appointments.

<sup>11</sup> If a provider offers both in-person and telehealth appointments at a practice location, do not include the provider in the "Telehealth" county. If selected to be surveyed, a provider who offers appointments in-person and via telehealth at a location may respond with the next available appointment regardless of the appointment modality.

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

**Provider Survey Types**

- i. Primary Care Providers:
  - 1) Primary Care Physicians; or
  - 2) Non-Physician Medical Practitioners providing primary care<sup>12</sup>
- ii. Non-Physician Mental Health Care (NPMH) Providers:
  - 1) Licensed Professional Clinical Counselor (LPCC);
  - 2) Psychologist (PhD-Level);
  - 3) Marriage and Family Therapist;
  - 4) Licensed Marriage and Family Therapist;
  - 5) Master of Social Work; or
  - 6) Licensed Clinical Social Worker.
- iii. Specialist Physicians, who practice in one or more of the following specialties or subspecialties<sup>13</sup>:
  - 1) Cardiovascular Disease: Cardiovascular Disease and Pediatric Cardiology;
  - 2) Dermatology: Dermatology and Pediatric Dermatology;
  - 3) Endocrinology: Endocrinology and Pediatric Endocrinology;
  - 4) Gastroenterology: Gastroenterology and Pediatric Gastroenterology;
  - 5) Neurology: Epilepsy, Neurology, and Pediatric Neurology;
  - 6) Oncology: Oncology and Pediatric Hematology/Oncology;
  - 7) Ophthalmology: Ophthalmology;
  - 8) Otolaryngology: Otolaryngology and Pediatric Otolaryngology;
  - 9) Pulmonology: Pediatric Pulmonology and Pulmonology; or
  - 10) Urology: Urology and Pediatric Urology.
- iv. Psychiatrists, who practice in one or more of the following specialties or subspecialties:
  - 1) Psychiatry;
  - 2) Addiction Psychiatry;
  - 3) Child and Adolescent Psychiatry; or
  - 4) Geriatric Psychiatry.

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<sup>12</sup> Primary Care Physicians may include Family Practice, General Practice, Pediatrics, OB/GYN, or Internal Medicine Physicians. For other specialty types, the health plan shall include only those providers that have agreed to serve as a primary care provider for the health plan. Primary Care Providers include non-physician medical practitioners who are physician assistants and/or nurse practitioners performing primary care services in compliance with Chapter 7.7 (commencing with section 3500) of Division 2 of the Business and Professions Code and/or nurse practitioners performing primary care services pursuant to Chapter 6 (commencing with section 2700) of Division 2 of the Business and Professions Code.

<sup>13</sup> Unless otherwise specified, “specialty” and “subspecialty” are defined in the definition section of the Timely Access and Annual Network Submission Instruction Manual.

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

- v. Ancillary Service Providers, which are facilities or entities providing:<sup>14</sup>
- 1) Mammogram appointments; or
  - 2) Physical therapy appointments.

10. The Department published a separate Contact List Report Form, enumerated in paragraph 3a-e, for each of the five Provider Survey Types set forth above. The health plan shall use the Report Form Instructions to complete a separate Contact List Report Form for each of the relevant Provider Survey Types. The health plan shall include:

- a. All Primary Care Providers into a single Primary Care Provider Contact List Report Form;
- b. All Non-Physician Mental Health Care Providers in a single Non-Physician Mental Health Care Providers Contact List Report Form;
- c. All Specialist Physicians into a single Specialist Physicians Contact List Report Form;
- d. All Psychiatrists into a single Psychiatrists Contact List Report Form; and
- e. All Ancillary Service Providers into a single Ancillary Service Providers Contact List Report Form.

11. If the health plan elects to use option (b) in paragraph 8 to report PAAS results for providers made available through a plan-to-plan contract, the health plan shall submit separate Contact List Report Forms and Raw Data Report Forms for providers made available through each plan-to-plan contract.

12. To obtain a sufficient number of responses to the survey, health plans shall ensure that the information in the Contact List is complete and accurate. For further information in the creation of the five required Contact List Report Forms, review the Report Form Instructions for each Contact List Report Form in the Timely Access and Annual Network Submission Instruction Manual.

### **Federally Qualified Health Centers and Rural Health Clinics**

13. Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC) shall be included on the Contact List Report Form and surveyed without regard to the availability of any individual provider.<sup>15</sup> The Survey Tool requires that the health plan inquire about the next available appointment at the FQHC/RHC. Only the name of the FQHC/RHC may be used in administering the survey.

14. The telephone, fax, and email address included in the working copy of Contact List Report Form that is used to administer the survey shall be associated with only the FQHC/RHC. In order to avoid surveying individual providers to assess availability at each FQHC/RHC, the health plan shall not include individual provider names, telephone

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<sup>14</sup> Ancillary service providers on the Contact List shall only include facilities or entities; do not include individual persons providing ancillary services on the Contact List.

<sup>15</sup> Welfare and Institutions Code section 14087.325(b) requires that enrollees be “assigned directly to the federally qualified health center or rural health clinic, and not to an individual provider performing services on behalf of the federally qualified health center or rural health clinic.”



**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

numbers, fax numbers, and email addresses associated with FQHCs/RHCs in the Contact List Report Form.

**Identify Unique Providers on the Contact List Report Form**

15. Unique providers are those provider records remaining in each Contact List Report Form after all duplicate records have been identified. Duplicate records are entries in which the same provider appears more than once in a single county for a single network.

16. A Contact List Report Form may include providers with duplicate records representing data variation (e.g., additional addresses, specialties, etc. may require the health plan enter duplicate records to ensure its Contact List Report Form is complete). As a result, unique providers shall be identified on the Contact List Report Form prior to conducting the random sample selection process.

17. To ensure that each provider has an equal chance of being selected to be surveyed during the random sample selection process, the health plan shall select a random sample of providers only from the providers that have been identified as unique providers. Identify unique providers and duplicate records for each of the five Provider Survey Types using all of the following fields:

**Individual Providers:**

- a. Last Name;
- b. First Name;
- c. National Provider Identifier;
- d. County; and
- e. Network Name.

**FQHC/RHC:**

- a. FQHC/RHC Name;
- b. County; and
- c. Network Name.

**Ancillary Service Providers:**

- a. Entity or Facility Name;
- b. National Provider Identifier;
- c. County; and
- d. Network Name.

18. Unique providers and duplicate records shall be identified in the “Unique Provider” field of the Contact List Report Forms. For each unique provider, there shall be exactly one record marked “Y.” In the “Unique Provider” field enter:

- a. “Y” to indicate that the record represents a unique provider.
- b. “N” to indicate that the record is a duplicate.

There may be multiple duplicate records marked “N” in the “Unique Provider” field for a single provider. Duplicate records marked “N” shall be excluded from consideration when selecting a random sample of providers to survey.

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

19. Any corrections to the data on Contact List Report Forms that affect the identification of duplicate records, such as slight name corrections, shall also be corrected on the PAAS Report Forms submitted to the Department.

**Step 3: Determine Sample and Oversample Size (Rule 1300.67.2.2(f)(1)(C)-(D))**

**Determine the Sample Size**

20. This methodology ensures that an appropriate number of providers for each County/Network are surveyed to produce statistically reliable and comparable results across all health plans, in accordance with the requirements in section 1367.03(f)(2). The number of providers that a health plan is required to obtain valid survey responses for each County/Network (required sample size) shall be determined by the health plan, separately for each of the five Provider Survey Types, by using the Sample Size Chart set forth in Appendix 1. A valid survey response shall be identified in the Raw Data Report Forms in the “Outcome” field as “Eligible – Completed Survey.”

21. For each of the five Provider Survey Types in each County/Network, the health plan shall either survey:

- a. A random sample of unique providers until the required sample size has been met (random sample); or
- b. All unique providers in the County/Network (census).

22. The health plan shall determine the number of unique providers for each Provider Survey Type in each County/Network on the Contact List Report Form. The health plan shall use this number and the Sample Size Chart in Appendix 1 to determine the appropriate sample size for each Provider Survey Type in each County/Network. The health plan shall obtain a sufficient number of valid survey responses to meet the sample size regardless of whether the health plan elects to survey a random sample or census. The failure to meet the required sample size may result in the Department taking disciplinary action against the health plan. (Rule 1300.67.2.2(j).)

23. A health plan may choose to survey a sample larger than what is required on the Sample Size Chart (e.g., survey additional providers for internal quality assurance processes, etc.). However, a health plan shall include data and results on its Raw Data Report Forms and Results Report Forms only for 1) all providers in the County/Network (census), or 2) the number of providers required to meet the required sample size, as identified in the Required Sample Size column in the Sample Size Chart set forth in Appendix 1. Where census is used, all providers in the County/Network will be surveyed, and the oversample selection process set forth in paragraphs 24-26 is not applicable.

**Determine the Oversample Size for Replacements**

24. In order to ensure that it will meet required sample sizes, a health plan that uses the random sampling approach shall also use an “oversample.” An “oversample” is a randomly selected group of providers that will replace providers who were selected to be surveyed as part of the random sample, but who cannot be included in the survey because the provider is ineligible to participate, or because the provider is determined to be a non-responding

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

provider. As noted in paragraph 26 below, the size of the oversample used by the health plan shall include all providers within the County/Network for a Provider Survey Type or be of sufficient size to allow for replacement of all ineligible and all non-responding providers. (Paragraphs 58-61 contain additional information related to non-responding providers and ineligible providers.)

25. The health plan is required to obtain the number of valid survey responses sufficient to meet the required sample size, as identified in Appendix 1, regardless of whether a random sample or census is surveyed. (See paragraphs 59-60 for information related to ineligible providers.) Obtaining a sufficient number of valid survey responses to meet the required sample size ensures that the health plan's reported rates of compliance are representative of the network, statistically reliable, and comparable with all other health plan survey results. The health plan shall obtain valid survey responses to reach the required sample size in each County/Network for each of the five Provider Survey Types. Ineligible or non-responding providers shall be replaced with another provider, if available in the County/Network, in order to meet the required sample size. To identify whether a provider is required to be replaced, review the Replacements of Non-Responding and Ineligible Providers section in paragraphs 58-61 below.

26. The health plan shall select an oversample of each Provider Survey Type for the County/Network using the random sample selection process. The size of the oversample shall be sufficient to replace all non-responding and ineligible providers necessary to meet the required sample size. If all providers in the initial oversample are used as replacements (the oversample is exhausted), and additional providers remain in the County/Network, use this same process to add additional providers of that same Provider Survey Type to the oversample. The health plan shall continue to add providers to the oversample using the random sample selection process until either the required sample size is reached, or all providers within the County/Network for the applicable Provider Survey Type have been contacted.

**Step 4: Select Random Samples (Rule 1300.67.2.2(f)(1)(D))**

27. Once the appropriate sample and oversample size for each Provider Survey Type in each County/Network has been determined, use the random sample selection process described below to identify which providers to survey and include in the Raw Data Report Form from the health plan's working copy of the Contact List Report Form. To sort the Contact List Report Form in a random order and select the providers that are required to be surveyed, the health plan shall perform the following actions:

- a. Assign a random number to each unique provider on the health plan's Contact List Report Form;
- b. Sort each Contact List Report Form by the random number within each County/Network by each Provider Survey Type;
- c. Starting with the first unique provider, as defined in paragraphs 15-19, in each of the randomly sorted Contact List Report Forms, select the required number of unique providers in the sample and oversample for the largest network in each county. (See Step 3: Determine Sample and Oversample Size for further instructions.); and

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

- d. If there is only one health plan network in the county, move to Step 5: Engage in Provider Outreach.

28. The health plan may use Excel, SAS, or other software to assign a random number and to complete the random sample selection process.

**Counties with Multiple Networks**

29. The process used to sample multiple networks is designed to sample the smallest number of providers needed to produce results for all networks. A health plan with multiple networks in a single county shall use the process described above to select a random sample from the network in the county. A health plan may begin with the network with the largest number of providers in a county for efficiency.

30. Once the first sample is selected, use the First Name, Last Name, FQHC/RHC Name, NPI, and County fields to identify whether the provider participates in other networks the health plan maintains in that same county. For Ancillary Service Providers, use the Entity or Facility Name, FQHC/RHC Name, NPI, and County fields. Apply the providers sampled from the larger network to all of the smaller networks in which the sampled provider participates. The provider shall be surveyed only once; the provider's response shall be applied to the provider for all networks the provider is sampled until the sample size for the applicable network is met. No additional provider responses may be applied to a particular network once the required sample size has been met for that network.

31. Review each network by size to determine whether additional providers need to be sampled to meet the required sample size. If so, select additional unique providers from that network on the randomly-sorted Contact List Report Form and apply these providers to all smaller networks in the county. This process will continue until a sufficient sample is identified for each Provider Survey Type in all Counties/Networks.

32. The health plan shall randomly select the providers included in the oversample for replacement of ineligible and non-responding providers by following the same random sample selection process, set forth in paragraphs 27-31.

**Centralized Survey Administration**

33. A centralized survey administration process reduces the number of times a provider is contacted. By identifying the overlap in providers who are contracted with multiple health plan networks, a single survey administrator may survey a provider once and apply the survey response across all applicable health plan networks. To conduct centralized survey administration, multiple health plans may use a single survey administrator to select and survey random samples of providers on behalf of all the health plans. The survey administrator selects the random sample of providers and administers the survey to those providers.

34. If a single survey administrator is used by multiple health plans, each participating health plan shall ensure that:

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

- a. All processes adhere to the PAAS Methodology, including identifying unique providers, and selecting and surveying a random sample of providers (if census is not used). The sampling process shall mirror the process for sampling across multiple networks in a single county, with sequential samples starting with the largest County/Network. The response of each provider sampled shall be applied to all networks (regardless of health plan) that the provider participates in, until the required sample size is met for each network. Once the required sample size has been met for a particular network, no additional provider responses may be applied to that network. A health plan shall not implement different sampling processes, unless all participating health plans have received prior approval from the Department through a material modification submitted to the Department, pursuant to section 1352(b);
- b. To the extent possible, each provider selected to be surveyed is surveyed only once (on behalf of all health plans participating in the centralized sampling process) in each county in which the provider practices;
- c. The results from each provider survey are used by the health plan only for the County/Network in which the provider is contracted;
- d. The health plan submits PAAS Report Forms containing data only for those providers who are network providers under that health plan's network as of the network capture date; and
- e. Each participating health plan shall adhere to all mutually agreed upon timelines and deliverables when participating in a centralized survey administration process so that the administration of the survey is not delayed and all requirements of the PAAS Manual and PAAS Report Form are met.

**Step 5: Engage in Provider Outreach**

35. In order to accurately report network performance across the time-elapsing standards, the health plan shall obtain survey responses from the required sample size of providers. Simple, strategic communications with health plan-network providers can yield a significant increase in response rates, putting the health plan (and its providers) in the best position to demonstrate compliance with time-elapsing appointment availability standards. The communications may focus on provider groups and Provider Survey Types that had high non-response rates in prior measurement years in order to ensure adequate responses to meet the required sample size.

36. If the health plan elects to send an outreach communication, the outreach communication shall clearly state that providers shall not respond directly to the Department, and shall, as applicable:

- a. Inform the provider who is administering the survey, what the survey is, why it is being done, the importance of the survey, how it is administered, and the types of questions that will be asked;
- b. Identify the date range during which the survey is likely to occur;
- c. Inform the provider that the rates of compliance and response rates will be part of publicly available information;

## **RY 2024/MY 2023 PAAS Manual**

(Revised December 21, 2022)

- d. Inform providers that they may participate in the survey through Manual or Electronic Extraction, set forth in paragraphs 43-45, to avoid providing this information through another survey mode; and
- e. Remind providers of any contractual obligations indicating that they shall furnish appointment availability information to the health plan. (See section 1367.03(f)(1).)

### **Step 6: Prepare Survey Questions (Rule 1300.67.2.2(f)(1)(E))**

37. The Department developed a standardized Survey Tool, set forth in Appendix 2, to be used in administering the PAAS. To ensure that survey results are comparable, as required by section 1367.03(f)(2), a health plan shall not amend the standardized questions set forth in the Survey Tool, except as permitted in paragraphs 38-39.

38. Health plans are permitted to revise the Survey Tool to:

- a. Make minor adjustments to the Survey Tool introductory language;
- b. Indicate that the provider is contractually required to furnish the requested information, if applicable;
- c. Incorporate additional survey questions; or
- d. Incorporate provider identification, verification items, and required provider contacts and notifications, including those set forth under section 1367.27.

39. A health plan may make the permissible revisions identified in paragraph 38 to the Survey Tool if all of the following conditions are met:

- a. All of the Department's PAAS Methodology is followed;
- b. The Department's questions, set forth in the Survey Tool, are included as a block at the beginning of the survey. No modifications can be made to the Survey Tool's standardized questions or the order of the questions;
- c. If a health plan includes additional questions in the Survey Tool, the responses from the questions may not be considered in determining the health plan's results, including the rate of compliance submitted to the Department;
- d. The resulting survey is not burdensome or decreases providers' willingness to respond;
- e. The additional questions are designed to ensure valid and reliable results are obtained;
- f. The data and responses for the Department's PAAS questions are transferred to the Department's PAAS Raw Data Report Form and Results Report Form;
- g. The contact and/or notification comply with all other requirements of the Knox-Keene Act; and
- h. Unless otherwise specified, any revisions to the Department's standardized Survey Tool are identified by track changes and filed as an Exhibit J-13 in the Department's eFiling system within 30 calendar days of the amendment, pursuant to section 1352(a) and Rule 1300.52(e), but no later than by May 1 of the measurement year.

40. A health plan may use software or a computer program for capturing survey data if all of the following requirements are met:

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

- a. The survey questions used to administer the survey are identical to the survey questions in the Survey Tool;
- b. The health plan captures the same data fields included in the Survey Tool; and
- c. The health plan populates all PAAS Report Forms in accordance with the PAAS Methodology and these documents are submitted in its Timely Access Compliance Report.

**Step 7: Administer Survey (Rule 1300.67.2.2(f)(1)(F)-(G))**

**Timeframes and Administration**

41. A health plan shall complete all surveys between June 1 through December 31 of each measurement year. To ensure the survey responses for each Provider Survey Type within a network are distributed in a manner that is representative over the timeframe of the survey, there are two options for administering the surveys. A health plan shall administer surveys using continuous survey administration and/or wave administration.<sup>16</sup>

**a. Continuous Survey Administration:**

- i. A health plan shall obtain valid survey responses for each network on at least two separate days in a calendar week, in at least eight calendar weeks.<sup>17</sup> The calendar weeks are not required to be consecutive weeks.
- ii. In a single calendar week, a health plan shall not initiate more than one-third of the total surveys for a network or total surveys for a Provider Survey Type in a network (where there are at least three providers of a Provider Survey Type).
- iii. A health plan shall enter “CSA” in the “Wave/CSA” field of the applicable Raw Data Report Form to indicate continuous survey administration.

**b. Wave Administration:**

- i. For each County/Network, a health plan shall split the sample (or with census, all providers to be surveyed) into two waves, with approximately 50% (and no more than 60%) of the providers from each Provider Survey Type in each wave.
- ii. A health plan shall survey the providers in the first wave and then begin surveying providers in the second wave after at least 21 calendar days from the final contact attempt during the first wave.

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<sup>16</sup> A health plan may use extraction to survey some providers, which requires administration in two waves, and use continuous survey administration for the remaining providers. (See paragraphs 42-53.) Further, conducting the survey via waves may be more appropriate for smaller networks.

<sup>17</sup> A calendar week is Monday through Sunday. Valid survey responses to the survey include only those providers who are identified as “Eligible – Survey Completed” on the Raw Data Report Form.

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

- iii. If a health plan is surveying a sample of providers:
  - 1) Wave One: The health plan shall survey all providers included in the first wave and replace all ineligible and non-responding providers with providers from the oversample until the health plan obtains valid survey responses from approximately 50% of the required sample size in the first wave, or the oversample is exhausted.<sup>18</sup>
  - 2) Wave Two: The health plan shall survey all providers selected to be included in the second wave and replace all ineligible and non-responding providers from the remaining providers in the oversample, if available.
- iv. If the County/Network includes fewer than five providers in a Provider Survey Type, the health plan may survey these providers in a single wave.
- v. The survey waves may be of any duration necessary to complete the survey of all providers included in each wave.<sup>19</sup>
- vi. Waves may be staggered by Provider Survey Type to avoid periods in which surveys are not being administered.
- vii. The health plan shall identify in the "Wave/CSA" field of the applicable Raw Data Report Form, whether the provider is part of the first or second wave using the following values: "Wave One" and "Wave Two."

### **Survey Administration Modality**

42. All surveys shall be administered using one or a combination of the three survey administration modalities: Extraction (Option 1), the Three Step Protocol (Option 2), or through an Advanced Access Program (Option 3).

#### **Option 1: Extraction (Rule 1300.67.2.2(f)(1)(F))**

43. A health plan may obtain the next available urgent care and non-urgent<sup>20</sup> appointments for providers that were selected to be surveyed from the provider's practice management software (e.g., appointment scheduling software or system) instead of surveying the provider using the Three Step Protocol or an Advanced Access Program. A health plan may obtain the appointment data by either:

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<sup>18</sup> Valid survey responses to the survey include only those providers who are identified as "Eligible – Survey Completed" on the Raw Data Report Form.

<sup>19</sup> For details related to the duration of the Electronic Extraction waves, see Option 1 in Survey Administration Modality below.

<sup>20</sup> References to non-urgent appointments are inclusive of initial and follow-up appointments, except where NPMH provider non-urgent follow-up appointments are required to be reported separately. Data related to non-urgent follow-up appointments is also separately collected for those provider types distinguished in Section 1367.03(a)(5)(F).



**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

- a. Manual Extraction: The health plan obtains appointment data that is manually extracted from the provider's practice management software (e.g., the provider's office checks the appointment scheduling system for the next available urgent care and non-urgent appointment for each provider manually, and provides this information to the health plan); or
- b. Electronic Extraction: The health plan obtains appointment data that is electronically extracted from the provider's practice management software (e.g., the provider's office or provider group electronically download from the appointment scheduling system the next available urgent care and non-urgent appointment for each provider, and provides this information to the health plan).

44. A health plan may use Manual or Electronic Extraction to obtain the next available urgent care and non-urgent appointment for a provider that was selected to be surveyed, if all of the following requirements are met:

- a. Prior to administering the survey, a method is in place to identify the providers that are able and willing to allow the health plan to access the next available urgent care and non-urgent appointment dates and times via Manual or Electronic Extraction;
- b. The method used by the health plan to obtain appointment data from a provider or provider group's practice management software reliably and accurately captures appointment dates and times (i.e., those appointments that would actually be available to enrollees requesting an appointment at the time the data was extracted from the provider's practice management software);
- c. The method used by the health plan obtains appointment data from a provider or provider group's practice management software that allows the health plan to distinguish between eligible, ineligible, and non-responding providers. Non-responding providers shall be surveyed through the Three Step Protocol, set forth below;
- d. The date and time the appointment data was extracted from the provider's practice management software (e.g., the date the practice management software is queried or downloaded) are captured and used to populate the "Date Survey Completed," "Time Survey Completed," and "Date Survey is Initiated" fields on the Raw Data Report Form;
- e. The method used by the health plan captures the date and time of the next available urgent care and non-urgent appointments, (including NPMH non-urgent follow-up appointments) for the individual provider selected to be surveyed. The health plan shall populate this information in the appropriate survey question field on the Raw Data Report Form;
- f. The health plan's administration of the survey adheres to the Department's PAAS Methodology, including the selection of the random sample or census of providers, as set forth in paragraphs 20-34. The sample shall be randomly selected from all providers on the Contact List Report Form, and may not be selected based on whether providers' appointment data can be accessed via Option 1: Extraction, or the provider can be deemed compliant via Option 3: Advance Access Providers;

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

- g. Unless surveying all providers in a County/Network (census), the health plan shall include only those providers who were randomly selected to be sampled on the Raw Data Report Forms and Results Report Form, even if Extraction is available for all providers in a provider group; and
- h. The health plan completes the Contact List Report Forms, Raw Data Report Forms, and Results Report Forms in accordance with the Report Form Instructions set forth in the Timely Access and Annual Network Submission Instruction Manual and submits these documents to the Department as part of its Timely Access Compliance Report.

45. For Electronic Extraction, the health plan shall randomly assign extraction dates to provider groups and/or providers with practice management software that allows Electronic Extraction over a three-week period during each of the survey waves. If the total number of providers in any provider group selected for appointment data extraction (whether selecting a sample or using census) is less than 50% of the entire sample for the county, the health plan may include all providers in the provider group that will furnish appointment data by Extraction in Wave One or Wave Two. (This may allow the health plan to access the provider group's practice management software only once.) If a single provider group constitutes more than 50% of the sample, the health plan shall extract appointment data from the provider group across both waves.

**Option 2: The Three Step Protocol (Rule 1300.67.2.2(f)(1)(F))**

46. The Three Step Protocol sets forth a sequence the health plan shall follow in administering the survey. The sequence is ordered to reduce disruption to providers.

47. All surveys shall be completed, including any required follow-up calls, within 17 business days of sending the initial survey invitation via email, electronic communication, or fax (survey invitation) to the provider requesting the provider respond to the survey, as set forth in paragraphs 49-53 below. The following provides an example in which the survey may take 17 business days to complete:

- a. Day 0: The survey invitation is sent via email, electronic communication, or fax. This date is recorded on the Raw Data Report Form as the "Date Survey is Initiated."
- b. Days 1-5: Wait for a response to survey invitation via email, electronic communication, or fax.
- c. Days 2-15: A reminder notice may be sent. (This optional notice does not impact or extend the time to complete the survey.)
- d. Days 6-15: A telephone call survey is initiated on day 14, but there is no answer. A call is made again during the next business day (on day 15), and a message is left requesting a callback within two business days.
- e. Days 16-17: Wait for the provider to respond to the survey via email, electronic communication, fax, or telephone. If no response is received by the end of day 17, the provider shall be identified as a non-responder on the Raw Data Report Form.

48. If an email, electronic communication, or fax survey invitation was not sent because the provider prefers to be surveyed via telephone or appropriate contact information (e.g., email

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

address or fax number) was not available, the survey shall be completed by telephone within five business days from the date of the initial telephone call. The following provides an example in which the survey may take 5 business days to complete:

- a. Day 0: No email, electronic communication, or fax contact information for the provider is available. A telephone call survey is initiated, but there is no answer. This date is recorded on the Raw Data Report Form as the “Date Survey is Initiated.”
- b. Day 1: A call is made again during the next business day, and the provider’s office requests a callback within two business days (day 3).
- c. Day 2: Wait for the scheduled follow-up time to occur.
- d. Day 3: The follow-up telephone call is initiated, but a message is left requesting a callback within two business days.
- e. Days 4-5: Wait for the provider to respond to the survey via telephone. If no response is received by the end of day 5, the provider shall be identified as a non-responder on the Raw Data Report Form.

49. Step One: Initiate the Survey via Email, Electronic Communication, or Fax.<sup>21</sup> The health plan shall initiate the survey set forth in the Email, Electronic Communication, or Fax Survey Tool by sending a survey invitation to the provider either by email or electronic communication (except as described in paragraph 48). The health plan shall record this date as the “Date Survey Initiated” on the Raw Data Report Form.<sup>22</sup> (If an email or electronic communication contact is not preferred or available, the health plan may use fax to initiate the survey or skip to Step 3: Conduct a Telephone Survey.) The survey invitation may be addressed to one or more providers at the same email, electronic communication, or fax contact; however, the survey shall require responses from each individual provider to each survey question. The survey invitation shall:

- a. Either include the survey or direct the provider to take the survey through a website, internet portal, application, or another electronic communication; and
- b. Indicate that the provider has five business days to respond, otherwise the provider will be contacted by telephone to take the survey.

50. Step Two: Send a Survey Reminder. If the provider has not responded within two business days of sending the survey invitation, a reminder notice may be sent to the provider. If the health plan elects to send a reminder notice, it shall notify providers who have not responded of the remaining time to respond to the survey. The reminder may not be used to extend the time available to respond.

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<sup>21</sup> See the Calculating Timeframes section below for further information related to calculating business days.

<sup>22</sup> If the survey response indicates the provider is not affiliated with the contact information used to conduct the survey and there is sufficient time remaining within the Three Step Protocol, the health plan may either correct the contact information, survey via another modality (e.g., fax), or begin surveying the provider via telephone. Alternatively, if appropriate given the circumstances, the health plan may record the provider as ineligible in the “Outcome” field of the Raw Data Report Form and replace the provider with another provider from the oversample.

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

51. Step Three: Conduct a Telephone Survey. If the provider does not respond within five business days of the health plan sending the survey invitation, the health plan shall initiate the survey via telephone, using the Telephone Survey Tool. The telephone survey shall be initiated within 6-15 business days of sending the survey invitation. If an email, electronic communication, or fax contact is not available, and the health plan initiated the survey via telephone, record the date of the initial telephone call in the “Date Survey Initiated” field on the Raw Data Report Form.

- a. If a provider responds to the survey via email, electronic communication, or fax prior to initiation of the telephonic survey (e.g., within the 6-15 business day period), the response shall be entered into the Raw Data Report Form and no telephone call shall be made to the provider.
- b. The health plan may conduct the survey of several providers during a single telephone call, but the health plan shall obtain each individual provider’s response to the survey questions.
- c. If a provider’s office does not answer the initial call, the health plan shall call the provider back on or before the next business day to initiate the telephone survey. The health plan may also leave a message requesting that the provider complete the survey (via returning the call by a specific number and/or email, electronic communication, or fax<sup>23</sup>) within two business days of the message.
- d. If a provider declines to respond to the survey, the health plan shall offer the provider’s office the option to respond at a later time. If the provider is willing to participate at a later time, the health plan shall offer the provider the option to receive a follow-up call within the next two business days.

52. If the provider does not complete the telephone survey within two business days of the initial telephone call, the message left requesting the provider complete the survey, or during the follow-up telephone call, the outcome of the provider’s survey shall be recorded on the Raw Data Report Form as “Refused – No Response,” and the non-responding provider shall be replaced with a provider from the oversample.

53. If the health 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.

**Option 3: Advanced Access Providers (Rule 1300.67.2.2(f)(1)(F))**

54. Qualified Advanced Access Providers: Health plans are required to verify that Primary Care Providers participating in an advanced access program schedule appointments consistent with the definition of advanced access. (Rule 1300.67.2.2(d)(2)(E).) A primary care provider is a qualified advanced access provider if a health plan has confirmed, independent of the PAAS, within the last 36 months that the primary care provider:

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<sup>23</sup> If a provider responds multiple times to the survey (e.g., telephone call and via email), the health plan shall enter only the response first received by the provider into the Raw Data Report Form.

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

- a. Schedules enrollee appointments consistent with the definition of advanced access set forth in Rule 1300.67.2.2(b)(1); and
- b. Has policies and procedures in place requiring that appointments be available to enrollees consistent with the definition of advanced access, as set forth in Rule 1300.67.2.2(b)(1).

55. Qualified advanced access providers shall be designated on the Contact List Report Form in the “Qualified Advanced Access Provider” field. If a qualified advanced access provider is selected to be surveyed (through a random sample or through census), the health plan shall not obtain further appointment availability responses from the qualified advanced access provider through the PAAS. Qualified advanced access providers that are both (1) part of the random sample (or census), and (2) identified on the Raw Data Report Form as participating in a verified advanced access program shall be counted as compliant for all applicable standards on the Raw Data Report Form and included in the health plan’s calculations set forth on the Results Report Form.

56. Non-Qualified Advanced Access Providers: A health plan may use the PAAS to conduct the verification of an advanced access program. If the PAAS is used to verify that Primary Care Providers are scheduling appointments in a manner consistent with the requirements of an advanced access program, the health plan shall survey the provider and report the corresponding data for the advanced access providers who were selected to be surveyed using Option 1 or 2, as set forth in the Survey Administration Modality section above. 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. If the provider meets all other requirements set forth in paragraphs 54-55 and the health plan verifies advanced access programs every three years, the health plan may use the information obtained during the PAAS to verify the provider participates in an advanced access program to deem the provider compliant in two years following the PAAS.

57. Designation of Advanced Access Providers: If a health plan has an advanced access program, the health plan is required to submit in its Timely Access Compliance Report a list of all network providers and provider groups using advanced access appointment scheduling. (Rule 1300.67.2.2(h)(6)(D).) To meet this requirement, the health plan shall designate the Primary Care Providers participating in an advanced access program on the Contact List Report Form in the “Advanced Access Provider” field.

### **Non-Responding Providers**

58. A non-responding provider is a provider that does not respond to one or more applicable items within the required timeframe or declines to participate in the survey. If a survey is completed after the end of the measurement year, the health plan shall mark the provider as a non-responder on the Raw Data Report Form. A non-responding provider may decline to respond, or the health plan may not receive a response from the provider within the applicable timeframes when attempting to survey the provider using any of the methods set forth in the Survey Administration Modality section set forth above. A health plan shall identify a provider that refuses or declines to respond to the survey in the “Outcome” field of the Raw Data Report Form as “Refused – Refused/Decline to Respond.” A health plan shall

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

identify a provider that does not respond to the survey within the required timeframes in the “Outcome” field of the Raw Data Report Form as “Refused – No Response.”

**Ineligible Providers**

59. A provider is ineligible to take the survey if the health plan identifies that the provider meets one or more of the following outcomes:

- a. “Provider Not in Health Plan Network” – The provider no longer participates in the health plan’s network at the time the survey is administered or did not participate in the health plan’s network on the network capture date<sup>24</sup>;
- b. “Provider Not in County” – The provider does not practice in the relevant county at the time the survey is administered or on the network capture date;
- c. “Provider Retired or Ceasing to Practice” – The provider retired or for other reasons is no longer practicing;
- d. “Provider Listed Under Incorrect Specialty” – The provider was included in the Contact List Report Form under an incorrect Provider Survey Type;
- e. “Contact Information Issue (Incorrect Phone or Fax Number/Email)” – The provider was unable to be surveyed because the provider was listed in the database with incorrect contact information that could not be corrected; or
- f. “Provider Does Not Offer Appointments” – The provider does not offer enrollees appointments (e.g., provides only hospital-based services or peer-to-peer e-consultation services).

60. A health plan shall record the reason the provider is ineligible in its Raw Data Report Form using the outcomes set forth in paragraph 59. The health plan’s discovery that a provider is ineligible may require the health plan to update information in its online provider directory, in accordance with the requirements set forth in section 1367.27. A health plan shall use the information obtained in administering the survey to update health plan records to improve the Contact List Report Form data for the following measurement year (e.g., update contact information to correct contact information and exclude certain ineligible providers, such as the providers who have retired, from future Contact List Report Forms).

**Replacements of Non-Responding and Ineligible Providers**

61. A non-responding or ineligible provider, as defined in paragraphs 58-59, shall be replaced if a provider from the oversample of the same Provider Survey Type and within the same County/Network is available. When the replacement of a provider is necessary, the health plan shall use the next provider from the oversample (in the order the provider was selected) as a replacement until the required sample size is reached. The health plan shall continue to replace providers until either the required sample size is reached, or the health

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<sup>24</sup> Providers that were selected to be surveyed, but were subsequently identified by the health plan, independent of the survey, as ineligible may be deemed ineligible and replaced with a provider from the oversample. Thus, if a provider is terminated from a network, retires, or moves out of the county and that provider was selected to be surveyed, the health plan does not need to send a survey invitation to the provider. The health plan may instead deem that provider ineligible and replace the provider with another provider from the oversample.

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

plan has surveyed or attempted to survey all providers of that same Provider Survey Type in the County/Network, so that no replacements remain. (As noted in Step 4, above, the health plan shall oversample the number of providers necessary to meet the required sample size.)

**Survey Administration Notes**

62. The health plan shall adhere to the following requirements in administering the PAAS:

- a. If the provider reports that the date and time of the next available appointment depends upon whether the patient is a new or existing patient, request the dates for both and use the earlier date (the shorter duration time);
- b. If the provider reports that patients are served on a walk-in or same day basis, ask the provider to provide the date and approximate time that a patient walking in at the time of the call would be seen. Record the date and approximate time the patient would be seen on the Raw Data Report Form.
- c. Appointments occurring prior to the date and time of the call shall not be deemed compliant;
- d. Referral of a patient to a different provider (e.g., a provider covering for a provider on vacation or in a separate urgent care center) cannot be recorded as the initially surveyed provider providing an appointment. An appointment offered at a different office in the same county with the same provider can be recorded as an available appointment with the initially surveyed provider. (For FQHCs/RHCs, appointment availability at a separate site with any provider of that Provider Survey Type within the same FQHC/RHC qualifies as an available appointment.);
- e. If a provider's office indicates that urgent care appointments are not offered, record "NA" on the Raw Data Report Form in the applicable urgent care appointment time, date, and compliance calculation fields.
- f. If the provider is not scheduling appointments at the time of the survey because the provider is out of the office (e.g., vacation, maternity leave, etc.), record "Unknown" in the appointment date and time fields and "N" in the calculation fields on the Raw Data Report Form to indicate that the provider does not have an urgent care and non-urgent appointment available within the applicable standard; and
- g. All outgoing survey calls shall be conducted from 8:00 am through 5:00 pm, Pacific Time.
- h. If the provider reports that the date and time of the next available appointment depends upon whether the appointment is in-person or via telehealth, inform the provider that the appointment modality does not matter and ask for the next available appointment, meaning the earliest next appointment regardless of whether it is in-person or via telehealth. If the provider indicates that the next available appointment is a telehealth appointment, record "Telehealth" in the applicable "Urgent Care Appointment Type" or "Non-Urgent Appointment Type" field of the Raw Data Template.

**Record the Response and/or Outcome on the Raw Data Report Form**

63. Once the health plan has a response to the applicable survey questions (or has identified the provider as being ineligible or non-responsive), record the response and

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

outcome to that provider for all applicable networks within the county on the Raw Data Report Form. A provider that responded to the PAAS with appointment dates and times for an urgent care or non-urgent appointment or was deemed compliant as a qualified advanced access provider shall be identified by the health plan on the Raw Data Report Form by entering "Eligible – Completed Survey" in the "Outcome" field. (See paragraphs 58-60 for further information related to completing the "Outcome" field for ineligible and non-responding providers.) The health plan shall record all the required information obtained through administering the survey (designated with an "\*" asterisk) on the Raw Data Report Form for each provider it surveys or attempts to survey (if the provider is ineligible or non-responding) using one of the three survey modalities set forth above.

**Step 8: Calculate Appointment Wait Times and the PAAS Results (Rule 1300.67.2.2(f)(1)(G)-(H))**

64. The health plan is required to calculate the rates of compliance, the number of providers surveyed, whether it surveyed a sufficient number of providers to meet the required sample size, and the percentage of providers that were ineligible or did not respond. These figures shall be calculated for each County/Network using the provider responses to the PAAS for each Provider Survey Type. The health plan shall use the Report Form Instructions for the Results Report Form, the health plan's Raw Data Report Form, and the calculation instructions set forth below to complete each calculation and enter the required information on each Provider Survey Type Results Tab located in the Results Report Form.

**Calculate the Total Number of Providers That Responded to the Survey**

65. The health plan shall determine the number of providers that responded to the survey via Three Step Protocol, Extraction, and as a Qualified Advanced Access Provider on the Raw Data Report Form for each Provider Survey Type in each County/Network. This number shall be recorded on the applicable Provider Survey Type Results Tab in the Results Report Form. Based on these numbers, the Results Report Form will auto-calculate the total number of providers that responded to the survey using any of these methods. For each Provider Survey Type in each County/Network the health plan shall:

- a. Count the number of providers on the Raw Data Report Form that responded via the Three Step Protocol, and record this number on the applicable Results Tab in the "Number of Providers Responded via Three Step Protocol" field;
- b. Count the number of providers on the Raw Data Report Form that responded via Extraction, and record this number in the applicable Results Tab in the "Number of Providers Responded via Extraction" field; and
- c. For Primary Care Providers only, count the number of providers on the Primary Care Provider Raw Data Report Form that were deemed compliant as a result of being a qualified advanced access provider, as identified in the "Qualified Advanced Access Provider" field. Record this number on the Primary Care Provider Results Tab in the "Number of Providers Responded as a Qualified Advanced Access Provider" field.

The Results Report Form automatically adds the "Number of Providers Responded via Three Step Protocol," the "Number of Providers Responded via Extraction" and (for Primary



**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

Care Providers only) the “Number of Providers Responded as a Qualified Advanced Access Provider” to calculate the “Total Number of Providers Responded to Survey.”

**Identify Whether the Required Sample Size was Achieved**

66. Each health plan shall obtain a sufficient number of valid survey responses in each County/Network for each Provider Survey Type in order to meet the required sample size and ensure that its reported rates of compliance are statistically reliable and comparable across the industry. The health plan shall determine and record on each applicable Provider Survey Type Results Tab in the Results Report Form whether it was able to successfully survey a sufficient number of providers for each Provider Survey Type in each County/Network, in accordance with the following instructions:

- a. Identify the number of unique providers on the Contact List. Record this number in the “Number of Providers within County/Network” field on the Results Report Form in the applicable Provider Survey Type Results Tab;
- b. Use the “Number of Providers within County/Network” and Appendix 1: Sample Size Chart to identify the required sample size. Record the required sample size in the “Required Sample Size” field on the Results Tab; and
- c. If the health plan was able to successfully survey a sufficient number of providers to reach the required sample size based on the numbers in the “Required Sample Size” and the “Total Number of Providers Responded to Survey” fields, enter “Y” in the “Required Sample Size Achieved” field. Enter “N” if the health plan was unable to meet the required sample size.

67. If the health plan did not survey a sufficient number of providers in the County/Network to meet the required sample size by five or more providers, the health plan shall include in the health plan’s Quality Assurance Report a narrative response explaining the reasons why the health plan failed to meet the required sample size and describing corrective actions the health plan intends to take to ensure that it meets the required sample size in future reporting years. (For example, if the health plan was unable to meet the required sample size because it ran out of time while administering the survey, the health plan’s corrective action might indicate that it will begin the survey on June 1 instead of July 1 in future measurement years.) Each health plan shall report all required information in the Results Report Form, even if it was unable to meet the required sample size in a County/Network. (See paragraphs 81-84 for further information.)

**Calculating Appointment Wait Times**

68. To ensure consistency, appointment wait times shall be calculated in accordance with the following instructions:

- a. When calculating appointment wait times to make a compliance determination, use the date and time the provider responded to the survey or the health plan (or provider) extracted the appointment dates and times from the provider’s practice management software as the date of the request for the appointment. Do not use the date of the initial contact for this calculation (e.g., where email is used or a follow-up survey is necessary, use the date the provider responded, not the date the communication was sent.) If a provider responds

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

to the survey with an appointment date and time that occurred in the past (before the date and time the provider completed the survey), the appointment shall not be considered compliant with the appointment wait time standards;<sup>25</sup>

- b. Urgent care appointment wait times are measured in hours. As a result, a health plan shall capture the date and time the provider responded to the questions and the date and time of the next available appointment identified by the provider's office;
- c. Exclude the holidays set forth in subsection (a)(2)-(a)(16) of Government Code section 6700 and weekends (Saturdays and Sundays) when calculating urgent care appointment timeframes; and<sup>26</sup>
- d. Non-urgent appointment standards are set forth in section 1367.03(a)(5)(C)-(G) and Rule 1300.67.2.2(c)(5)(C)-(F) in terms of business days. For consistency, all health plans shall use the following rules in calculating business days and compliance with non-urgent appointment wait time standards:
  - i. Count 10 business days for primary care provider non-urgent appointments and non-physician mental health care provider non-urgent appointments(including non-urgent follow-up appointments). Business days exclude holidays and weekends (Saturdays and Sundays);
  - ii. Count 15 business days for specialist physician, psychiatrist, and ancillary service provider appointments. Business days exclude holidays and weekends (Saturdays and Sundays);
  - iii. When calculating business days, exclude the first day (e.g., the day of the request) and include the last day; and
  - iv. The holidays set forth in subsection (a)(2)-(a)(16) of Government Code section 6700 are excluded only when calculating non-urgent appointment wait times, and when calculating timeframes to administer the survey using the Three Step Protocol.

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<sup>25</sup> For example, if the survey was completed on Friday, October 13<sup>th</sup> at 10:00 am, and the provider responded that the next available appointment is Thursday, October 12<sup>th</sup> at 8:00 am, this appointment cannot be considered compliant with the applicable appointment wait time standard.

<sup>26</sup> Recognizing the nature of this statistical methodology, which is used in ascertaining compliance with urgent care appointments standards, the Department has adopted rules regarding application of urgent care appointment standards and calculation of urgent care appointment timeframes for purposes of monitoring the sufficiency of the health plan's network. Specifically, this methodology measures urgent care appointments for non-physician mental health care providers, specialist physicians, and psychiatrists against a 96-hour appointment standard, irrespective of whether the health plan requires prior authorization for these services. Further, the methodology also requires the health plan exclude the holidays set forth in subsection (a)(2)-(a)(16) of Government Code section 6700 and weekends (Saturdays and Sundays) when calculating urgent care appointment timeframes. The rules regarding calculation of urgent care appointments set forth in this methodology do not alter the health plan's obligations to provide timely appointments to enrollees in accordance with the standards set forth under section 1367.03(a)(5) and Rule 1300.67.2.2(c).

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

69. Example: If a primary care provider responds with an appointment date and time on Tuesday the 15<sup>th</sup>, then the appointment identified shall be on or before Wednesday the 30<sup>th</sup> in order to meet the 10-business days standard (calculated by counting forward 10 business days and excluding the holiday on the 28<sup>th</sup> and the weekends) for non-urgent primary care appointments.<sup>27</sup>

### **Compliance Determinations**

70. For each provider response to questions related to appointment availability (whether the response was obtained through the Three Step Protocol, Manual or Electronic Extraction, or Qualified Advanced Access Program), the health plan shall make a compliance determination by calculating whether the appointment waiting time, measured from the time the survey was completed to the next available urgent care, non-urgent appointment,<sup>28</sup> and, where measured separately, non-urgent follow-up appointment, meets the applicable time-elapsed standard. All compliance determinations shall be recorded on the applicable Raw Data Report Form in accordance with the instructions listed below:

### **Qualified Advanced Access Providers**

- a. If the primary care provider is included in the health plan's advanced access program and is identified as a qualified advanced access provider in "Qualified Advanced Access Provider" field on the Raw Data Report Form, the primary care provider is counted as having a compliant appointment for the relevant appointment type(s).

### **Providers Surveyed via Extraction or the Three Step Protocol**

- b. Record on the Raw Data Report Form the date and time of the next available urgent care appointment provided in response to Question 1 and the next available non-urgent appointment provided in response to Question 2. Calculate whether each appointment was available within the applicable appointment wait time standard in accordance with the instructions set forth in

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<sup>27</sup> In this example, 10 business days is counted as follows: Day 0: Tuesday the 15<sup>th</sup> is not counted as a business day because the day of the request is excluded, Day 1: Wednesday the 16<sup>th</sup>, Day 2: Thursday the 17<sup>th</sup>, Day 3: Friday the 18<sup>th</sup>, Excluded Weekend: Saturday the 19<sup>th</sup>, Excluded Weekend: Sunday the 20<sup>th</sup>, Day 4: Monday the 21<sup>st</sup>, Day 5: Tuesday the 22<sup>nd</sup>, Day 6: Wednesday the 23<sup>rd</sup>, Day 7: Thursday the 24<sup>th</sup>, Day 8: Friday the 25<sup>th</sup>, Excluded Weekend: Saturday the 26<sup>th</sup>, Excluded Weekend: Sunday the 27<sup>th</sup>, Excluded Holiday: Monday the 28<sup>th</sup>, Day 9: Tuesday the 29<sup>th</sup>, and Day 10: Wednesday the 30<sup>th</sup>.

<sup>28</sup> Question 2 in the PAAS Survey Tool requests the provider respond with the next available appointment and does not distinguish between initial and follow-up appointments for any of the Provider Survey Types. References to non-urgent appointments are inclusive of initial and follow-up appointments, except where NPMH provider non-urgent follow-up appointments are required to be reported separately. Data related to non-urgent follow-up appointments is also separately collected for those provider types distinguished in section 1367.03(a)(5)(F).

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

the Calculating Appointment Wait Times section above and the instructions below:

**Urgent Care Appointments**

- i. If the response to Question 1 indicates that: “Yes, there is an available urgent care appointment within [48 hours for Primary Care Providers] or [96 hours for Non-Physician Mental Health Care Providers, Specialist Physicians, and Psychiatrists]” (as applicable), the provider’s next available appointment is counted as compliant for urgent care appointments in the “Calculation 1” field on the Raw Data Report Form.
- ii. If the provider’s response to Question 1 indicates: “No, there is no available urgent care appointment within [48 hours for Primary Care Providers] or [96 hours for NPMH providers, Specialist Physicians, and Psychiatrists]” (as applicable), the provider’s next available appointment is counted as non-compliant in the “Calculation 1” field on the Raw Data Report Form.

**Non-Urgent Appointments**

- iii. If the response to Question 2 indicates that: “Yes, there is an available non-urgent appointment within [10 business days for Primary Care Providers and NPMH providers] or [15 business days for Specialist Physicians, Psychiatrists, and Ancillary Service Providers]” (as applicable), the provider’s next available appointment is counted as compliant in the “Calculation 2” field on the Raw Data Report Form.<sup>29</sup>
- iv. If the provider’s response to Question 2 indicates: “No, there is no available non-urgent appointment within [10 business days for Primary Care Providers and NPMH providers] or [15 business days for Specialist Physicians, Psychiatrists, and Ancillary Service Providers]” (as applicable), the provider’s next available appointment is counted as non-compliant in the “Calculation 2” field on the Raw Data Report Form.

**NPMH Provider Non-Urgent Follow-Up Appointments**

- v. If the NPMH provider’s response to Question 3 indicates that: “Yes, there is an available non-urgent follow-up appointment within 10 business days,” the provider’s next available appointment is counted as compliant in the “Calculation 3” field on the Raw Data Report Form.<sup>30</sup>
- vi. If the NPMH provider’s response to Question 3 indicates: “No, there is no available non-urgent follow-up appointment within 10 business days,” the

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<sup>29</sup> For Ancillary Service Providers, the question in the Survey Tool related to the next available non-urgent appointment is Question 1. For all other Provider Survey Types, the question related to the next available non-urgent appointment is Question 2. For Ancillary Service Providers, conduct the compliance calculations using the same instructions for non-urgent appointments but replace “Question 2” with “Question 1” in these instructions.

<sup>30</sup> Question 3 related to follow-up appointments is only included in the NPMH provider survey.

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

provider's next available appointment is counted as non-compliant in the "Calculation 3" field on the Raw Data Report Form.

**Calculating the Unweighted Percentage of Providers with an Urgent Care, Non-Urgent, or Non-Urgent Follow-Up Appointment Available within Each Applicable Standard**

71. Each Results Tab in the Results Report Form includes two formulas that auto-calculate the percentage of providers with an appointment within the time-elapsd standards for urgent care and non-urgent appointments (the Results - Ancillary Tab only calculates the percentage of providers with an appointment for non-urgent appointments), based on the information entered into the Results Tab by the health plan in paragraph 72.<sup>31</sup> For each Provider Survey Type, in each County/Network, the formula divides:

**Urgent Care Appointments**

- a. The total number of providers identified with an appointment that is compliant under the applicable urgent care time-elapsd standard (the numerator), by the total number of providers that responded to the question regarding the availability of an urgent care appointment (the denominator), and records the result in the "Percentage of Providers with an Urgent Care Appointment Available within [specific urgent care standard] (Unweighted)" field.

**Non-Urgent Appointments**

- b. The total number of providers identified with an appointment that is compliant under the applicable non-urgent time-elapsd standard (the numerator), by the total number of providers that responded to the question regarding the availability of a non-urgent appointment (the denominator), and records the result in the "Percentage of Providers with a Non-Urgent Appointment Available within [specific non-urgent standard] (Unweighted)" field.

**NPMH Provider Non-Urgent Follow-Up Appointments**

- c. The NPMH Results Tab includes a formula that auto-calculates the percentage of providers with an appointment within the time-elapsd standards for non-urgent follow-up appointments based on the information entered into the Results Tab by the health plan as described in paragraph 72. In each County/Network, the formula divides the total number of NPMH providers identified as having an appointment that is as compliant under the applicable non-urgent follow-up standard (the numerator), by the total number of providers that responded to the question regarding the availability of a non-urgent follow-up appointment (the denominator), and records the result in the "Percentage of Providers with a Non-Urgent Follow-Up Appointment Available within 10 Business Days (Unweighted)" field.

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<sup>31</sup> See the Survey Tool and paragraph 69 for further details and instructions regarding the applicable standards for each Provider Survey Type and paragraph 72 for calculating the numerator and denominator.

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

If a sample was taken, but more providers were surveyed than required to meet the required sample size for a County/Network, the health plan shall use only the providers necessary to meet the target sample size for each network, in the order they were randomly selected, when completing the Raw Data Report Form and calculating the information required on the Results Report Form.

72. Using the compliance determinations in the calculation fields set forth on the Raw Data Report Form, the health plan shall record a numerator and denominator for each of the appointment standards, as set forth below. The numerator and denominator shall be calculated and recorded on the Results Tab for each County/Network for each Provider Survey Type to develop the percentage of providers with an appointment available for each Provider Survey Type, in accordance with the instructions listed below:

**Urgent Care Appointments**

- a. Numerator: Add together the total number of providers with a compliant appointment identified in the “Calculation 1” field on the Raw Data Report Form. Record this number in either the “Number of Providers with an Urgent Care Appointment Available within 48 Hours” field (48 hours for Primary Care Providers) or the “Number of Providers with an Urgent Care Appointment Available within 96 Hours” field (96 hours for Non-Physician Mental Health Care Providers, Specialist Physicians, and Psychiatrists) on the Results Tab for the applicable Provider Survey Type. This number is used as the numerator to calculate the percentage of providers with an urgent care appointment available within the applicable time elapsed standard.
- b. Denominator: Calculate the total number of providers that responded to the question regarding the availability of an urgent care appointment, which includes only providers with appointments that are compliant and non-compliant. Record this number (the denominator) in the “Number of Providers Responded to the Question Regarding the Availability of an Urgent Care Appointment within 48 Hours” field (48 hours for Primary Care Providers) or the “Number of Providers Responded to the Question Regarding the Availability of an Urgent Care Appointment within 96 Hours” field (96 hours for Non-Physician Mental Health Care Providers, Specialist Physicians, and Psychiatrists) on the Results Tab for the applicable Provider Survey Type. This number is used as the denominator to calculate the percentage of providers with an urgent care appointment available within the applicable time elapsed standard.
- c. Do not count “NA” responses in the denominator or numerator for the 48 or 96 hour standards for urgent care appointments.
- d. The formula in each Results Tab automatically divides the numerator by the denominator to calculate the unweighted percentage of providers with an urgent care appointment available within the applicable time elapsed standard. The result is then automatically recorded in the applicable field: “Percentage of Providers with an Urgent Care Appointment Available within 48 Hours (Unweighted)”; or “Percentage of Providers with an Urgent Care Appointment Available within 96 Hours (Unweighted).”

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

**Non-Urgent Appointments**

- e. Numerator: Add the total number of providers with a compliant appointment identified in the “Calculation 2” field on the Raw Data Report Form. Record this number in either the “Number of Providers with a Non-Urgent Appointment Available within 10 Business Days” field (10 business days for Primary Care Providers and NPMH providers) or the “Number of Providers with a Non-Urgent Appointment Available within 15 Business Days” field (15 business days for Specialist Physicians, Psychiatrists, and Ancillary Service Providers) on the Results Tab for the applicable Provider Survey Type. This number is used as the numerator to calculate the percentage of providers with a non-urgent appointment available within the applicable time elapsed standard.
- f. Denominator: Calculate the total number of providers that responded to the question regarding the availability of a non-urgent appointment, which includes only providers with appointments that are compliant and non-compliant. Record this number (the denominator) in the “Number of Providers Responded to the Question Regarding the Availability of a Non-Urgent Appointment within 10 Business Days” field (10 business days for Primary Care Providers and NPMH providers) or the “Number of Providers Responded to the Question Regarding the Availability of a Non-Urgent Appointment within 15 Business Days” field (15 business days for Specialist Physicians, Psychiatrists, and Ancillary Service Providers) on the Results Tab for the applicable Provider Survey Type. This number is used as the denominator to calculate the percentage of providers with a non-urgent appointment available within the applicable time elapsed standard.
- g. Do not count “NA” responses in the denominator or numerator for the 10 or 15 business day standards for non-urgent appointments.
- h. The formula in each Results Tab automatically divides the numerator by the denominator to calculate the unweighted percentage of providers with a non-urgent appointment available within the applicable time elapsed standard. The result is then automatically recorded in the applicable field: “Percentage of Providers with a Non-Urgent Appointment Available within 10 Business Days (Unweighted)”; or “Percentage of Providers with a Non-Urgent Appointment Available within 15 Business Days (Unweighted).”

**NPMH Provider Non-Urgent Follow-Up Appointments**

- i. Numerator: Add the total number of NPMH providers with a compliant appointment identified in the “Calculation 3” field on the Raw Data Report Form. Record this number in the “Number of Providers with a Non-Urgent Follow-Up Appointment Available within 10 Business Days” field on the NPMH Results Tab. This number is used as the numerator to calculate the percentage of NPMH providers with a non-urgent follow-up appointment available within the applicable time elapsed standard.
- j. Denominator: Calculate the total number of NPMH providers that responded to the question regarding the availability of a non-urgent follow-up appointment, which includes only providers with appointments that are compliant and non-compliant. Record this number (the denominator) in the “Number of Providers

## RY 2024/MY 2023 PAAS Manual

(Revised December 21, 2022)

who Responded to the Question Regarding the Availability of a Non-Urgent Follow-Up Appointment within 10 Business Days” field on the NPMH Results Tab. This number is used as the denominator to calculate the percentage of NPMH providers with a non-urgent follow-up appointment available within the applicable time elapsed standard.

- k. Do not count “NA” responses in the denominator or numerator for the 10 business day standards for non-urgent follow-up appointments.
- l. The formula in the NPMH Results Tab automatically divides the numerator by the denominator to calculate the unweighted percentage of providers with a non-urgent follow-up appointment available within the applicable time elapsed standard. The result is then automatically recorded in the applicable field: “Percentage of Providers with a Non-Urgent Follow-Up Appointment Available within 10 Business Days (Unweighted).”

### **Calculating the Weighted Percentage of Urgent Care and Non-Urgent Appointments within the Time Elapsed Standards**

73. The Results Report Form auto-calculates for each Provider Survey Type a weighted percentage of urgent care and non-urgent appointments within the applicable time elapsed standard for each network in the “Percentage of Urgent Care and Non-Urgent Appointments within Timely Access Standards (Weighted by Number of Providers in County) for [Provider Survey Type]” fields on the Summary of Rates of Compliance Tab.<sup>32</sup> The values in these fields are copied from the “Percentage of Urgent Care and Non-Urgent Appointments within Timely Access Standards (Weighted)” field on the Network by Provider Survey Type Tab for each Provider Survey Type. In order for the formulas to accurately calculate rates of compliance, the health plan shall enter all required information in each Provider Survey Type Results Tab, including plan-to-plan contracts, on a single Results Report Form.

74. The “Percentage of Urgent Care and Non-Urgent Appointments within Timely Access Standards for [Provider Survey Type, except Ancillary Service Providers]” fields are calculated using the total number of providers by Provider Survey Type in each county network as weights to estimate the total number of providers with timely appointments in each county for both urgent care and non-urgent appointments. These fields are calculated by taking the product of the “Total Number of Providers in Network (Urgent Care Appointments)” field and “Percentage of Providers with Timely Appointments for Urgent Care Appointments (Weighted)” field and summing it with the product of the “Total Number of Providers in Network (Non-Urgent Appointments)” field and “Percentage of Providers with Timely Appointments for Non-Urgent Appointments (Weighted)” field and dividing this value by the sum of the “Total Number of Providers in Network (Urgent Care Appointments)” field and the “Total Number of Providers in Network (Non-Urgent Appointments)” field on the Network by Provider Survey Type Tab. For Ancillary Service Providers, the “Percentage of Non-Urgent Appointments within the Timely Access Standard for Ancillary Service Providers” field on the Summary of Rates of Compliance Tab is equal to the “Percentage of Providers with Timely Appointments for Non-Urgent Appointments (Weighted)” field on the Network by Provider Survey Type Tab. The network percentage reflects the expected rate

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<sup>32</sup> For Ancillary Service Providers, this value represents the percentage of providers with an appointment available within the non-urgent appointment time elapsed standard only.



**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

at which all providers in a network offer timely appointments for both urgent care and non-urgent appointments. The Report Form Instructions in the Timely Access and Annual Network Review Instruction Submission Manual includes an explanation as to how each item in the Results Report Form is calculated.

### **Calculating the Rate of Compliance**

75. The Summary of Rates of Compliance Tab in the Results Report Form includes formulas that calculate a weighted rate of compliance for each appointment type for each of the health plan networks. In order for the formulas to accurately calculate a single rate of compliance for each of the appointment types by network, the health plan shall enter all required information in each Provider Survey Type Results Tab, including appointment availability information regarding subcontracted plans' providers, on a single Results Report Form.

76. The following weighted fields on the Summary of Rates of Compliance Tab are calculated using the total number of providers by Provider Survey Type in each county network as weights: "Rate of Compliance Urgent Care Appointments (All Provider Survey Types)," "Rate of Compliance Non-Urgent Appointments (All Provider Survey Types)," or "Rate of Compliance Non-Urgent Follow-Up Appointments (NPMH Providers Only)." The Rates of Compliance are calculated as:

#### **Urgent Care Appointments**

- a. The product of the "Total Number of Providers in Network (Urgent Care Appointments)" field and the "Percentage of Providers with Timely Appointments for Urgent Care Appointments (Weighted)" field summed across each Provider Survey Type (excluding Ancillary Service Providers) for the network (the numerator) divided by the sum of "Total Number of Providers in Network (Urgent Care Appointments)" field summed across each Provider Survey Type (excluding Ancillary Service Providers) on the Network by Provider Survey Type Tab.

#### **Non-Urgent Appointments**

- b. The product of the "Total Number of Providers in Network (Non-Urgent Appointments)" field and the "Percentage of Providers with Timely Appointments for Non-Urgent Appointments (Weighted)" field summed across each Provider Survey Type for the network (the numerator) divided by the sum of "Total Number of Providers in Network (Non-Urgent Appointments)" field summed across each Provider Survey Type on the Network by Provider Survey Type Tab.

#### **NPMH Providers Non-Urgent Follow-Up Appointments**

- c. The product of the "Total Number of Providers in Network (Non-Urgent Follow-Up Appointments)" field and the "Percentage of Providers with Timely Appointments for Non-Urgent Follow-Up Appointments (Weighted)" field for Non-Physician Mental Health Providers (the numerator) is divided by the

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

“Total Number of Providers in Network (Non-Urgent Follow-Up Appointments)”  
field for Non-Physician Mental Health Providers in the Network by Provider  
Survey Type Tab.

The Report Form Instructions in the Timely Access and Annual Network Review Instruction Submission Manual includes an explanation as to how each item on the Results Report Form is calculated.

77. The health plan shall review the rates of compliance in the Summary of Rates of Compliance Tab to identify any patterns of non-compliance, as set forth and defined in Rule 1300.67.2.2(b)(12)(A). If a pattern of non-compliance is identified, the health plan shall submit in its annual Timely Access Compliance Report the information set forth in Rule 1300.67.2.2(h)(6)(C).

### **Calculating the Percentage of Ineligible and Non-Responding Providers**

78. The health plan shall separately report the percentage of providers that are ineligible and those who do not respond or declined to respond to one or more survey questions for each Provider Survey Type in each County/Network on the applicable Results Tab in the Results Report Form.<sup>33</sup> Each Results Tab includes a formula to auto-calculate both percentages in the “Percentage of Non-Responding Providers” field and the “Percentage of Ineligible Providers.” To use these formulas, the health plan shall record on the Results Tab the numerator for each Provider Survey Type in each County/Network in accordance with the instructions set forth in paragraphs 79-80.

#### **Ineligible Providers**

79. For each County/Network for each Provider Survey Type:

- a. Numerator: Count the number of providers identified as ineligible from the sample and oversample on the Raw Data Report Form. Record this number on the applicable Provider Survey Type Results Tab in the “Number of Ineligible Providers” field. This field is used as the numerator to calculate the percentage of ineligible providers.
- b. Denominator: The Results Tab automatically adds the “Total Number of Providers Responded to Survey,” the “Number of Non-Responding Providers,” and the “Number of Ineligible Providers” to calculate the denominator.
- c. The Results Tab formula then automatically divides the numerator by the denominator to calculate and record the percentage of ineligible providers on each Provider Survey Type Results Tab in the “Percentage of Ineligible Providers” field.

#### **Non-Responding Providers**

80. For each County/Network for each Provider Survey Type:

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<sup>33</sup> Ineligible and non-responders may be identified through the Three Step Protocol or through Extraction.

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

- a. Numerator: Count the number of providers identified as non-responding in the sample and oversample from the Raw Data Report Form. Record this number on the applicable Provider Survey Type Results Tab in the “Number of Non-Responding Providers” field. This field is used as the numerator to calculate the percentage of non-responding providers.
- b. Denominator: The Results Tab automatically adds the “Total Number of Providers Responded to Survey” and the “Number of Non-Responding Providers” to calculate the denominator.
- c. The Results Tab formula then automatically divides the numerator by the denominator to calculate and record the percentage of non-responding providers on each Provider Survey Type Results Tab in the “Percentage of Non-Responding Providers” field.

**Step 9: Create Quality Assurance Report (Rule 1300.67.2.2(f)(1)(J) and (f)(3)-(4))**

81. Each health plan shall have a quality assurance process to ensure that it followed the PAAS Methodology and Report Form Instructions set forth in the Timely Access and Annual Network Submission Instruction Manual, that it met all Timely Access Compliance Report statutory and regulatory requirements, and that all information in the Timely Access Compliance Report submitted to the Department is true, complete, and accurate. (Rule 1300.67.2.2(a)(3), (a)(5), (f)(3)-(4), (h)(2), (i), and (j).)

82. As part of this quality assurance process, the health plan shall contract with an external vendor to conduct a review to ensure accuracy and completeness of the health plan’s PAAS data and processes, pursuant to Rule 1300.67.2.2(f)(3)-(4). This review shall be documented in a Quality Assurance Report, including a summary of the external vendor’s findings. Any changes or corrections made by the health plan or the external vendor, as a result of the data validation and quality assurance review, shall be identified in the Quality Assurance Report. This includes issues that are identified but deemed resolved by explanation or clarification.

83. The Quality Assurance Report shall be included in the health plan’s submission of the Timely Access Compliance Report to the Department. At a minimum, the external vendor’s review shall ensure all of the following:

- a. The health plan used the applicable Department-published PAAS Manual and PAAS Report Forms;
- b. The health plan reported all required information in each required field for each PAAS Report Form in accordance with the Report Form Instructions set forth in the Timely Access and Annual Network Submission Instructions Manual;
- c. The health plan reported results for all applicable networks, including those networks maintained exclusively for use by the health plan through a plan-to-plan contract;
- d. In accordance with the requirements set forth in the PAAS Methodology, the health plan identified the providers required to be surveyed, surveyed the providers, and recorded the provider’s survey responses on the Raw Data Report Form;

## **RY 2024/MY 2023 PAAS Manual**

(Revised December 21, 2022)

- e. The health plan surveyed and reported results for all Provider Survey Types, including each sub-type, in the health plan's network as of the network capture date;
- f. The PAAS Report Forms accurately reflect and report PAAS data only for providers who were part of the health plan's Department-regulated network(s) on the network capture date. The vendor shall use the health plan's Annual Network Report Forms as a baseline to conduct a comparison with the providers listed on the health plan's PAAS Report Forms. The vendor shall verify the following information on the health plan's Annual Network Report Forms and PAAS Report Forms to ensure that all providers included on the PAAS Report Forms were correctly reported and were in the health plan's network on the network capture date:
  - i. First Name, Last Name and NPI;
  - ii. Number of Providers in each Network;
  - iii. The correct Provider Survey Type is reported for each provider; and
  - iv. PAAS Report Forms did not exclude a Provider Survey Type that is required to be surveyed.
- g. The health plan did not inadvertently include providers serving solely non-Knox Keene Act licensed lines of business;
- h. If the health plan is using a vendor that serves multiple health plans to administer the survey, the vendor did not inadvertently include providers who were not part of the health plan's network on the health plan's PAAS Report Forms;
- i. The administration of the survey followed all requirements set forth in the PAAS Manual. The review shall verify that the health plan:
  - i. Conducted the PAAS during the appropriate measurement year;
  - ii. Accurately identified the number PAAS responses sufficient to meet the required sample sizes;
  - iii. Obtained a sufficient number of PAAS responses to meet all required sample sizes;
  - iv. If random samples were used, the health plan followed the prescribed random sampling process in selecting the providers to be surveyed;
  - v. If census was used, the health plan followed the prescribed survey process for conducting a census;
  - vi. Identified unique providers and duplicate records in its Contact List Report Form in accordance with the requirements of the PAAS Manual; and
  - vii. The health plan complied with all other requirements of the PAAS Manual in conducting the PAAS.
- j. All outcomes and calculations (including the rates of compliance and compliance determinations) recorded on the Raw Data Report Form and the Results Report Form are accurately calculated and recorded, and are consistent with and supported by data entered on the health plan's Raw Data Report Form (and that there have been no alterations or changes to the calculations embedded on the Results Report Forms). Each calculation was made in accordance with the requirements set forth in the Department's PAAS

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

Manual and Report Form Instructions set forth in the Timely Access and Annual Network Submission Instructions Manual; and

- k. The following calculations and/or data items shall be validated and reported to the Department accurately:
- i. The numbers used to report the percentage of providers with an appointment available for each standard and the rate of compliance, including the denominator and numerator, shall be correct and supported by the information on the Raw Data Report Form;
  - ii. All results shall be mathematically possible (e.g., rates above 100% shall not be reported to the Department);
  - iii. Each calculation is consistent with the survey logic set forth in the PAAS Manual and Report Form Instructions set forth in the Timely Access and Annual Network Submission Instructions Manual (e.g., the compliance determination for a particular standard is accurate based on the provider's response to the PAAS.);
  - iv. The responses from providers (source data) are recorded accurately on the Raw Data Report Form and are set forth in the appropriate columns;
  - v. The percentage of providers with an appointment available for each standard and the rate of compliance for each standard reported on the Results Report Form were derived from the appropriate survey question(s);
  - vi. The number of providers reported on the Raw Data Report Form and Results Report Forms is consistent (e.g., if responses for 15 providers in a network in a particular county were included on the Raw Data Report Form, this number shall be consistent with what is set forth on the Results Report Form.) The Raw Data Report Forms shall not indicate that a larger or smaller number of providers responded when that information is compared against information set forth on the Raw Data Report Form;
  - vii. No duplicate records are included on the Raw Data Report Form and/or Results Report Forms; and
  - viii. If a health plan reports that zero percent (0%) of providers reported an appointment available within the applicable wait time standard for an urgent care appointment or non-urgent standard appointment on the Results Report Form, this calculation shall be consistent with information on the Raw Data Report Form and shall not be entered or reported as "NA."

84. All health plans are required to use an external vendor to review the health plan's PAAS Report Forms and conduct a quality assurance review of the health plan's Timely Access Compliance Report, prior to submission of the report to the Department. Each health plan is responsible for securing its own agreement with an external vendor and ensuring that the health plan's Timely Access Compliance Report is submitted no later than May 1<sup>st</sup> of each year.

85. The health plan's Quality Assurance Report shall be prepared by an external vendor and shall summarize the results of the vendor's quality assurance review, as set forth above. The Quality Assurance Report shall include:

- a. An explanation of the process used by the vendor to review each verification item set forth in paragraph 83;

## **RY 2024/MY 2023 PAAS Manual**

(Revised December 21, 2022)

- b. A summary of the findings made during the vendor's review;
- c. Identification of all changes or corrections made by the health plan or vendor as a result of the quality assurance review, or following completion of the quality assurance review;
- d. An explanation by the health plan that addresses each issue identified by the vendor during its review of the verification items set forth in paragraph 83. If the health plan believes that its process adhered to the requirements of the PAAS Manual and Report Form Instructions, this shall be noted in the explanation related to the issue. If the health plan concludes that its process failed to adhere to the requirements of the PAAS Manual and Report Form Instructions, the health plan shall note this in the explanation, describe the underlying cause related to the issue, and identify steps that the health plan has taken or intends to take to ensure compliance with the PAAS Manual requirements and Report Form Instructions in future reporting years. (See section 1367.03(f)(3).); and
- e. To ensure that all providers included in the health plan's submission are part of the health plan's network, the quality assurance review shall include a comparison of the providers in the health plan's Contact List Report Form, Raw Data Report Form, and Annual Network Report Forms created during the same measurement year, as required in paragraph 83f. The health plan shall provide the results of the comparison and, if applicable, an explanation for any discrepancies. The explanation shall include the following information:
  - i. **Non-Network Provider Discrepancies:** Whether any non-network providers (providers who the health plan confirmed are not part of the health plan's network) were identified during the comparison and whether the non-network providers were included in the data submitted on the health plan's PAAS Report Forms. If any non-network providers are included in the health plan's PAAS Report Forms, the health plan shall provide an explanation for the inclusion of those providers and the steps it intends to take to ensure only network providers are included in the health plan's submission in future reporting years.
  - ii. **Network Provider Discrepancies:** If the comparison identifies discrepancies between the data sources that amount to 10% or more of the plan's providers for each Provider Survey Type or are a result of a block transfer, the health plan shall provide an explanation for each discrepancy identified, how the plan confirmed each provider was a network provider, and identify any relevant filings that may support or provide further explanation for the discrepancies.
- f. If the health plan did not meet the required sample size for any County/Network for a Provider Survey Type by five or more providers, regardless of whether the plan surveyed a sample of providers or conducted a census, the Quality Assurance Report shall include the following information in a narrative:
  - i. The reasons why the health plan failed to meet the required sample size. (See paragraph 67.)

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

- ii. A description of the corrective actions the health plan intends to take to ensure that it meets the required sample size in future reporting years.<sup>34</sup> (See paragraph 67.)
- iii. The steps the health plan will take to improve the accuracy of the health plan's Contact List in future years, including confirming that the health plan included corrections from ineligible providers from prior years and included corrections from the provider directory verification process. (See section 1367.27 and paragraph 60.)

**Step 10: Submit the Health Plan's Timely Access Compliance Report (Rule 1300.67.2.2(f)(1)(K) and (h))**

86. By May 1<sup>st</sup> of each year, each health plan is required to submit all applicable items identified in the Timely Access Compliance Report Instructions, set forth in the Timely Access and Annual Network Submission Instruction Manual, through the Department's web portal, accessible at [www.dmhc.ca.gov](http://www.dmhc.ca.gov).

In addition, each health plan may provide in its submission an evaluation and an assessment of the efficacy of the questions regarding NPMH providers follow-up appointments set forth in the Appendix 2: Survey Tool. The DMHC recommends that the assessment identify any confusion or pertinent information obtained when administering the NPMH provider follow-up appointment question(s) and make recommendations for improvement of the Survey Tool.

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<sup>34</sup> For example, the health plan may increase provider participation in the survey by offering provider groups the opportunity to respond to the survey via extraction and/or conducting provider outreach. (See paragraphs 35 and 43-45.) Additionally, the health plan may improve its ability to meet the required sample size by surveying a census of providers, ensuring all providers within the County/Network are included in oversample, or beginning the survey earlier in the year to ensure adequate time for completion. (See paragraphs 21 and 24-26.)

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

**Appendix 1: Sample Size Chart**

To determine the required number of completed surveys, identify the required sample size<sup>35</sup> for each network by identifying the total number of unique providers identified in the County/Network in the “Number of Providers within County/Network” column and the corresponding required sample size.

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

<sup>35</sup> Sample sizes were calculated to produce confidence limits of +/- 5% for an expected compliance rate of 85% with a 95% confidence level. The required sample sizes are expected to produce maximum confidence limits of +/- 5% for County/Networks.



**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

**Sample Size Chart Continued**

<b>Number of Providers within County/Network</b>	<b>Required Sample Size</b>	<b>Number of Providers within County/Network</b>	<b>Required Sample Size</b>
111 – 115	73	281 – 285	117
116 – 120	75	286 – 290	118
121 – 125	77	291 – 300	119
126 – 130	79	301 – 305	120
131 – 135	81	306 – 310	121
136 – 140	82	311 – 315	122
141 – 145	84	316 – 325	123
146 – 150	86	326 – 330	124
151 – 155	87	331 – 340	125
156 – 160	89	341 – 345	126
161 – 165	90	346 – 355	127
166 – 170	92	356 – 360	128
171 – 175	93	361 – 370	129
176 – 180	95	371 – 380	130
181 – 185	96	381 – 385	131
186 – 190	97	386 – 395	132
191 – 195	98	396 – 405	133
196 – 200	100	406 – 415	134
201 – 205	101	416 – 425	135
206 – 210	102	426 – 435	136
211 – 215	103	436 – 445	137
216 – 220	104	446 – 455	138
221 – 225	105	456 – 465	139
226 – 230	107	466 – 480	140
231 – 235	108	481 – 490	141
236 – 240	109	491 – 505	142
241 – 245	110	506 – 515	143
246 – 250	111	516 – 530	144
251 – 255	112	531 – 545	145
256 – 265	113	546 – 560	146
266 – 270	114	561 – 575	147
271 – 275	115	576 – 590	148
276 – 280	116	591 – 605	149

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

**Sample Size Chart Continued**

<b>Number of Providers within County/Network</b>	<b>Required Sample Size</b>	<b>Number of Providers within County/Network</b>	<b>Required Sample Size</b>
606 – 620	150	1476 – 1550	175
621 – 640	151	1551 – 1635	176
641 – 660	152	1636 – 1725	177
661 – 675	153	1726 – 1825	178
676 – 695	154	1826 – 1940	179
696 – 720	155	1941 – 2065	180
721 – 740	156	2066 – 2205	181
741 – 765	157	2206 – 2370	182
766 – 790	158	2371 – 2550	183
791 – 815	159	2551 – 2765	184
816 – 840	160	2766 – 3015	185
841 – 870	161	3016 – 3305	186
871 – 900	162	3306 – 3660	187
901 – 935	163	3661 – 4090	188
936 – 970	164	4091 – 4635	189
971 – 1005	165	4636 – 5330	190
1006 – 1045	166	5331 – 6265	191
1046 – 1085	167	6266 – 7580	191
1086 – 1130	168	7581 – 9565	193
1131 – 1175	169	9566 – 12920	194
1176 – 1225	170	12921 – 41649	195
1226 – 1280	171	41650 and above	196
1281 – 1340	172		
1341 – 1405	173		
1406 – 1475	174		

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

**Appendix 2: Survey Tool**

The Department developed the Survey Tool to conduct the PAAS via the Three Step Protocol. The Survey Tool contains the following four survey scripts to be used in administering the PAAS:

Email, Electronic Communication, or Fax Survey Scripts for:

(1) Primary Care Providers, Specialist Physicians, Psychiatrists, and Ancillary Service Providers; and

(2) Non-Physician Mental Health Care Providers.

Telephonic Survey Scripts for:

(3) Primary Care Providers, Specialist Physicians, Psychiatrists, and Ancillary Service Providers; and

(4) Non-Physician Mental Health Care Providers.

Before making any changes to the Survey Tool, the health plan shall review the PAAS Manual for specifications related to allowable changes to the Survey Tool and eFiling submission requirements. (See paragraphs 37-39.)

Instructions to the surveyor in the survey scripts related to completing specific fields in the Raw Data Report Forms or administering the survey are in italics. Responses to the survey and compliance calculations shall be recorded on the Raw Data Report Form and submitted to the Department in the health plan's Timely Access Compliance Report.

## **RY 2024/MY 2023 PAAS Manual**

(Revised December 21, 2022)

### **Email, Electronic Communication, or Fax Survey Script (Primary Care Providers, Specialist Physicians, Psychiatrists, and Ancillary Service Providers)**

Please respond to this survey on or before mm/dd/yy; otherwise, *(name of survey vendor)* will contact you via telephone to complete this survey.

Thank you for participating in this survey. Health plans are required by law to obtain information from their network providers regarding appointment availability. This survey is designed to assist [insert health plan name(s)] in assessing enrollee access to provider services. Please respond to this survey no later than five business days from the date of this communication. *[If sending a reminder, the health plan shall change the requested response time to indicate the amount of time remaining to respond.]*

The date and time you respond to the survey is used to calculate appointment wait times. Please indicate the date and time of this response:

Date: (mm/dd/yy)

Time: (hh:mm am/pm) PT

*[Allow space for the provider to insert date (mm/dd/yy) and time (hh:mm am/pm). If the online software or program used to conduct the survey accurately captures the time and date of the response in Pacific Time, this question shall be omitted, and this data shall be used to populate the response date and time on the Raw Data Report Form. All fax surveys shall include this field.]*

*[Confirm the provider's contact information, including name and specialty. (Address, county, telephone number, NPI, etc. are optional fields that may be validated during the survey.) The health plan may allow the provider to update the contact information during the survey or provide information on how to separately report any updates or corrections to the provider's information.]*

Please indicate whether any of the following items apply to [Provider Name or FQHC/RHC Name]:

1. The provider does not practice in [County].
2. The provider is retired or for other reasons is no longer practicing.
3. The provider is not [insert type of provider being surveyed].
4. The provider is not affiliated with the email or fax number to which this survey was sent.
5. The provider does not provide appointments.
6. The provider is not scheduling appointments because the provider is out of the office on leave (e.g., maternity leave, vacation, etc.).

*[If the provider checked items one, two, three, or five, record the provider as ineligible in the "Outcome" field of the Raw Data Report Form and replace the provider with another provider from the oversample. If the provider checked item four and there is sufficient time remaining within the Three Step Protocol, the plan may either correct the contact information, survey via another modality (e.g., fax), or begin surveying the provider via*

## RY 2024/MY 2023 PAAS Manual

(Revised December 21, 2022)

*telephone. If the provider checked item four and it is appropriate given the circumstances, the health plan may record the provider as ineligible in the "Outcome" field of the Raw Data Report Form and replace the provider with another provider from the oversample. If the provider is not scheduling appointments because the provider is on leave, on the Raw Data Report Form record "Unknown" in the question fields and "N" in the calculation fields to indicate that the provider does not have an urgent care and non-urgent appointment available within the applicable appointment standards.]*

If any of the above items apply, the survey is complete. Please submit the survey by *[the health plan shall insert directions to submit the survey in this section]*. Thank you for your time.

If none of the above items apply, please note the following items and provide a response to the following questions:

- If patients are served on a walk-in or same day basis, provide the date and approximate time that a patient walking in at the time you are responding to the survey would be seen.
- If appointment wait times depend upon whether the patient is a new or existing patient, provide the next available appointment, meaning the earlier appointment date and time.
- If appointment wait times depend upon whether the appointment is in-person or telehealth, provide the next available appointment, meaning the earlier appointment date and time.

### *Question 1:*<sup>36</sup>

Urgent care services are for a condition which requires prompt attention but does not rise to the level of an emergency. When is [Provider Name or FQHC/RHC Name]'s next available appointment date and time for urgent care services?<sup>37</sup>

*[Allow space for the provider to insert date (mm/dd/yy) and time (hh:mm am/pm) PT, indicate that this appointment is a telehealth appointment or indicate that this appointment type is not applicable and provide a brief explanation. Indicate this information in the "Question 1" field of the applicable Raw Data Report Form.]*

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<sup>36</sup> Urgent care appointments are not measured for Ancillary Service Providers in the PAAS. Health plans shall exclude this question from surveys sent to Ancillary Service Providers and renumber the questions and calculations appropriately.

<sup>37</sup> For FQHC/RHC providers, the question shall specify the type of services for which the provider was selected to be surveyed. A health plan shall modify the survey question for FQHC/RHC providers as follows: "When is [FQHC/RHC Name]'s next available appointment date and time for urgent [enter type of service, e.g., primary care, one of the specialties or subspecialties set forth in paragraph 9. d iii of the PAAS Manual or psychiatry] services?"

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

*Calculation 1:*<sup>38</sup>

*Calculate whether the appointment date and time in Question 1 is within 48 hours of this request for a Primary Care Provider appointment or 96 hours of this request for Specialist Physician and Psychiatrist appointments by calculating the number of hours between the date and time of the request for the appointment and the date and time of the available appointment.<sup>39</sup> Record on the Raw Data Report Form in the “Calculation 1” field whether the provider’s next available urgent care appointment is within the appropriate wait time standard:*

- *Mark “Y” to indicate “Yes, there is an available urgent care appointment within 48 hours (Primary Care Providers) or 96 hours (Specialist Physicians and Psychiatrists).”*
- *Mark “N” to indicate “No, there is no available urgent care appointment within 48 hours (Primary Care Providers) or 96 hours (Specialist Physicians and Psychiatrists).” (Mark “N” if the provider is not scheduling appointments while the provider is out of the office on leave.)*
- *Mark “NA” to indicate that this question is not applicable because this provider does not offer urgent care appointments.*

*Question 2:*

When is [Provider Name or FQHC/RHC Name]’s next available appointment date and time for non-urgent services?<sup>40</sup>

*[Allow space for the provider to insert date (mm/dd/yy) and time (hh:mm am/pm) PT, indicate that this appointment is a telehealth appointment or indicate that this appointment type is not applicable and provide a brief explanation. Indicate this information in the “Question 2”<sup>41</sup> field of the applicable Raw Data Report Form.]*

*Calculation 2:*

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<sup>38</sup> Urgent care appointments are not measured for Ancillary Service Providers in the PAAS. Health plans shall exclude this question from surveys sent to Ancillary Service Providers and renumber the questions and calculations appropriately.

<sup>39</sup> Exclude the holidays set forth in subsection (a)(2)-(a)(16) of Government Code section 6700 and weekends (Saturdays and Sundays) when calculating urgent care appointment timeframes.

<sup>40</sup> For FQHC/RHC and ancillary service providers, the question shall specify the type of services for which the provider was selected to be surveyed. A health plan shall modify the survey question as follows: "When is the next available appointment date and time with [FQHC/RHC Name]’s for non-urgent [enter type of service, e.g., primary care, one of the specialties or subspecialties set forth in paragraph 9. d iii of the PAAS Manual, psychiatry, mammography or physical therapy] services?"

<sup>41</sup> Urgent care appointments questions are not included in the survey of Ancillary Service Providers. As a result, the health plan shall record this information in the “Question 1” field on the Ancillary Service Provider Raw Data Report Form.

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

*Calculate whether the appointment date and time in Question 2 is available within 10 business days of this request for Primary Care Provider appointments or within 15 business days of this request for Specialist Physicians, Psychiatrist and Ancillary Service Providers appointments.<sup>42</sup> Indicate on the Raw Data Report Form in the “Calculation 2” field whether the provider’s next available non-urgent appointment is within the appropriate wait time standard:<sup>43</sup>*

- *Mark “Y” to indicate “Yes, there is an available non-urgent appointment within 10 business days (Primary Care Providers) or 15 business days (Specialist Physicians, Psychiatrists, and Ancillary Service Providers).”*
- *Mark “N” to indicate “No, there is no available non-urgent appointment within 10 business days (Primary Care Providers) or 15 business days (Specialist Physicians, Psychiatrists, and Ancillary Service Providers).” (Mark “N” if the provider is not scheduling appointments while the provider is out of the office on leave.)*
- *Mark “NA” to indicate that this question is not applicable because this provider does not offer non-urgent appointments.*

This concludes our survey. [Insert directions to submit the survey.] Thank you very much  
for your time.

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<sup>42</sup> When calculating business days, exclude the first day (e.g., the day of request) and include the last day. Saturday and Sunday shall be excluded when calculating business days. The holidays set forth in subsections (a)(2)-(a)(16) of Government Code section 6700 are excluded when calculating non-urgent appointment wait times.

<sup>43</sup> Urgent care appointment questions are not included in the survey of Ancillary Service Providers. As a result, the health plan shall record this information in the “Calculation 1” field on the Ancillary Service Provider Raw Data Report Form.

## **RY 2024/MY 2023 PAAS Manual**

(Revised December 21, 2022)

### **Email, Electronic Communication, or Fax Survey Script (Non-Physician Mental Health Care Providers)**

Please respond to this survey on or before mm/dd/yy; otherwise, *(name of survey vendor)* will contact you via telephone to complete this survey.

Thank you for participating in this survey. Health plans are required by law to obtain information from their network providers regarding appointment availability. This survey is designed to assist [insert health plan name(s)] in assessing enrollee access to provider services. Please respond to this survey no later than five business days from the date of this communication. *[If sending a reminder, the health plan shall change the requested response time to indicate the amount of time remaining to respond.]*

The date and time you respond to the survey is used to calculate appointment wait times. Please indicate the date and time of this response:

Date: (mm/dd/yy)

Time: (hh:mm am/pm) PT

*[Allow space for the provider to insert date (mm/dd/yy) and time (hh:mm am/pm). If the online software or program used to conduct the survey accurately captures the time and date of the response in Pacific Time, this question shall be omitted, and this data shall be used to populate the response date and time on the Non-Physician Mental Health Care Providers Raw Data Report Form. All fax surveys shall include this field.]*

*[Confirm the provider's contact information, including name and specialty. (Address, county, telephone number, NPI, etc. are optional fields that may be validated during the survey.) The health plan may allow the provider to update the contact information during the survey or provide information on how to separately report any updates or corrections to the provider's information.]*

Please indicate whether any of the following items apply to [Provider Name or FQHC/RHC Name]:

1. The provider does not practice in [County].
2. The provider is retired or for other reasons is no longer practicing.
3. The provider is not [insert type of provider being surveyed].
4. The provider is not affiliated with the email or fax number to which this survey was sent.
5. The provider does not provide appointments.
6. The provider is not scheduling appointments because the provider is out of the office on leave (e.g., maternity leave, vacation, etc.).

*[If the provider checked items one, two, three or five, record the provider as ineligible in the "Outcome" field of the Non-Physician Mental Health Care Providers Raw Data Report Form and replace the provider with another provider from the oversample. If the provider checked item four and there is sufficient time remaining within the Three Step Protocol, the plan may either correct the contact information, survey via another modality (e.g., fax), or begin surveying the provider via telephone. If the provider checked item four and it is appropriate*



## RY 2024/MY 2023 PAAS Manual

(Revised December 21, 2022)

*given the circumstances, the health plan may record the provider as ineligible in the "Outcome" field of the Raw Data Report Form and replace the provider with another provider from the oversample. If the provider is not scheduling appointments because the provider is on leave, on the Non-Physician Mental Health Care Providers Raw Data Report Form record "Unknown" in the question fields and "N" in the calculation fields to indicate that the provider does not have an urgent care, non-urgent, and non-urgent follow-up appointment available within the applicable appointment standards.]*

If any of the above items apply, the survey is complete. Please submit the survey by *[the health plan shall insert directions to submit the survey in this section]*. Thank you for your time.

If none of the above items apply, please provide a response to the questions below, keeping the following parameters in mind:

- If patients are served on a walk-in or same day basis, provide the date and approximate time that a patient walking in at the time you are responding to the survey would be seen.
- If appointment wait times depend upon whether the patient is a new or existing patient, provide the next available appointment, meaning the earlier appointment date and time.
- If appointment wait times depend upon whether the appointment is in-person or telehealth, provide the next available appointment, meaning the earlier appointment date and time.

### *Question 1:*

Urgent care services are for a condition which requires prompt attention but does not rise to the level of an emergency. When is [Provider Name or FQHC/RHC Name]'s next available appointment date and time for urgent care services?<sup>44</sup>

*[Allow space for the provider to insert date (mm/dd/yy) and time (hh:mm am/pm) PT, indicate that this appointment is a telehealth appointment or indicate that this appointment type is not applicable and provide a brief explanation. Indicate this information in the "Question 1" field of the Non-Physician Mental Health Care Providers Raw Data Report Form.]*

### *Calculation 1:*

*Calculate whether the appointment date and time in Question 1 is within 96 hours of this request for an appointment by calculating the number of hours between the date and time of the request for the appointment and the date and time of the available appointment.<sup>45</sup>*

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<sup>44</sup> For FQHC/RHC providers, the question shall specify the type of services for which the provider was selected to be surveyed. A health plan shall modify the survey question for FQHC/RHC providers as follows: "When is [FQHC/RHC Name]'s next available appointment date and time for urgent non-physician mental health care services?"

<sup>45</sup> Exclude the holidays set forth in subsection (a)(2)-(a)(16) of Government Code section

## RY 2024/MY 2023 PAAS Manual

(Revised December 21, 2022)

*Record on the Non-Physician Mental Health Care Providers Raw Data Report Form in the “Calculation 1” field whether the provider’s next available urgent care appointment is within the appropriate wait time standard:*

- *Mark “Y” to indicate “Yes, there is an available urgent care appointment within 96 hours.”*
- *Mark “N” to indicate “No, there is no available urgent care appointment within 96 hours.” (Mark “N” if the provider is not scheduling appointments while the provider is out of the office on leave.)*
- *Mark “NA” to indicate that this question is not applicable because this provider does not offer urgent care appointments.*

### Question 2:

When is [Provider Name or FQHC/RHC Name]’s next available appointment date and time for non-urgent services?<sup>46</sup>

*[Allow space for the provider to insert date (mm/dd/yy) and time (hh:mm am/pm) PT, indicate that this appointment is a telehealth appointment, or indicate that this appointment type is not applicable and provide a brief explanation. Indicate this information in the “Question 2” field of the Non-Physician Mental Health Care Providers Raw Data Report Form.]*

### Calculation 2:

*Calculate whether the appointment date and time in Question 2 is available within 10 business days of this request for an appointment.<sup>47</sup> Indicate on the Non-Physician Mental Health Care Providers Raw Data Report Form in the “Calculation 2” field whether the provider’s next available non-urgent appointment is within the appropriate wait time standard:*

- *Mark “Y” to indicate “Yes, there is an available non-urgent appointment within 10 business days.”*
- *Mark “N” to indicate “No, there is no available non-urgent appointment within 10 business days.” (Mark “N” if the provider is not scheduling appointments while the provider is out of the office on leave.)*
- *Mark “NA” to indicate that this question is not applicable because this provider does*

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6700 and weekends (Saturdays and Sundays) when calculating urgent care appointment timeframes.

<sup>46</sup> For FQHC/RHC providers, the question shall specify the type of services for which the provider was selected to be surveyed. A health plan shall modify the survey question as follows: "When is the next available appointment date and time with [FQHC/RHC Name]’s for non-urgent non-physician mental health care services?"

<sup>47</sup> When calculating business days, exclude the first day (e.g., the day of request) and include the last day. Saturday and Sunday shall be excluded when calculating business days. The holidays set forth in subsections (a)(2)-(a)(16) of Government Code section 6700 are excluded when calculating non-urgent appointment wait times.

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

*not offer non-urgent appointments.*

**Question 3:**

If a patient was seen today, what is the earliest date and time this patient would be seen by [Provider Name or FQHC/RHC Name] for a non-urgent follow-up appointment?<sup>48</sup> You may respond to this question with the earliest available appointment or with an appointment for an existing patient with regularly scheduled appointments that is being seen today.

*[Allow space for the provider to insert date (mm/dd/yy) and time (hh:mm am/pm PT), indicate that this appointment is a telehealth appointment, or indicate that this appointment type is not applicable and provide a brief explanation. Indicate this information in the “Question 3” field of the Non-Physician Mental Health Care Providers Raw Data Report Form.]*

**Calculation 3:**

*Calculate whether the non-urgent follow-up appointment date and time in Question 3 is available within 10 business days of the date of the request for a non-urgent follow-up appointment.<sup>49</sup> Indicate on the Non-Physician Mental Health Care Providers Raw Data Report Form in the “Calculation 3” field whether the non-urgent follow-up appointment is within the appropriate wait time standard:*

- *Mark “Y” to indicate “Yes, there is an available non-urgent follow-up appointment within 10 business days.”*
- *Mark “N” to indicate “No, there is no available non-urgent follow-up appointment within 10 business days.” (Mark “N” if the provider is not scheduling appointments while the provider is out of the office on leave.)*
- *Mark “NA” to indicate that this question is not applicable because this provider does not offer non-urgent follow-up appointments (e.g., this provider only offers intake appointments and on-going follow-up care is done by another provider).*

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<sup>48</sup> For FQHC/RHC providers, the question shall specify the type of services for which the provider was selected to be surveyed. A health plan shall modify the survey question as follows: “If a patient was seen today, what is the earliest date and time this patient would be seen at [FQHC/RHC Name] for a non-urgent follow-up appointment for non-physician mental health care services? You may respond to this question with the earliest available appointment or with an appointment for an existing patient with regularly scheduled appointments that is being seen today.”

<sup>49</sup> When calculating business days, exclude the first day (e.g., the day of request) and include the last day. Saturday and Sunday shall be excluded when calculating business days. The holidays set forth in subsections (a)(2)-(a)(16) of Government Code section 6700 are excluded when calculating non-urgent appointment wait times.

## RY 2024/MY 2023 PAAS Manual

(Revised December 21, 2022)

### Telephonic Survey Script (Primary Care Providers, Specialist Physicians, Psychiatrists, and Ancillary Service Providers)

Date Survey Completed: [mm/dd/yy]  
Time Survey Completed: [hh:mm am/pm] PT  
Provider First Name:  
Provider Last Name:  
FQHC/RHC Name:  
Person Spoken to:  
Health plan creating survey data:  
Name of individual conducting survey:  
Provider Survey Type:  
Specialty/Subspecialty/Provider Category:  
Address: [Optional to validate]  
County of this Office Location: [Optional to validate]

#### Introduction:

"Hello. My name is [Say Name]. I am calling [from health plan name or on behalf of health plan name(s)] to conduct an appointment availability survey. Health plans are required by law to obtain information from their network providers regarding appointment availability. This survey should take no more than [five] minutes.<sup>50</sup> Are you the appropriate person to respond to survey questions regarding scheduling appointments for [Provider Name or FQHC/RHC Name]?"

- If no, "May I speak to someone in the office who is able to respond to survey questions regarding the scheduling of appointments in your office?" [Repeat introduction when transferred to the appropriate person.]
- If no one is available, ask what time would be convenient during the next two business days to call again. Schedule and conduct follow-up calls within two business days.

#### *Validate Provider Information*

*If yes, validate the office information above with the person spoken to and conduct the survey. Please ensure that the individual conducting the survey on behalf of the health plan has access to the provider's address located within the appropriate county in case this information is necessary to access appointment data; however, the survey questions relate to the next available appointment at any office in the county the medical provider delivers services.*

"When responding to the questions regarding appointment availability, keep the following parameters in mind:

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<sup>50</sup> If additional Department-approved questions are included, revise the anticipated completion time for the survey, as appropriate.

**RY 2024/MY 2023 PAAS Manual**  
(Revised December 21, 2022)

- If patients are served on a walk-in or same day basis, provide the date and approximate time that a patient walking in at the time you are responding to the survey would be seen.
- If appointment wait times depend upon whether the patient is a new or existing patient, provide the next available appointment, meaning the earlier appointment date and time.
- If appointment wait times depend upon whether the appointment is in-person or telehealth, provide the next available appointment, meaning the earlier appointment date and time.”

*If the provider is a non-responder or is ineligible to take the survey for any of the reasons set forth above in paragraphs 58-60, mark the provider as a non-responder or ineligible for the survey in the “Outcome” field on the Raw Data Report Form, then move on to the next provider in the oversample to ensure the required sample sizes are met or there are no additional Provider Survey Types remaining in the County/Network to survey.*

*Question 1:*<sup>51</sup>

“Urgent care services are for a condition which requires prompt attention but does not rise to the level of an emergency. When is the next available appointment date and time with [Provider Name or FQHC/RHC Name] for urgent care services?”<sup>52</sup> *[Record this information in the “Question 1” field of the applicable Raw Data Report Form.]*

Date:       mm/dd/yy

Time:       hh:mm am/pm PT

In-person or Telehealth Appointment<sup>53</sup>

Not applicable. This provider does not offer urgent care appointments.

Unknown. This provider is not scheduling appointments because the provider is out of the office on leave.

*Calculation 1:*<sup>54</sup>

*Calculate whether the appointment date and time in Question 1 is within 48 hours of this request for Primary Care Provider appointments or 96 hours of this request for Specialist*

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<sup>51</sup> Urgent care appointments are not measured for Ancillary Service Providers in the PAAS. Health plans shall exclude this question from surveys sent to Ancillary Service Providers and renumber the questions and calculations appropriately.

<sup>52</sup> For FQHC/RHC providers, the question shall specify the type of services for which the provider was selected to be surveyed. A health plan shall modify the survey question for FQHC/RHC providers as follows: “When is [FQHC/RHC Name]’s next available appointment date and time for urgent [enter type of service, e.g., primary care, one of the specialties or subspecialties set forth in paragraph 9. d iii of the PAAS Manual, or psychiatry] services?”

<sup>53</sup> If the provider does not specify, inquire whether the next available appointment time and date given in response to this question was for an in-person or telehealth appointment.

<sup>54</sup> Urgent care appointments are not measured for Ancillary Service Providers in the PAAS. Health plans shall exclude this question from surveys sent to Ancillary Service Providers and renumber the questions and calculations appropriately.

## RY 2024/MY 2023 PAAS Manual

(Revised December 21, 2022)

*Physician and Psychiatrist appointments by calculating the number of hours between the date and time of the request for the appointment and the date and time of the available appointment.<sup>55</sup> Record on the Raw Data Report Form in the “Calculation 1” field whether the provider’s next available urgent care appointment is within the appropriate wait time standard:*

- *Mark “Y” to indicate “Yes, there is an available urgent care appointment within 48 hours (Primary Care Providers) or 96 hours (Specialist Physicians and Psychiatrists).”*
- *Mark “N” to indicate “No, there is no available urgent care appointment within 48 hours (Primary Care Providers) or 96 hours (Specialist Physicians and Psychiatrists).” (Mark “N” if the provider is not scheduling appointments while the provider is out of the office on leave.)*
- *Mark “NA” to indicate that this question is not applicable because this provider does not offer urgent care appointments.*

*(Go to Question 2.)*

### *Question 2:*

*“When is the next available appointment date and time with [Provider Name or FQHC/RHC Name] for non-urgent services?”<sup>56</sup> [Record this information in the “Question 2”<sup>57</sup> field of the applicable Raw Data Report Form.]*

Date: mm/dd/yy

Time: hh:mm am/pm PT

In-person or Telehealth Appointment<sup>58</sup>

Not applicable. This provider does not offer non-urgent appointments.

Unknown. This provider is not scheduling appointments because the provider is out of the office on leave.

### *Calculation 2:*

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<sup>55</sup> Exclude the holidays set forth in subsection (a)(2)-(a)(16) of Government Code section 6700 and weekends (Saturdays and Sundays) when calculating urgent care appointment timeframes.

<sup>56</sup> For FQHC/RHC and ancillary service providers, the question shall specify the type of services for which the provider was selected to be surveyed. A health plan shall modify the survey question as follows: “When is the next available appointment date and time with [Provider Name or FQHC/RHC Name]’s for non-urgent [enter type of service, e.g., primary care, one of the specialties or subspecialties set forth in paragraph 9. d iii of the PAAS Manual, psychiatry, non-physician mental health care, mammography or physical therapy] services?”

<sup>57</sup> Urgent care appointments questions are not included in the survey of Ancillary Service Providers. As a result, the health plan shall record this information in the “Question 1” field on the Ancillary Service Provider Raw Data Report Form.

<sup>58</sup> If the provider does not specify, inquire whether the next available appointment time and date given in response to this question was for an in-person or telehealth appointment.

## RY 2024/MY 2023 PAAS Manual

(Revised December 21, 2022)

*Calculate whether the appointment date and time in Question 2 is available within 15 business days of this request for Specialist Physician, Psychiatrist and Ancillary Service Provider appointments or within 10 business days of this request for Primary Care Provider appointments.<sup>59</sup> Indicate on the Raw Data Report Form in the “Calculation 2” field whether the provider’s next available non-urgent appointment is within the appropriate wait time standard.<sup>60</sup>*

- *Mark “Y” to indicate “Yes, there is an available non-urgent appointment within 10 business days (Primary Care Providers) or 15 business days (Specialist Physicians, Psychiatrists, and Ancillary Service Providers).”*
- *Mark “N” to indicate “No, there is no available non-urgent appointment within 10 business days (Primary Care Providers) or 15 business days (Specialist Physicians, Psychiatrists, and Ancillary Service Providers).” (Mark “N” if the provider is not scheduling appointments while the provider is out of the office on leave.)*
- *Mark “NA” to indicate that this question is not applicable because this provider does not offer non-urgent appointments.*

*(Conclude survey.)*

*“This concludes our survey. Thank you very much for your time.”*

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<sup>59</sup> When calculating business days, exclude the first day (e.g., the day of request) and include the last day. Saturday and Sunday shall be excluded when calculating business days. The holidays set forth in subsection (a)(2)-(a)(16) of Government Code section 6700 are excluded when calculating non-urgent appointment wait times.

<sup>60</sup> Urgent care appointments questions are not included in the survey of Ancillary Service Providers. As a result, the health plan shall record this information in the “Calculation 1” field on the Ancillary Service Provider Raw Data Report Form.

## **RY 2024/MY 2023 PAAS Manual**

(Revised December 21, 2022)

### **Telephonic Survey Script (Non-Physician Mental Health Care Providers)**

Date Survey Completed: [mm/dd/yy]  
Time Survey Completed: [hh:mm am/pm] PT  
Provider First Name:  
Provider Last Name:  
FQHC/RHC Name:  
Person Spoken to:  
Health plan creating survey data:  
Name of individual conducting survey:  
Provider Survey Type: NPMH  
Specialty/Subspecialty/Provider Category:  
Address: [Optional to validate]  
County of this Office Location: [Optional to validate]

#### Introduction:

"Hello. My name is [Say Name]. I am calling [from health plan name or on behalf of health plan name(s)] to conduct an appointment availability survey. Health plans are required by law to obtain information from their network providers regarding appointment availability. This survey should take no more than [five] minutes.<sup>61</sup> Are you the appropriate person to respond to survey questions regarding scheduling appointments for [Provider Name or FQHC/RHC Name]?"

- If no, "May I speak to someone in the office who is able to respond to survey questions regarding the scheduling of appointments in your office?" [Repeat introduction when transferred to the appropriate person.]
- If no one is available, ask what time would be convenient during the next two business days to call again. Schedule and conduct follow-up calls within two business days.

#### *Validate Provider Information*

*If yes, validate the office information above with the person spoken to and conduct the survey. Please ensure that the individual conducting the survey on behalf of the health plan has access to the provider's address located within the appropriate county in case this information is necessary to access appointment data; however, the survey questions relate to the next available appointment at any office in the county the medical provider delivers services.*

*"When answer the questions regarding appointment availability, please keep the following parameters in mind:*

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<sup>61</sup> If additional Department-approved questions are included, revise the anticipated completion time for the survey, as appropriate.



## RY 2024/MY 2023 PAAS Manual

(Revised December 21, 2022)

- If patients are served on a walk-in or same day basis, provide the date and approximate time that a patient walking in at the time you are responding to the survey would be seen.
- If appointment wait times depend upon whether the patient is a new or existing patient, provide the next available appointment, meaning the earlier appointment date and time.
- If appointment wait times depend upon whether the appointment is in-person or telehealth, provide the next available appointment, meaning the earlier appointment date and time.”

*If the provider is a non-responder or is ineligible to take the survey for any of the reasons set forth above in paragraphs 58-60, mark the provider as a non-responder or ineligible for the survey in the “Outcome” field on the Non-Physician Mental Health Care Providers Raw Data Report Form, then move on to the next provider in the oversample to ensure the required sample sizes are met or there are no additional Provider Survey Types remaining in the County/Network to survey.*

### Question 1:

“Urgent care services are for a condition which requires prompt attention but does not rise to the level of an emergency. When is the next available appointment date and time with [Provider Name or FQHC/RHC Name] for urgent care services?”<sup>62</sup> *[Record this information in the “Question 1” field of the Non-Physician Mental Health Care Providers Raw Data Report Form.]*

Date:       mm/dd/yy

Time:       hh:mm am/pm PT

In-person or Telehealth Appointment<sup>63</sup>

Not applicable. This provider does not offer urgent care appointments.

Unknown. This provider is not scheduling appointments because the provider is out of the office on leave.

### Calculation 1:

*Calculate whether the appointment date and time in Question 1 is within 96 hours of this request for an appointment by calculating the number of hours between the date and time of the request for the appointment and the date and time of the available appointment.<sup>64</sup> Record on the Non-Physician Mental Health Care Providers Raw Data Report Form in the*

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<sup>62</sup> For FQHC/RHC providers, the question shall specify the type of services for which the provider was selected to be surveyed. A health plan shall modify the survey question for FQHC/RHC providers as follows: "When is [FQHC/RHC Name]'s next available appointment date and time for urgent non-physician mental health care services?"

<sup>63</sup> If the provider does not specify, inquire whether the next available appointment time and date given in response to this question was for an in-person or telehealth appointment.

<sup>64</sup> Exclude the holidays set forth in subsection (a)(2)-(a)(16) of Government Code section 6700 and weekends (Saturdays and Sundays) when calculating urgent care appointment timeframes.

## RY 2024/MY 2023 PAAS Manual

(Revised December 21, 2022)

*“Calculation 1” field whether the provider’s next available urgent care appointment is within the appropriate wait time standard:*

- *Mark “Y” to indicate “Yes, there is an available urgent care appointment within 96 hours.”*
- *Mark “N” to indicate “No, there is no available urgent care appointment within 96 hours.” (Mark “N” if the provider is not scheduling appointments while the provider is out of the office on leave.)*
- *Mark “NA” to indicate that this question is not applicable because this provider does not offer urgent care appointments.*

*(Go to Question 2.)*

### *Question 2:*

*“When is the next available appointment date and time with [Provider Name or FQHC/RHC Name] for non-urgent services?”<sup>65</sup> [Record this information in the “Question 2” field of the Non-Physician Mental Health Care Providers Raw Data Report Form.]*

Date: mm/dd/yy

Time: hh:mm am/pm PT

In-person or Telehealth Appointment<sup>66</sup>

Not applicable. This provider does not offer non-urgent appointments.

Unknown. This provider is not scheduling appointments because the provider is out of the office on leave.

### *Calculation 2:*

*Calculate whether the appointment date and time in Question 2 is available within 10 business days of this request for an appointment. <sup>67</sup> Indicate on the Non-Physician Mental Health Care Providers Raw Data Report Form in the “Calculation 2” field whether the provider’s next available non-urgent appointment is within the appropriate wait time standard:*

- *Mark “Y” to indicate “Yes, there is an available non-urgent appointment within 10 business days.”*

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<sup>65</sup> For FQHC/RHC, the question shall specify the type of services for which the provider was selected to be surveyed. A health plan shall modify the survey question as follows: “When is the next available appointment date and time with [FQHC/RHC Name]’s for non-urgent non-physician mental health care services?”

<sup>66</sup> If the provider does not specify, inquire whether the next available appointment time and date given in response to this question was for an in-person or telehealth appointment.

<sup>67</sup> When calculating business days, exclude the first day (e.g., the day of request) and include the last day. Saturday and Sunday shall be excluded when calculating business days. The holidays set forth in subsection (a)(2)-(a)(16) of Government Code section 6700 are excluded when calculating non-urgent appointment wait times.

## RY 2024/MY 2023 PAAS Manual

(Revised December 21, 2022)

- Mark "N" to indicate "No, there is no available non-urgent appointment within 10 business days." (Mark "N" if the provider is not scheduling appointments while the provider is out of the office on leave.)
- Mark "NA" to indicate that this question is not applicable because this provider does not offer non-urgent appointments.

(Go to Question 3.)

### Question 3:

"If a patient was seen today, what is the earliest date and time this patient would be seen by [Provider Name or FQHC/RHC Name] for a non-urgent follow-up appointment? You may respond to this question with the earliest available appointment or with an appointment for an existing patient with regularly scheduled appointments that is being seen today."<sup>68</sup>

Date: mm/dd/yy

Time: hh:mm am/pm PT

In-person or Telehealth Appointment<sup>69</sup>

Not applicable. This provider does not offer non-urgent appointments or non-urgent follow-up appointments (e.g., *this provider only offers intake appointments and on-going follow-up care is done by another provider*).

Unknown. This provider is not scheduling appointments because the provider is out of the office on leave.

### Calculation 3:

Calculate whether the non-urgent follow-up appointment date and time in Question 3 is available within 10 business days of the date of the request for a non-urgent follow-up appointment.<sup>70</sup> Indicate on the Non-Physician Mental Health Care Providers Raw Data Report Form in the "Calculation 3" field whether the non-urgent follow-up appointment is within the appropriate wait time standard:

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<sup>68</sup> For FQHC/RHC providers, the question shall specify the type of services for which the provider was selected to be surveyed. A health plan shall modify the survey question as follows: "If a patient was seen today, what is the earliest date and time this patient would be seen at [FQHC/RHC Name] for a non-urgent follow-up appointment for non-physician mental health care services? You may respond to this question with the earliest available appointment or with an appointment for an existing patient with regularly scheduled appointments that is being seen today."

<sup>69</sup> If the provider does not specify, inquire whether the next available appointment time and date given in response to this question was for an in-person or telehealth appointment.

<sup>70</sup> When calculating business days, exclude the first day (e.g., the day of request) and include the last day. Saturday and Sunday shall be excluded when calculating business days. The holidays set forth in subsections (a)(2)-(a)(16) of Government Code section 6700 are excluded when calculating non-urgent appointment wait times.

## **RY 2024/MY 2023 PAAS Manual**

(Revised December 21, 2022)

- *Mark “Y” to indicate “Yes, there is an available non-urgent follow-up appointment within 10 business days.”*
- *Mark “N” to indicate “No, there is no available non-urgent follow-up appointment within 10 business days.” (Mark “N” if the provider is not scheduling appointments while the provider is out of the office on leave.)*
- *Mark “NA” to indicate that this question is not applicable because this provider does not offer non-urgent follow-up appointments (e.g., this provider only offers intake appointments, on-going follow-up care is done by another provider).*

*(Conclude survey.)*

“This concludes our survey. Thank you very much for your time.”