1st Comment Period – Changes noted by underline and strikeout

§ 1300.67.2.2. Timely Access to Non-Emergency Health Care Services and Annual Timely Access and Network Reporting Requirements.

(a) Application.
(1) A~~ll~~ health care service plan~~s~~ that provides or arranges for the provision of hospital or physician services, including a specialized mental health plan~~s~~ that provides physician or hospital services, or ~~that~~ provides mental health services pursuant to a contract with a full service plan, shall comply with the requirements of this section.
(2) A specialized d~~D~~ental, vision, chiropractic, ~~and~~ or acupuncture plan~~s~~ shall comply with subsections (c)(1), (c)(3), (c)(4), (c)(7), (c)(9), ~~and~~ (c)(10), ~~and subsections~~ (d)(1), (h)(1) and (h)(8)(A)-(C)~~and (g)(1)~~. ~~A~~ Dental plans shall also comply with subsection (c)(6).
(3) The obligation of a plan to comply with this section shall not be waived when the plan delegates to its provider groups ~~medical groups, independent practice associations,~~ or other contracting entities any services or activities that the plan is required to perform. A plan's implementation of this section shall be consistent with the requirements of the Health Care Providers' Bill of Rights, and a material change in the obligations of a plan's ~~contracting~~ network providers shall be considered a material change to the provider contract, within the meaning of subsections (b) and (~~g)~~(h)(2) of s~~S~~ection 1375.7 of the Knox-Keene Act.
(4) This section confirms requirements for plans to provide or arrange for the provision of ~~access to~~ health care services in a timely manner, and establishes additional metrics for measuring and monitoring the adequacy of a plan's ~~contracted provider~~ network to provide enrollees with timely access to needed health care services. This section does not:

(A) Establish professional standards of practice for health care providers;
(B) Establish requirements for the provision of emergency services; or
(C) Create a new cause of action or a new defense to liability for any person.

(5) All reports submitted by the plan pursuant to this section shall be timely, accurate and complete. The plan's material misstatements or material omissions in the reported information or data shall create a presumption that the plan lacks the administrative capacity to fulfill the plan's responsibilities under this section, as described in section 1367(g) of the Knox-Keene Act.

(b) Definitions.
For purposes of this section, the following definitions apply.
(1) "Advanced access" means the provision, by a~~n~~ network ~~individual~~ provider, or by the ~~medical~~ provider group ~~or independent practice association~~ to which an enrollee is assigned, of appointments with a primary care physician, or other qualified primary care provider such as a nurse practitioner or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the enrollee prefers not to accept the appointment offered within the same or next business day.
(2) "Appointment waiting time" means the time from the initial request for health care services by an enrollee or the enrollee's treating provider to the earliest date offered for the appointment for services inclusive of time for obtaining authorization from the plan

or completing any other condition or requirement of the plan or its ~~contracting~~ network providers.

~~(3) "Preventive care" means health care provided for prevention and early detection of disease, illness, injury or other health condition and, in the case of a full service plan includes but is not limited to all of the basic health care services required by subsection (b)(5) of Section 1345 of the Act, and Section 1300.67(f) of Title 28.~~

(3) "Measurement year," effective January 1, 2022, means the time periods within which plans shall collect the required information for the Timely Access Compliance Report and the Annual Network Report.

(A) The Timely Access Compliance Report measurement year is January 1 to December 31 of the year immediately preceding the year in which the information set forth in subsection (h)(6) is required to be submitted to the Department.

(B) The Annual Network Report measurement year is the year in which the report is required to be submitted to the Department, as set forth in subsection (h)(7), except as otherwise indicated in subsections (h)(7)(A)(iv) and (h)(7)(C) of this section.

(4) "Network" means a discrete set of network providers, as defined in subsection (b)(9), the plan has designated to deliver all covered services for a specific network service area, as defined in subsection (b)(10).

(5) "Network adequacy" means the sufficiency of a plan's network to ensure the delivery of all covered services, on an ongoing basis, in a manner that meets the network accessibility and availability requirements set forth in the Knox-Keene Act, including subsection (a)(5) of section 1371.31 and subsections (d) and (e) of section 1367 of the Knox-Keene Act, and regulation sections 1300.51 and 1300.67.2.

(6) "Network capture date" means the date the plan shall capture all data for each network required to be reported pursuant to subsections (h)(6)(B)(i)a.-e. and (h)(7)(A)(i)-(iii), for the Timely Access Compliance Report and the Annual Network Report. Effective January 1, 2022, the following network capture dates apply:

(A) For the Annual Network Report, the network capture date is January 15 of the year in which the report is required to be submitted to the Department, as set forth in subsection (h)(7).

(B) For the Timely Access Compliance Report, the network capture date is January 15 of the year immediately preceding the year in which the information set forth in subsection (h)(6) is required to be submitted to the Department.

(7) "Network identifier" is the fixed identifier assigned to each network by the Department.

(8) "Network name" is the name used by the plan to identify a specific network in plan communications and submissions to the Department.

(9) "Network provider" means any provider as defined in subsection (i) of section 1345 of the Knox-Keene Act, located inside or outside of the network service area of a designated network, meeting all of the following criteria:

(A) The provider is available to provide covered services to all plan enrollees in all product lines using the designated network.

(B) The provider is one or more of the following:

(i) An employee of the plan;

(ii) An individual health professional or health facility contracted directly with the plan pursuant to section 1379 of the Knox-Keene Act and related regulations;
(iii) An individual health professional or health facility contracted with the plan through an association, provider group, or other entity, pursuant to section 1379 and subsection (d) of section 1351 of the Knox-Keene Act, and related regulations;
(iv) An individual health professional or health facility designated to deliver covered services to enrollees in the network through a plan-to-plan contract, as defined in subsection (b)(12); or
(v) An individual health professional or health facility required to be part of the plan's network under a corrective action plan submitted to the Department, as required by the Department pursuant to section 1373.65 of the Knox-Keene Act, or as otherwise required by order of the Department.

(C) The provider is accessible to enrollees of the designated network without limitations other than established:
(i) In-network referral or authorization processes applicable to network providers; or
(ii) Processes for changing provider groups consistent with section 1373.3 of the Knox-Keene Act, in networks where enrollees are assigned to a provider group.

(D) A network provider shall not include:
(i) Providers made available through single-case agreements, letters of intent, or similarly limited contract agreements;
(ii) For any line-of-business that includes an out-of-network benefit (e.g. preferred provider organization (PPO) or point-of-service (POS)), providers who are available to enrollees only at non-participating or out-of-network cost-share levels; or
(iii) Noncontracting individual health professionals, as defined in subsection (f)(5) of section 1371.9 of the Knox-Keene Act.

(10) "Network service area" means the geographical area, and population points contained therein, where the plan is approved by the Department to arrange health care services consistent with network adequacy requirements. "Population points" shall mean a representation of where people live and work in the state of California based on United States Census Bureau population data and United States Postal Service (USPS) delivery route data, as made available by the Department on the web portal accessible at www.dmhc.ca.gov.

(11) "Patterns of non-compliance," with respect to the standards set forth in (c), means any of the following:

(A) Effective January 1, 2022, for purposes of the Provider Appointment Availability Survey:

Fewer than 70% of the network providers, as calculated on the Provider Appointment Availability Survey Results Report Form, for a specific network had a non-urgent or urgent appointment available within the time-elapsed standards set forth in subsection (c)(5) for the measurement year.

(B) The Department finds, within a period of a year or less, the plan's network was unable to deliver timely, available or accessible health care services in three or more instances pursuant to the requirements of subsection (c), and as demonstrated by other sources of information, including any findings of non-compliance identified pursuant to subsection (i)(1)(B).

(12) "Plan-to-plan contract" means an arrangement between two plans, in which the subcontracted plan makes network providers available to primary plan enrollees, and may be responsible for other primary plan functions. Plan-to-plan contracts include administrative service agreements, management service agreements or other contracts between a primary and subcontracted plan.

(A) "Primary plan" means a licensed plan that holds a contract with a group, individual subscriber, or a public agency, to arrange for the provision of health care services.

(B) "Subcontracted plan" means a licensed plan or specialized plan that is contracted to allow a primary plan's enrollees access to the subcontracted plan's network providers. The contract may be between the primary plan and the subcontracted plan or between two subcontracted plans.

(13) "Product line" means the combination of the plan's product and the type of market segment (e.g., individual, large group, small group, government) in which the product is offered. "Product" means a discrete package of health care benefits the plan is licensed to offer using a particular line of business (e.g., health maintenance organization (HMO), PPO, POS, and exclusive provider organization (EPO)) within a network service area.

(14)~~(4)~~ "Provider group" has the meaning set forth in subsection (g) of s~~S~~ection 1373.65 of the Knox-Keene Act.

(15) "Provider Survey Types" means the following five types of network providers required to be surveyed in the Provider Appointment Availability Survey Manual, pursuant to subsection (f) of this section:

(A) Primary care providers;

(B) Non-physician mental health care providers;

(C) Specialist physicians;

(D) Psychiatrists; and

(E) Ancillary service providers.

(16) "Reporting plan" means a licensed full-service or behavioral health plan that holds a contract with a group, individual subscriber, or a public agency, to arrange for the provision of health care services and has one or more networks approved by the Department as of the applicable network capture date. A reporting plan shall submit the reports set forth in subsection (h) of this section, or as set forth in section 1300.67.2.3, on behalf of itself or on behalf of a subcontracted plan through a plan-to-plan contract.

(17) "Reporting year" means the calendar year in which the plan's Timely Access Compliance Report and Annual Network Report is submitted to the Department.

(18)~~(5)~~ "Triage" or "screening" means the assessment of an enrollee's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to

screen or triage an enrollee who may need care, for the purpose of determining the urgency of the enrollee's need for care.
(19)~~(6)~~ “Triage or screening waiting time” means the time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an enrollee who may need care.
(20)~~(7)~~ “Urgent care” means health care for a condition which requires prompt attention, consistent with subsection (h)(2) of s~~S~~ection 1367.01 of the Knox-Keene Act.

(c) Standards for Timely Access to Care.
(1) Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. Plans shall establish and maintain ~~provider~~ networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard.
(2) Plans shall ensure that all plan and provider processes necessary to obtain covered health care services, including ~~but not limited to~~ ~~prior authorization~~ the processes required under section 1367.01 of the Knox-Keene Act, are completed in a manner that assures the provision of covered health care services to enrollees in a timely manner appropriate for the enrollee's condition and in compliance with the requirements of this section.
(3) When it is necessary for a provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice, and consistent with the objectives of s~~S~~ection 1367.03 of the Knox-Keene Act and the requirements of this section.
(4) Interpreter services required by s~~S~~ection 1367.04 of the Knox-Keene Act and s~~S~~ection 1300.67.04~~ of Title 28~~ shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. This subsection does not modify the requirements established in s~~S~~ection 1300.67.04, or approved by the Department pursuant to s~~S~~ection 1300.67.04 for a plan's language assistance program.
(5) In addition to ensuring compliance with the clinical appropriateness standard set forth in ~~at~~ subsection (c)(1), each plan shall ensure that its ~~contracted provider~~ network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the following timeframes:

(A) Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, except as provided in subsection (c)(5)(G);
(B) Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment, except as provided in subsection (c)(5)(G);
(C) Non-urgent appointments for primary care: within ten business days of the request for appointment, except as provided in in subsection (c)(5)(G) and in subsection (c)(5)(H);

(D) Non-urgent appointments with specialist physicians: within fifteen business days of the request for appointment, except as provided in subsection (c)(5)(G) and in subsection (c)(5)(H);
(E) Non-urgent appointments with a non-physician mental health care provider: within ten business days of the request for appointment, except as provided in subsection (c)(5)(G) and in subsection (c)(5)(H);
(F) Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within fifteen business days of the request for appointment, except as provided in subsection (c)(5)(G) and in subsection (c)(5)(H);
(G) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee;
(H) Preventive care services~~, as defined at subsection (b)(3),~~ and periodic follow up care, including ~~but not limited to,~~ standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice; and
(I) A plan may demonstrate compliance with the primary care time-elapsed standards established by this subsection through implementation of standards, processes and systems providing advanced access to primary care appointments, as defined at subsection (b)(1).

(6) In addition to ensuring compliance with the clinical appropriateness standard set forth in ~~at~~ subsection (c)(1), each dental plan, and each full service plan offering coverage for dental services, shall ensure that ~~contracted~~ dental ~~provider~~ networks have adequate capacity and availability of licensed health care providers to offer enrollees appointments for covered dental services in accordance with the following requirements:
(A) Urgent appointments within the dental plan network shall be offered within 72 hours of the time of request for appointment, when consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice;
(B) Non-urgent appointments shall be offered within 36 business days of the request for appointment, except as provided in subsection (c)(6)(C); and
(C) Preventive dental care appointments shall be offered within 40 business days of the request for appointment.

(7) Plans shall ensure they have sufficient numbers of ~~contracted~~ network providers to maintain compliance with the standards established by this section.
(A) This section does not modify the requirements regarding provider-to-enrollee ratios or geographic accessibility established by s~~S~~ections 1300.51, 1300.67.2 or 1300.67.2.1 ~~of Title 28~~.

(B) A plan operating in a network service-area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring enrollees to, or, in the case of a preferred provider organization or point-of-service network, by assisting enrollees to locate, available and accessible ~~contracted~~ network providers in neighboring network service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs.

(C) Plans shall arrange for the provision of covered ~~specialty~~ services from providers ~~specialists~~ outside the plan's ~~contracted~~ network if unavailable within the network, when medically necessary for the enrollee's condition. Plans shall ensure that e~~E~~nrollee costs for medically necessary referrals to non-network providers under this section shall not exceed applicable in-network co-payments, co-insurance and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific ~~contracted~~ network provider.

(8) A p~~P~~lan~~s~~ shall provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone as defined at subsection (b)(18)~~(5)~~.

(A) A ~~P~~plan~~s~~ shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the enrollee's condition, and ~~that~~ the triage or screening waiting time does not exceed 30 minutes.

(B) A plan may provide or arrange for the provision of telephone triage or screening services through one or more of the following means: plan-operated telephone triage or screening services consistent with subsection (b)(18)~~(5)~~; telephone medical advice services pursuant to s~~S~~ection 1348.8 of the Knox-Keene Act; the plan's contracted primary care and mental health care ~~provider~~ network; or other method that provides triage or screening services consistent with the requirements of this subsection.

~~1.~~ (i) A plan that arranges for the provision of telephone triage or screening services through ~~contracted~~ primary care and mental health care network providers shall require those providers to maintain a procedure for triaging or screening enrollee telephone calls, which, at a minimum, shall include the employment, during and after business hours, of a telephone answering machine and/or an answering service and/or office staff, that will inform the caller:

a. Regarding the length of wait for a return call from the provider, which shall not exceed 30 minutes; and

b. How the caller may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by telephone, or if needed, deliver urgent or emergency care.

~~2.~~ (ii) A plan that arranges for the provision of triage or screening services through ~~contracted~~ network primary care and mental health care providers who are unable to meet the time-elapsed standards established in paragraph (8)(A) shall also provide or arrange for the provision of plan-contracted or plan-operated triage or screening services, which shall, at a minimum, be

made available to enrollees affected by that portion of the plan's network.
~~3.~~ (iii) Unlicensed staff persons handling enrollee calls may ask questions on behalf of a licensed staff person in order to help ascertain the condition of an enrollee so that the enrollee can be referred to a licensed staff person. However, under no circumstances shall unlicensed staff persons use the answers to those questions ~~in an attempt~~ to assess, evaluate, advise, or make any decision regarding the condition of an enrollee or determine when an enrollee needs to be seen by a licensed medical professional.

(9) A plan that provides d~~D~~ental, vision, chiropractic, ~~and~~ or acupuncture services ~~plans~~ shall ensure that ~~contracted~~ network providers delivering these health care services employ an answering service or a telephone answering machine during non-business hours, that ~~which~~ provides instructions regarding how enrollees may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by telephone, or if needed, deliver urgent or emergency care.

(10) A plan ~~Plans~~ shall ensure that, during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed ten minutes.

(d) Quality Assurance Processes.

Effective January 1, 2022, e~~E~~ach plan shall have written quality assurance systems, policies and procedures designed to ensure that the plan's ~~provider~~ network is sufficient to provide accessibility, availability and continuity of covered health care services as required by the Knox-Keene Act and this section. In addition to the requirements established by s~~S~~ection 1300.70 ~~of Title 28~~, a plan's quality assurance program shall address:

(1) Standards for the provision of covered services in a timely manner consistent with the requirements of this section.

(2) Compliance monitoring policies and procedures, filed for the Department's review and approval, designed to accurately measure the accessibility and availability of ~~contracted~~ network providers~~, which shall include~~ including:

(A) Tracking and documenting network capacity and availability with respect to the standards set forth in:

(i) ~~s~~Subsections (c)(1)-(4) and (c)(6),(7)(B)-(C), and (8)-(9); and

(ii) Subsection (c)(5) by administering the Provider Appointment Availability Survey, pursuant to subsection (f) and subsections (c)(7)(A) and (c)(10).

(B) Conducting an annual E~~e~~nrollee E~~e~~xperience S~~s~~urvey~~,~~. The Enrollee Experience Survey shall:

(i). ~~which shall b~~Be conducted in accordance with a statistically valid and reliable survey methodology.

(ii) Obtain enrollees' perspectives and concerns regarding their experience obtaining timely appointments for health care services within ~~and designed to ascertain compliance with~~ the standards set forth in ~~at~~ subsection (c).~~;~~

(iii) Inform enrollees of their right to obtain an appointment within each of the time-elapsed standards set forth in subsection (c)(1) and (5), and their right to

receive interpreter services at that appointment, as required by subsection (c)(4). The requirement to notify enrollees who are surveyed about their right to obtain a timely appointment shall be in addition to the notice requirements set forth in section 1367.031 of the Knox-Keene Act.

(iv) Evaluate the experience of limited English proficient enrollees in obtaining interpreter services by obtaining the enrollee's perspectives and concerns regarding:

a. Coordination of appointments with an interpreter;

b. Availability of interpreters who speak the enrollee's preferred language; and

c. Quality and accuracy of interpreter services received.

(v) Be translated into the enrollee's preferred language, in those situations where:

a. The plan is aware of the enrollee's preferred language; and

b. The enrollee's preferred language is, as of the date the survey is sent to the enrollee, one of the top 15 languages spoken by limited English proficient individuals in California as determined by the Department of Health Care Services.

(C) Conducting an annual P~~p~~rovider Satisfaction S~~s~~urvey, which shall be conducted in accordance with a statistically valid and reliable survey methodology and designed to obtain ~~solici~~t, from physicians and non-physician mental health providers, perspectives and concerns regarding compliance with the standards set forth in ~~at~~ subsection (c)~~;~~. In addition, the Provider Satisfaction Survey shall evaluate provider perspectives and concerns with the plan's language assistance program regarding:

(i) Coordination of appointments with an interpreter;

(ii) Availability of an interpreter, based on the needs of the enrollee; and

(iii) The ability of the interpreter to effectively communicate with the provider on behalf of the enrollee.

(D) Reviewing and evaluating, on not less than a quarterly basis, the information available to the plan regarding network capacity, accessibility, availability, ~~and~~ continuity of care, timely access, and network adequacy requirements set forth under the Knox-Keene Act. ~~including but not limited to information obtained through enrollee and provider surveys, enrollee grievances and appeals, and triage or screening services; and~~

(E) Verifying, at least once every three years, the advanced access programs reported by ~~contracted~~ network providers and provider groups~~, medical groups and independent practice associations to~~ by confirming that appointments are scheduled consistent with the definition of advanced access in subsection (b)(1). The plan shall require network providers to give written notice to the plan no later than 30 calendar days immediately following the date upon which a network provider no longer provides advanced access appointments to enrollees.

(F) A plan that provides services through a preferred provider organization ~~network~~ line of business may, for that ~~portion of its network~~ product line, demonstrate compliance with the timely access and continuity of care requirements of subsections (d)(2)(A)(i) and within subsection (d)(2)(D) by

monitoring, on not less than an annual basis: ~~the number of PPO primary care and specialty physicians under contract with the plan in each county of the plan's service area;~~ enrollee grievances and appeals regarding timely access; the results of the Enrollee Experience Survey; and the results of the Provider Satisfaction Survey. This subsection does not exempt a plan that provides services through a preferred provider organization line of business from all other requirements set forth in subsection (d)(2)(D). ~~and the rates of compliance with the time-elapsed standards established in subsection (c)(5).~~

(3) A ~~plan shall~~ plan's process for documenting and implementing prompt investigation and corrective action when compliance monitoring discloses that the plan's ~~provider~~ network is not sufficient to ensure timely access and network adequacy as required by this section.~~, including but not limited to~~ A plan's quality assurance process shall ensure the plan takes ~~ing~~ all necessary and appropriate action to identify the cause(s) underlying identified timely access and network adequacy deficiencies and to bring its network into compliance. Plans shall give advance written notice to all ~~contracted~~ network providers affected by a corrective action, and shall include a description of the identified deficiencies, the rationale for the corrective action, and the name and telephone number of the person authorized to respond to provider concerns regarding the plan's corrective action.

(e) Enrollee Disclosure and Education.

(1) Plans shall disclose in all E~~e~~vidences of C~~c~~overage the availability of triage or screening services and how to obtain those services. Plans shall disclose ~~annually, in plan newsletters or comparable enrollee communications, the plan's~~ standards for timely access in the manner required under section 1367.031 of the Knox-Keene Act.

(2) The telephone number at which enrollees can access triage and screening services shall be included on enrollee membership cards. A plan or its delegated provider group may comply with this requirement through an additional selection in its automated customer service telephone answering system, where applicable, so long as the customer service number is included on the enrollee's membership card.

(f) Provider Appointment Availability Survey.

(1) Beginning January 1, 2022, and annually thereafter, a plan shall demonstrate that each of its networks has adequate capacity and availability of network providers sufficient to offer enrollees appointments within the standards set forth in subsection (c)(5) by administering the Provider Appointment Availability Survey, and reporting a rate of compliance for each network. When conducting the Provider Appointment Availability Survey, the plan shall follow all requirements in the Provider Appointment Availability Survey Manual (Revised [OAL insert effective date here]), which is hereby incorporated by reference, and the Timely Access and Annual Network Submission Instruction Manual (Revised [OAL insert effective date here]), which is hereby incorporated by reference. In conducting the Provider Appointment Availability Survey, a plan must do all of the following:

(A) Determine the networks required to be surveyed;

(B) Complete a Contact List Report Form for each of the Provider Survey Types;

(C) Determine the number of network providers from which the plan is required to obtain survey responses to meet the required sample size;
(D) Select the network providers to be surveyed for each network;
(E) Prepare the survey questions;
(F) Administer the Provider Appointment Availability Survey using one or more of the three modalities set forth in Provider Appointment Availability Survey Manual: Extraction, the Three Step Protocol, or a Qualified Advanced Access Provider. If a plan uses the Three Step Protocol, the plan shall adhere to the following timeframes in conducting the survey:

(i) 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. If an email, electronic communication or fax survey invitation cannot be sent to a provider, because the appropriate contact was not available or the provider prefers to be contact by telephone, the survey shall be completed by telephone within 5 business days from the date of the initial telephone call.
(ii) If the provider has not responded within 2 business days of sending the initial survey invitation, a reminder notice may be sent to the provider.
(iii) If the provider does not respond to the survey within five business days of the plan sending the survey invitation, the plan shall initiate the survey via telephone within 6-15 business days of sending the initial survey invitation.
(iv) If a provider's office does not answer the initial call, the plan shall call the provider back on or before the next business day to initiate the telephone survey. If the plan is able to leave a telephone message requesting that the provider complete the survey via a call back number and/or email, electronic communication or fax, the survey must be completed by the provider within two business days of the telephone message.
(v) If a provider declines to respond to the survey, the 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 plan shall offer the provider the option to receive a follow-up call within the next 2 business days.
(vi) If the provider does not complete the telephone survey within 2 business days of the initial telephone call or the telephone message left requesting the provider complete the survey or during the follow-up telephone call, the non-responding provider shall be replaced with a provider from the oversample.
(vii) If the plan was unable to initiate a telephone survey of the provider within 10 business days of sending the initial survey attempt conducted 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.

(G) Record the survey outcome, the provider's survey responses, and compliance determinations on the Raw Data Report Form;
(H) Calculate and record the results of the Provider Appointment Availability Survey on the Results Report Form;

(I) Identify whether each network met or exceeded the threshold rate of compliance set forth in subsection (b)(11)(A). If a network failed to meet or exceed the threshold rate of compliance, the plan shall implement prompt investigation and corrective action, as required by subsection (d)(3), to bring the network into compliance with this section;

J) Conduct the quality assurance review and create the quality assurance report; and

(K) Submit the plan's Timely Access Compliance Report, in accordance with the requirements set forth in subsection (h) and the Timely Access and Annual Network Submission Instruction Manual.

(2) A plan shall complete the report forms identified in subsection (h)(6)(B) in accordance with the requirements set forth in the Provider Appointment Availability Survey Manual and Timely Access and Annual Network Submission Instruction Manual. A plan's final rates of compliance shall be determined and calculated in accordance with all requirements and instructions set forth in the Provider Appointment Availability Survey Manual and the Timely Access and Annual Network Submission Instruction Manual. A plan shall report rates of compliance that include survey results from network providers made available to the plan through a plan-to-plan contract with a subcontracted plan.

(3) After the annual Provider Appointment Availability Survey has been completed, a plan shall have an external vendor, who is not affiliated with the plan, conduct a quality assurance review. The quality assurance review shall be documented in a quality assurance report prepared by the plan's external vendor. The quality assurance review and report shall meet all requirements set forth in the Provider Appointment Availability Survey Manual. The quality assurance review shall ensure that:

(A) The plan followed all statutory and regulatory requirements related to the Provider Appointment Availability Survey, the Provider Appointment Availability Survey Manual, and Provider Appointment Availability Survey Report Form Instructions, as set forth in the Timely Access and Annual Network Submission Instruction Manual.

(B) All information in the plan's Provider Appointment Availability Survey Report Forms submitted to the Department is true, complete, and accurate.

(4) A plan shall ensure the following actions are conducted in accordance with the Provider Appointment Availability Manual and the Timely Access and Annual Network Submission Instruction Manual:

(A) Gathering information and data to complete the Provider Appointment Availability Survey Report Forms.

(B) Validating the information and data included in the Provider Appointment Availability Survey Report Forms, set forth in (h)(6)(B)(1), and rectifying any errors.

(C) Verifying all providers in the plan's Provider Appointment Availability Survey Report Forms meet all eligibility criteria.

(D) Reporting any errors the plan did not correct and identifying the steps the plan will take to ensure compliance with the Provider Appointment Availability Survey Manual and Provider Appointment Availability Survey

Report Form Instructions, as set forth in the Timely Access and Annual Network Submission Instruction Manual in future reporting years. Nothing in this section shall relieve the plan of its obligation to report accurate information and data in the Timely Access Compliance Report submitted to the Department pursuant to subsection (h)(6).

(5) A plan shall not require or instruct network providers to hold appointments open that are not available to patients for the purpose of satisfying appointment waiting time standards set forth under subsection (c)(5).

(6) This subsection (f) does not modify the requirements of a plan to maintain a network sufficient to provide timely access and network adequacy as set forth in subsection (c) and the Knox-Keene Act.

(f)(g) Requests for Alternative Access Standards.

In addition to a plan's ability to request alternative time and distance standards and alternative provider to enrollee ratios pursuant to section 1300.67.2.1, a plan Plans may also file, by a notice of material modification, a to request for the Department's approval of alternative time-elapsed standards, or alternatives to time-elapsed standards, or an alternative standard for the threshold rate of compliance set forth in the definition of patterns of non-compliance in subsection (b)(11)(A).

(1) A request for an alternative time-elapsed standard or an alternative to time-elapsed standards shall include:

(A)(1) An explanation of the plan's clinical and operational reasons for requesting the alternative standard, together with information and documentation, including scientifically valid evidence (based on reliable and verifiable data), demonstrating that the proposed alternative standard is consistent with professionally recognized standards of practice and a description of the expected impact of the alternative standard on clinical outcomes, on access for enrollees, and on contracted health care network providers;

(B)(2) The burden shall be on the plan to dDemonstratinge and substantiatinge why a proposed alternative standard is more appropriate than the time elapsed standards set forth in subsection (b)(11)(A) and subsection (c).;

(C) For Aa plan Plans that have received approval for an alternative standard, filingshall file, on an annual basis, an amendment requesting approval for continued use of the alternative standard, and providing updated information and documentation to substantiate the continued need for the alternative standard; and

(2)(3) In approving or disapproving a plan's proposed alternative standards, the Department may consider all relevant factors, including but not limited to the factors set forth in subsections (d) and (e) of Ssection 1367.03 of the Knox-Keene Act and subsection (c) of Ssection 1300.67.2.1. of Title 28.

(3) A request for an alternative standard to the threshold rate of compliance set forth in subsection (b)(11)(A), shall include the information set forth under subsection (g)(1)(B)-(C) and shall be subject to subsection (g)(2).

(g)(h) Filing, Implementation and Reporting Requirements Beginning for Reporting Year 2022.

~~(1) Not later than twelve months after the effective date of this section, plans shall implement the policies, procedures and systems necessary for compliance with the requirements of Section 1367.03 of the Act and this section. Not later than nine months after the effective date of this section, each plan shall file an amendment pursuant to Section 1352 of the Act disclosing how it will achieve compliance with the requirements of this section, which shall include substantiating documentation, including but not limited to, quality assurance policies and procedures, survey forms, subscriber and enrollee disclosures, and amendments to provider contracts. The amendment shall also include documentation sufficient to confirm the plan's compliance, as of the date of filing, with existing requirements regarding physician-to-enrollee ratios, including but not limited to updated Exhibits I-1 and I-4 to the plan's license application. If a plan asserts prior Department approval of alternative physician-to-enrollee ratios or an alternative method of demonstrating network adequacy, the filing shall contain confirming documentation. A plan may concurrently request approval of alternative physician-to-enrollee ratios or an alternative method of demonstrating network adequacy by filing a notice of material modification pursuant to section 1300.67.2.1 of Title 28.~~
~~(2) By March 31, 2012, and by March 31 of each year thereafter, plans shall file with the Department a report, pursuant to subsection (f)(2) of Section 1367.03 of the Act, regarding compliance during the immediately preceding year. The first reporting period shall be the calendar year ending December 31, 2011. The reports shall document the following information:~~
(1) The requirements set forth in subsection (h) shall apply only to reporting plans, unless otherwise indicated. Except as specified in subsection (h)(5), this subsection (h) shall be effective on and after January 1, 2022.

(A) By May 1, 2022, and by May 1 of each subsequent year, a reporting plan shall file with the Department a Timely Access Compliance Report, as described in subsection (h)(6), and an Annual Network Report, as described in subsection (h)(7). Both reports shall include the network access profile, as set forth in subsection (h)(8).

(B) By May 1, 2022, and by May 1 of each subsequent year, a subcontracted plan for one or more of the networks identified in subsection (h)(1)(A), and a plan set forth in subsection (a)(2), shall complete only the network access profile, as set forth in subsections (h)(8)(A)-(C).

(2) A plan shall submit the Timely Access Compliance Report and Annual Network Report using report form templates issued by the Department pursuant to this section, and shall designate a compliance officer who shall be responsible for reviewing and submitting the reports, and verifying, pursuant to section 1004, that the information and data submitted within the reports and the network access profile is true and correct and does not contain misstatements or omissions of material fact. The plan shall submit the required report forms and information through the Department's web portal, accessible at www.dmhc.ca.gov.
(3) When reporting networks that include network providers made available through plan-to-plan contracts, the primary plan is the reporting plan for the network, and is responsible for submitting all information and data, including the Timely Access Compliance Report and the Annual Network Report, as described in subsections (h)(1)(A), (h)(6) and (h)(7), on an annual basis. The subcontracted plan for a network is

subject to the reporting requirements set forth in subsection (h)(1)(B). The primary plan's submission shall include all network providers, enrollment, grievance and other required data set forth in these subsections, whether maintained by the plan, a subcontracted plan, or a delegated provider group.

(4) A plan shall submit the Timely Access Compliance Report, the Annual Network Report, and accompanying network access profile information as set forth in subsections (h)(6)(B), (h)(7)(A)(i)-(iii), and (h)(8), using the network capture date for the applicable measurement year, beginning on January 15, 2022.

(5) On or before June 1, 2021, a plan shall file an amendment pursuant to section 1352 of the Knox-Keene Act disclosing how the plan will achieve compliance with the requirements of this section. The submission shall include policies and procedures necessary for compliance with the requirements of this section.

(6) Timely Access Compliance Report. A plan shall submit the items set forth in subsections (h)(6) and (h)(8), as part of its Timely Access Compliance Report for each applicable measurement year, as defined in (b)(3)(A). Each item shall be submitted in accordance with the requirements set forth in the Timely Access and Annual Network Submission Instruction Manual. The following items shall be included in the plan's Timely Access Compliance Report:

(A) The ~~timely access standards set forth in the~~ plan's policies and procedures setting forth:

(i) The plan's timely access standards, consistent with the standards set forth in subsection (c), including, as may be applicable, any alternative time-elapsed standards and alternatives to time-elapsed standards for which the plan obtained the Department's prior approval by o~~O~~rder.~~;~~

~~(B) The rate of compliance, during the reporting period, with the time elapsed standards set forth in subsection (c)(5), separately reported for each of the plan's contracted provider groups located in each county of the plan's service area. A plan may develop data regarding rates of compliance through statistically reliable sampling methodology, including but not limited to provider and enrollee survey processes, or through provider reporting required pursuant to subsection (f)(2) of Section 1367.03 of the Act;~~

(ii) The plan's Quality Assurance Processes for monitoring each timely access standard and implementing corrective action, as set forth in subsection (d) and the Provider Appointment Availability Survey Manual, including any alternative standards to the threshold rate of compliance for urgent or non-urgent appointments approved by the Department.

(iii) The plan's oversight procedures for ensuring compliance with the timely access standards set forth in subsection (c), including any periodic reporting requirements related to adherence of timely access standards by subcontracted plans in plan-to-plan contracts.

(B) Provider Appointment Availability Survey Report Forms.

(i) A plan shall submit the information and data obtained by the plan from conducting the Provider Appointment Availability Survey for each of the Provider Survey Types set forth in the Provider Appointment Availability Survey Manual. A plan shall submit the information and data obtained by the plan from conducting the Provider Appointment Availability Survey on the

following report forms issued by the Department, form numbers 40-254 through 40-264, which are incorporated by reference and referred to collectively as "Provider Appointment Availability Survey Report Forms," as listed below:

a. Primary Care Providers Contact List Report Form (Form No. 40-254) (Eff. [OAL insert date here]).

b. Non-Physician Mental Health Care Providers Contact List Report Form (Form No. 40-255) (Eff. [OAL insert date here]).

c. Specialist Physicians Contact List Report Form (Form No. 40-256) (Eff. [OAL insert date here]).

d. Psychiatrists Contact List Report Form (Form No. 40-257) (Eff. [OAL insert date here]).

e. Ancillary Service Providers Contact List Report Form (Form No. 40-258) (Eff. [OAL insert date here]).

f. Primary Care Providers Raw Data Report Form (Form No. 40-259) (Eff. [OAL insert date here]).

g. Non-Physician Mental Health Care Providers Raw Data Report Form (Form No. 40-260) (Eff. [OAL insert date here]).

h. Specialist Physicians Raw Data Report Form (Form No. 40-261) (Eff. [OAL insert date here]).

i. Psychiatrists Raw Data Report Form (Form No. 40-262) (Eff. [OAL insert date here]).

j. Ancillary Service Providers Raw Data Report Form (Form No. 40-263) (Eff. [OAL insert date here]).

k. Results Report Form (Form No. 40-264) (Eff. [OAL insert date here]), 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;
6. Summary of Rates of Compliance Tab; and
7. Network by Provider Survey Type Tab.

(ii) A plan shall complete all Provider Appointment Availability Survey Report Forms as specified in the Provider Appointment Availability Survey Manual and Timely Access and Annual Network Submission Instruction Manual. For each Provider Survey Type, a plan shall submit:

a. At least one Contact List Report Form for each Provider Survey Type containing all network providers specified in the Provider Appointment Availability Survey Manual. A plan shall populate the Contact List Report Form with the required network provider information as of the network capture date for the applicable measurement year.

b. At least one Raw Data Report Form, which shall contain each of the network providers selected by the plan to be surveyed, and the outcome or response to the Provider Appointment Availability Survey.

c. The results of the survey in Results Tabs, set forth in subsection (h)(6)(B)(i)k.1-5, in a single Results Report Form. The Results Report Form shall be programmed to automatically calculate the rate of compliance using the formulas set forth on the Summary of Rates of Compliance Report Form and the Network by Provider Survey Type Report Form based on the information entered by the plan on each Results Tab set forth in subsection (h)(6)(B)(i)k.1-5.

(C)(i) A description of the plan's procedure for identifying any incidents of non-compliance resulting in substantial harm to an enrollee, as defined in Civil Code section 3428, and patterns of non-compliance, as defined in subsection (b)(11). This description shall include:

a. The plan's definition of an incident of non-compliance resulting in substantial harm to an enrollee, which at a minimum shall include the definition set forth in Civil Code section 3428;

b. The plan's definition of patterns of non-compliance, which at a minimum shall include the definitions set forth in subsection (b)(11); and

c. The plan's monitoring mechanism and the sources of information or data the plan uses to identify any patterns of non-compliance and incidents of non-compliance resulting in substantial harm to an enrollee.

(ii) Information describing whether the plan identified:

~~Whether the plan identified, during the reporting period,~~

~~(1)~~ a. A~~a~~ny incidents of non-compliance resulting in substantial harm to an enrollee that occurred during the measurement year; and ~~or~~

~~(2)~~ b. A~~a~~ny patterns of non-compliance that occurred during the measurement year. ~~and, if so,~~

(iii) A~~a~~ description of the identified non-compliance, set forth in subsection (h)(6)(C)(ii), and the plan's responsive investigation~~,~~ and determination.

(iv) A ~~and~~ corrective action~~;~~ plan, which shall include the following information with respect to each identified incident of non-compliance resulting in harm to an enrollee and pattern of non-compliance:

a. The steps the plan has taken or intends to take with respect to each issue of non-compliance in order to bring its network into compliance with the Knox-Keene Act; and
b. Any follow-up actions the plan has taken or intends to take to ensure compliance with the Knox-Keene Act.

(v) If the plan later identified, but did not submit, the information set forth in subsection (h)(6)(C)(i)-(ii) in a prior reporting year, the plan shall include the required information set forth in subsection (h)(6)(C)(i)-(ii).

(D) The plan's policies and procedures used for verifying network providers' advanced access programs, and a ~~A~~ list of all provider groups ~~and individual providers~~ network providers utilizing advanced access appointment scheduling.~~;~~

(E) A description of the implementation and use ~~by the plan and its contracting providers~~ of triage, telemedicine, including the applicable telehealth modalities, and health information technology used by the plan and its network providers to provide timely access to care.~~;~~

(F) The survey questions, survey methodology, and policies and procedures for administering the Enrollee Experience Survey and the Provider Satisfaction Survey. The plan shall include the results of the most recent annual ~~enrollee and provider surveys and~~ Enrollee Experience Survey and Provider Satisfaction Survey, and a comparison with the results of the prior year's Enrollee Experience Survey and Provider Satisfaction Survey ~~survey~~, including a discussion of the relative change in survey results.~~; and~~

(G) The quality assurance report including all information set forth in the Provider Appointment Availability Survey Manual.

~~Information confirming the status of the plan's provider network and enrollment at the time of the report, which shall include, on a county-by-county basis, in a format approved by the Department:~~

~~1. The plan's enrollment in each product line; and~~

~~2. A complete list of the plan's contracted physicians, hospitals, and other contracted providers, including location, specialty and subspecialty qualifications, California license number and National Provider Identification Number, as applicable. Physician specialty designation shall specify board certification or eligibility consistent with the specialty designations recognized by the American Board of Medical Specialties.~~

~~3. The information required by paragraphs (g)(2)(G)(1) and (2) shall be included with the annual report until the Department implements a web-based application that provides for electronic submission via a web portal designated for the collection of plan network data. Upon the Department's implementation of the designated network data collection web portal, the information required by paragraphs (G)(1) and (2), shall be submitted directly to the web portal.~~

(7) Annual Network Report. The Annual Network Report shall confirm the status of each of the plan's networks and enrollment, including the data categories set forth in subsections (a) and (g) of section 1367.035 of the Knox-Keene Act. The Annual Network Report shall consist of the items set forth in this subsection and subsection (h)(8), for the applicable measurement year. The plan shall submit the items described in this subsection within the Department's report forms in the manner described in subsection (h)(7)(B) and in the Timely Access and Annual Network Submission Instruction Manual.

(A) The Annual Network Report shall include the following information and data, in the format approved by the Department set forth in subsection (h)(7)(B) and incorporated documents:

(i) The plan's enrollment in each network and product line, on a ZIP Code and county basis.

(ii) The network service area of each network, on a ZIP Code and county basis.

(iii) A complete list of all network providers within each network.

(iv) All grievances regarding network adequacy and timely access compliance received for each network during the measurement year described in subsection (b)(3)(A).

(B) Annual Network Report Forms. Plans shall submit the network information and data set forth in subsection (h)(7) in accordance with the Timely Access and

Annual Network Submission Instruction Manual. Plans shall use and submit only the following report forms issued by the Department, form numbers 40-265 through 40-272, which are incorporated by reference and referred to collectively as "Annual Network Report Forms," as listed below:

(i) Network Service Area and Enrollment Report Form (Form No. 40-265) (Eff. [OAL insert date here]).

(ii) PCP and PCP Non-Physician Medical Practitioner Report Form (Form No. 40-266) (Eff. [OAL insert date here]).

(iii) Specialist and Specialist Non-Physician Medical Practitioner Report Form (Form No. 40-267) (Eff. [OAL insert date here]).

(iv) Mental Health Professional and Mental Health Facility Report Form (Form No. 40-268) (Eff. [OAL insert date here]).

(v) Other Outpatient Provider Report Form (Form No. 40-269) (Eff. [OAL insert date here]).

(vi) Hospital and Clinic Report Form (Form No. 40-270) (Eff. [OAL insert date here]).

(vii) Telehealth Report Form (Form No. 40-271) (Eff. [OAL insert date here]).

(viii) Timely Access and Network Adequacy Grievance Report Form (Form No. 40-272) (Eff. [OAL insert date here]).

(C) A plan required to submit data in accordance with subsection (a)(4) of section 1371.31 of the Knox-Keene Act, shall use and submit only the report form issued by the Department for the submission of the required data, which is incorporated by reference and referred to as "Out-of-Network Payment Report Form" (Form No. 40-273)(Eff. [OAL insert date here]). A plan shall submit this data in accordance with the Timely Access and Annual Network Submission Instruction Manual. The plan shall report data required for the Out-of-Network Payment Report Form in accordance with the measurement year described in subsection (b)(3)(A).

(8) Network Access Profile. Before submission of the report forms set forth in section (h)(6) and (h)(7), the plan shall complete or update the network access profile in the Department's web portal, so that it contains current information and data as of the network capture date for each applicable measurement year, as defined in subsection (b)(3)(A)-(B). The plan shall identify each network by its network name and network identifier, and describe each network identified pursuant to the requirements in this subsection and in the Timely Access and Annual Network Submission Instruction Manual. Prior to submission, the plan shall affirm the accuracy of the information and data, as described in subsection (h)(2). The plan shall submit the network access profile data as follows:

(A) The plan shall update the network access profile each year before submitting the reports to reflect changes to the reported networks as of the network capture date.

(B) Within the network access profile, the plan shall identify the network name and Department-assigned network identifier for each reported network. To the extent a plan has removed, added or changed a reported network since the prior measurement year, the plan shall identify the appropriate amendment or notice

of material modification of the plan's license, consistent with section 1352 of the Knox-Keene Act and related regulations.

(C) Within the network access profile, for each network the plan shall identify:

(i) The product lines that use the network;

(ii) The network service area; and

(iii) The source of network providers, including:

a. Whether the plan directly employs or contracts with network providers, in accordance with subsections (b)(9)(B)(i)-(iii);

b. Whether the plan serves as a primary plan or subcontracted plan for the network;

c. If the plan is a primary plan, the subcontracted plan networks that contribute network providers through plan-to-plan contracts, and any delegation of plan functions to those subcontracted plans, as applicable; and

d. If the plan serves as a subcontracted plan, the networks to which the plan contributes network providers through a plan-to-plan contract.

(D) Within the Timely Access and Annual Network Submission Instruction Manual and the Department's web portal, the Department shall set forth standardized terminology the plan shall use to submit data in the report forms. The plan shall report the required data within the report forms either by using the standardized terminology when reporting the information listed in subsections (h)(8)(D)(i)-(x), or by connecting the plan's own terminology to the standardized terminology, as available, via the crosswalk tables provided by the Department within the Department's web portal. Such areas of standardized terminology shall include the following:

(i) Hospital names. The plan shall report hospital names using the name on record with the California Office of Statewide Health Planning and Development (OSHPD), available at https://oshpd.ca.gov, as of the network capture date.

The Department shall make available annually a standardized list of hospital names within its web portal, based on the most recent data obtained from OSHPD.

(ii) Product line categories.

(iii) Provider types. The plan shall report physician specialty type, non-physician medical practitioner specialty type, mental health professional specialty type, other outpatient provider type, hospital and other inpatient provider type, clinic type, and mental health facility type, according to the standardized terminology. Plans shall identify physician specialties using the board certification or eligibility designation consistent with the physician specialty and subspecialty designations recognized by the American Board of Medical Specialties and the Knox-Keene Act. Non-physician medical practitioner specialty designations shall be based on the areas of specialization available through the appropriate licensing boards, as applicable.

(iv) Provider languages spoken.

(v) Provider group names. The plan shall report provider group names using the business name registered with the Secretary of State, the name on file with the Department for capitated provider groups, or the name on file with the Department for risk-bearing organizations that file information with the Department pursuant to section 1300.75.4.2, as applicable. The Department shall make available annually a standardized list of provider group names within the Department's web portal, based on filings with the Department and the Secretary of State. Each provider group reported by the plan shall match the most recent list on the Department's web portal. If the provider group is not listed on the Department's standardized list, the plan shall report the provider group using a name that is consistent within this subsection.

(vi) Type of license or certificate. The standardized terminology shall be consistent with one or more of the following sources: the Department of Consumer Affairs, the California Board of Registered Nursing, the Medical Board of California, the Osteopathic Medical Board of California, the National Plan and Provider Enumeration System taxonomy, or departments within California Health and Human Services Agency, including the Department of Health Care Services.

(vii) ZIP Code and county. The Department shall make available annually in its web portal a list of ZIP Codes and counties for the State of California, issued by the USPS. Each ZIP Code and county combination reported by the plan within California shall match the USPS list of ZIP Codes posted on the Department's web portal.

(viii) California license number and National Provider Identifier (NPI). The Department shall make available annually in its web portal a current list of active NPIs, derived from the National Plan and Provider Enumeration System (NPPES), NPI registry (npiregistry.cms.hhs.gov). The Department shall also make available annually in its web portal a list of California license numbers for physicians, derived from the Department of Consumer Affairs (www.dca.ca.gov). The plan shall report the NPI of each network provider, and the license number of each physician network provider using the standardized terminology. When reporting non-physician network providers and out-of-state network providers for which state licensure is required, the plan shall report the license number issued to the network provider by the appropriate licensing board.

(ix) Grievance field values. The plan shall report information related to timely access and network adequacy grievances, as set forth in section 1367.035(a)(6) of the Knox-Keene Act.

(x) Telehealth location and modality.

(9) Nothing in this section shall prohibit the Department from reviewing the information and data submitted pursuant to subsection (h) of this section for completeness or accurate reporting, and preventing submission of information and data that is incomplete or does not conform to the requirements set forth in this subsection or within any incorporated documents within this subsection. Information and data that is erroneous or contrary to the plan's representations to the Department within the plan's submission, or in other approved or pending filings, assessments, or actions with the

Department, may be omitted from the Department's review of the Timely Access Compliance Report or the Annual Network Report. The plan shall retain full responsibility for ensuring the accuracy of the information and data, as set forth and required by subsections (a)(3), (a)(5), (h)(2), (i), and (j).

(i) Determining Compliance and Non-Compliance.
(1) A network is non-compliant with the requirements of this section, and sections of the Knox-Keene Act related to timely access and network adequacy under any of the following circumstances:

(A) The plan failed to demonstrate it has met network adequacy for a network service area;
(B) The plan failed to provide timely access to care to an enrollee, as required by subsection (c);
(C) The results of the plan's Provider Appointment Availability Survey indicate a pattern of non-compliance, as described in subsection (b)(11)(A), was identified during a measurement year; or
(D) The plan failed to report sufficient or accurate information and data demonstrating network adequacy or timely access for a network service area.

(2) The Department may consider the failure of a plan to provide timely, complete, or accurate reports pursuant to subsections (h)(6)(B), (h)(7) and (h)(8) as a presumptive failure to satisfy network adequacy requirements and a failure to demonstrate compliance with subsection (c)(5). The burden is on the plan to submit information and data demonstrating the plan has an adequate network upon such a finding by the Department.
(3) ~~In determining~~ When evaluating ~~a plan's~~ compliance ~~or non-compliance~~ with the standards set forth in subsection (c), ~~requirements of this section,~~ the Department will focus more upon patterns of non-compliance rather than isolated episodes of non-compliance. ~~and~~
(4) The Department may consider all relevant factors when evaluating compliance, including ~~but not limited to~~:

(A) The efforts by a plan to evade the standards, such as referring enrollees to providers who are not appropriate for an enrollee's condition, failing to maintain an adequate number or variety of network providers necessary to deliver timely care, or inappropriately characterizing network providers who are available to deliver covered services;
(B) The nature and extent of a plan's efforts to avoid or correct non-compliance, including whether a plan has taken all necessary and appropriate action to identify the cause(s) underlying identified timely access and network adequacy deficiencies and to bring its network into compliance;
(C) The failure of a plan to follow the requirements of this section when submitting the annual reports set forth in subsection (h);
(D)~~(C)~~ The nature of physician practices, including group and individual practices, the nature of a plan's network, and the nature of the health care services offered;
(E)~~(D)~~ The nature and extent to which a single instance of non-compliance results in, or contributes to, serious injury or damages to an enrollee; and

~~(E) Other factors established in relevant provisions of law, and other factors that the Director deems appropriate in the public interest and consistent with the intent and purpose of the Act as applied to specific facts or circumstances.~~

(F) The nature and extent to which a single instance of non-compliance results from the plan's failure to monitor or make health care services readily available and accessible for the network service area in a manner prescribed under the Knox-Keene Act.

(5) The Department may take enforcement action against a plan for any finding of non-compliance. Prior to taking enforcement action, the Department will provide the plan with an opportunity to respond to the Department's findings of non-compliance, and present a corrective action plan as applicable. The Department may also take enforcement action if the plan's responsive information or corrective action plan does not sufficiently address the findings of non-compliance.

(j) Review and Enforcement.
Failure to comply with requirements of this section, including the failure to submit timely, complete and accurate information and data within the Department's web portal or required annual reports, or failure to correct an identified deficiency, may constitute a basis for disciplinary or enforcement action against the plan. The Department may request additional information from the plan as deemed necessary to complete the review of required reports or information or to carry out and complete any enforcement action. The reporting plan shall be responsible for demonstrating compliance with this section and the Knox-Keene Act. The Director shall have the civil, criminal, and administrative remedies available under the Knox-Keene Act, including section 1394. Nothing in this section shall be construed as affecting the director's authority pursuant to Article 7 (commencing with section 1386) or Article 8 (commencing with section 1390) of the Knox-Keene Act.

(k) Nothing in this regulation is intended to alter the legal and contractual obligations for Medi-Cal managed care plan reporting requirements to the Department of Health Care Services.

Note: Authority cited: Sections 1344, 1346, ~~and~~ 1367.03, 1386, and 1394 Health and Safety Code. Reference: Sections 1342, 1367, 1367.01, 1367.03, 1367.04, 1367.035, 1370, 1371.31, 1375.7 and 1380, Health and Safety Code.

Section 1300.67.2.3. Non-Emergency Annual Timely Access and Network Reporting Requirements for Measurement Year 2020; Timely Access Quality Assurance for Measurement Year 2021.

(a) Filing, Implementation and Reporting Requirements for Measurement Year 2020.
(1) By March 31, 2021 a plan shall file with the Department a report, pursuant to subsection (f)(2) of section 1367.03 of the Knox-Keene Act, regarding compliance during the preceding year. The report shall document the following information:

(A) The timely access standards set forth in the plan's policies and procedures including, as may be applicable, any alternative time-elapsed standards and alternatives to time-elapsed standards for which the plan obtained the Department's prior approval by order;
(B) The rates of compliance, during the reporting period, with the time-elapsed standards set forth in subsection (c)(5) of section 1300.67.2.2. A plan shall develop data regarding rates of compliance through a statistically reliable sampling methodology, including but not limited to provider and enrollee survey processes, or through provider reporting required pursuant to subsection (f)(2) of section 1367.03 of the Knox-Keene Act;
(C) Whether the plan identified, during the reporting period, (1) any incidents of non-compliance resulting in substantial harm to an enrollee or (2) any patterns of non-compliance and, if so, a description of the identified non-compliance and the plan's responsive investigation, determination and corrective action;
(D) A list of all provider groups and individual providers utilizing advanced access appointment scheduling;
(E) A description of the implementation and use by the plan and its network providers of triage, telemedicine, and health information technology to provide timely access to care;
(F) The results of the most recent annual enrollee and provider surveys and a comparison with the results of the prior year's surveys, including a discussion of the relative change in survey results; and
(G) Information confirming the status of the plan's network and enrollment at the time of the report, which shall include, on a county-by-county basis, in a format approved by the Department:

(i)The plan's enrollment in each product line; and
(ii) A complete list of the plan's network physicians, hospitals, and other network providers, including location, specialty and subspecialty qualifications, California license number and National Provider Identifier, as applicable. Physician specialty designation shall specify board certification or eligibility consistent with the specialty designations recognized by the American Board of Medical Specialties.
(iii) The information required by paragraphs (G)(i) and (ii), shall be submitted directly to the Department's web portal, accessible at www.dmhc.ca.gov.

(b) Quality Assurance Processes for Measurement Year 2021. Each plan shall have written quality assurance systems, policies and procedures designed to ensure that the plan's network is sufficient to provide accessibility, availability and continuity of covered health care services as required by the Knox-Keene Act and this section. In addition to the requirements established by section 1300.70, a plan's quality assurance program shall address:
(1) Standards for the provision of covered services in a timely manner consistent with the requirements of this section.
(2) Compliance monitoring policies and procedures, filed for the Department's review and approval, designed to accurately measure the accessibility and availability of contracted providers, which shall include:

(A) Tracking and documenting network capacity and availability with respect to the standards set forth in section 1300.67.2.2(c);
(B) Conducting an annual enrollee experience survey, which shall be conducted in accordance with a valid and reliable survey methodology and designed to ascertain compliance with the standards set forth at section 1300.67.2.2(c);
(C) Conducting an annual provider survey, which shall be conducted in accordance with a valid and reliable survey methodology and designed to solicit, from physicians and non-physician mental health providers, perspective and concerns regarding compliance with the standards set forth at section 1300.67.2.2(c);
(D) Reviewing and evaluating, on not less than a quarterly basis, the information available to the plan regarding accessibility, availability and continuity of care, including but not limited to information obtained through enrollee and provider surveys, enrollee grievances and appeals, and triage or screening services; and
(E) Verifying the advanced access programs reported by network providers, medical groups and independent practice associations to confirm that appointments are scheduled consistent with the definition of advanced access in section 1300.67.2.2(b)(1).
(F) A plan that provides services through a preferred provider organization network may, for that portion of its network, demonstrate compliance with subsections (b)(2)(A) and (D) of this section by monitoring, on not less than an annual basis: the number of PPO primary care and specialty physicians under contract with the plan in each county of the plan's network service area; enrollee grievances and appeals regarding timely access; and the rates of compliance with the time-elapsed standards established in section 1300.67.2.2, subsection (c)(5).

(3) A plan shall implement prompt investigation and corrective action when compliance monitoring discloses that the plan's network is not sufficient to ensure timely access as required by this section, including taking all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance. Plans shall give advance written notice to all network providers affected by a corrective action, and shall include a description of the identified deficiencies, the rationale for the corrective action, and the name and telephone number of the person authorized to respond to provider concerns regarding the plan's corrective action.

(c)(1) The definitions in section 1300.67.2.2 shall apply for the purpose of this section, except as specified in subsection (c)(2).
(2) The definition set forth in section 1300.67.2.2(b)(11)(A) shall not apply to reports or reviews for compliance pursuant to this section.

(d) This section shall become inoperative on December 31, 2021.

Note: Authority cited: Sections 1344, 1346 and 1367.03, Health and Safety Code. Reference: Sections 1342, 1367, 1367.01, 1367.03, 1367.04, 1367.035, 1370, 1371.31, 1375.7 and 1380, Health and Safety Code.

Timely Access and Annual Network Submission Instruction Manual

Eff. Date [**OAL insert effective date here**]

Timely Access and Annual Network Submission Instruction Manual

Table of Contents

Introduction 3
A. Definitions 3
I. Instructions for Required Annual Reporting 9
A. Report Form Submission Requirements (Rules 1300.67.2.2(h)(6) and (h)(7)) 9
1. Validation (Rule 1300.67.2.2(h)(9)) 9
B. Network Access Profile Requirements (Rule 1300.67.2.2(h)(8)) 10
II. General Instructions Applicable to All Required Report Forms (Rule 1300.67.2.2(h)(6) and (7)) 15
A. Reporting Data from Subcontracted Plans 15
B. Reporting Multiple Entries for the Same Data Field 15
C. Reporting With Standardized Terminology (Rule 1300.67.2.2(h)(8)(D)) 16
III. Timely Access Compliance Report (Rule 1300.67.2.2(h)(6)) 19
A. Timely Access Policies and Procedures (Rule 1300.67.2.2(h)(6)(A)) 19
1. Timely Access Policies and Procedures setting forth each Time-Elapsed Standard (Rule 1300.67.2.2(h)(6)(A)(i)) 19
2. Timely Access Policies and Procedures setting forth Approved Alternative Access Standards (Rule 1300.67.2.2(h)(6)(A)(i)) 19
B. Quality Assurance Monitoring Policies and Procedures (Rule 1300.67.2.2(h)(6)(A)(ii)) 20
1. Quality Assurance Monitoring Policies and Procedures related to Appointment Time-Elapsed Standards (Rule 1300.67.2.2(h)(6)(A)(ii)) 20
2. Quality Assurance Monitoring Policies and Procedures Related to All Other Timely Access Standards (Rule 1300.67.2.2(h)(6)(A)(ii)) 20
3. Oversight of Plan-to-Plan Contracts - Policies and Procedures (Rule 1300.67.2.2(h)(6)(A)(ii)) 21
C. Provider Appointment Availability Survey Report Forms (Rule 1300.67.2.2(f) and (h)(6)(B)) 21
D. Patterns of Non-Compliance or Incidents of Non-Compliance (Rule 1300.67.2.2(h)(6)(C)) 22
1. Procedure (Rule 1300.67.2.2(h)(6)(C)(i)) 22
2. Incidents of Non-Compliance Resulting in Substantial Harm to an Enrollee (Rule 1300.67.2.2(h)(6)(C)(ii)-(iv)) 22
3. Patterns of Non-Compliance (Rule 1300.67.2.2(h)(6)(C)(ii)-(iv)) 22
E. Policies and Procedures for Advanced Access Program Verification (Rule 1300.67.2.2(h)(6)(D)) 23

F. Health Plan and Contractor Use of Triage, Telemedicine, and Health Information Technology (I.T.) (Rule 1300.67.2.2(h)(6)(E)) 23
G. Provider Satisfaction Survey and Enrollee Experience Survey (Rule 1300.67.2.2(h)(6)(F)) 23
1. Provider Satisfaction Survey Methodology 23
2. Provider Satisfaction Survey Results 24
3. Enrollee Experience Survey Methodology 24
4. Enrollee Experience Survey Results 24
H. Quality Assurance Report (Rule 1300.67.2.2(h)(6)(G)) 24
IV. Provider Appointment Availability Survey Report Form Instructions (Rule 1300.67.2.2(f) and (h)(6)(B)) 25
A. Health Plan Information Tab 26
B. Contact List Report Forms – Instructions 26
C. Raw Data Report Forms – Instructions 40
D. Results Report Form – Instructions 70
V. Annual Network Report Forms 96
A. Network Service Area and Enrollment Report Form Instructions 96
B. PCP and PCP Non-Physician Medical Practitioner Report Form (Form No. 40-265): Instructions 99
C. Specialist and Specialist Non-Physician Medical Practitioner Report Form (Form No. 40-266): Instructions 105
D. Mental Health Professional and Mental Health Facility Report Form (Form No. 40-269): Instructions 110
E. Other Outpatient Provider Report Form (Form No. 40-268): Instructions 115
F. Hospital and Clinic Report Form (Form No. 40-267): Instructions 119
G. Telehealth Report Form (Form No. 40-271): Instructions 123
H. Timely Access and Network Adequacy Grievance Report Form (Form No. 40-272): Instructions 127
I. Out-of-Network Payment Report Form (Form No. 40-273): Instructions 129
VI. Standardized Terminology Appendices 132
Appendix A: Product Line Categories 132
Appendix B: Provider Types 134
Appendix C: Provider Languages 143
Appendix D: Type of License and Certificate 152
Appendix E: Telehealth Terminology 153
Appendix F: Grievance Field Values 154

Introduction

The California Code of Regulations, title 28, section 1300.67.2.2 and Health and Safety Code sections 1367.03, 1367.035 and 1371.31 require health care service plans (health plans) to submit to the Department of Managed Health Care (Department), on an annual basis, a Timely Access Compliance Report and an Annual Network Report.[1] As part of this reporting, health plans shall annually report grievance data and, as applicable, out-of-network provider data. This Timely Access and Annual Network Submission Instruction Manual (Instruction Manual) sets forth health plan reporting requirements in accordance with these provisions. The Instruction Manual shall be read in conjunction with the Provider Appointment Availability Survey (PAAS) Manual for purposes of submitting the Timely Access Compliance Report.

A. Definitions

The definitions below, and the definitions set forth in Rule 1300.67.2.2 apply to the information in this Instruction Manual:

1. "Accepting new patients" means the network provider's practice is open to establish patient care with enrollees who are not currently patients as set forth in section 1367.035(a)(4), and all of the following criteria apply:

    a. The network provider's practice is open in all product lines using the network, without limitations other than the established processes described in Rule 1300.67.2.2(b)(9)(C).
    b. The network provider's practice is open to new patient appointments at the reported practice address within the same appointment timeframes available to existing patients.
    c. The network provider has notified the health plan that the practice is open to new patients, and as applicable, the network provider is listed as accepting new patients in the health plan provider directory maintained pursuant to section 1367.27, at the reported practice address.
    d. The network provider's practice does not limit the accessibility or availability to establish patient care through a waitlist, or through wait times for appointments that are applicable only to enrollees establishing care as a new patient.

[1] References to "section" are to sections of the California Health and Safety Code, including but not limited to section 1340, et seq. (the Knox-Keene Act as codified in the California Health and Safety Code). References to "Rule" are to title 28 of the California Code of Regulations.

2. "Basic hospital services" or "general acute care hospital services" means the services described in the definition of general acute care hospital as set forth in section 1250(a).

3. "Clinic" shall have the definition set forth in section 1200(a).

4. "Crosswalk" or "crosswalk table" is a tool that allows health plans to identify internal terminology that is equivalent to the Department's required standardized terminology for the data category provided in the crosswalk table. Completion of a crosswalk table allows health plans to report data within the report forms using the health plan's internal terminology that does not conform to the Department's standardized terminology. Once a crosswalk table has been completed by a health plan, the health plan's uploaded report forms will associate the health plan's internal terminology with the standardized terminology required pursuant to Rule 1300.67.2.2(h)(8)(D).

5. "Entity provider" means an organization comprised of more than one individual provider that delivers a particular health care service to patients.

6. "Facility" means a licensed hospital, ambulatory surgery center, laboratory, radiology or imaging center, or other outpatient setting as described in section 1248.1, and any other facility described under section 1371.9(f)(1).

7. "Full-time" means the network provider dedicates 32 hours per week or more to providing health care services to patients within the network provider's practice area.

8. "Grievance" shall have the same definition as Rule 1300.68(a)(1) and (2). When collecting grievance data, the Department will rely on the following definitions:

a. "Complaint Categories" means the categories of timely access or network adequacy grievance based on the topic of the enrollee's complaint, consistent with Rule 1300.68(e)(2). Complaint categories may include the following:

i. Geographic Access - Enrollee complaint regarding distance or travel time to a network provider (e.g. travel distance is too far from home or work, travel time takes too long from home or work).

ii. Language Assistance Plan - Enrollee complaint regarding difficulty obtaining interpreter or translation services from health plan.

iii. Language Assistance Provider - Enrollee complaint regarding difficulty obtaining interpreter or translation services from provider.

iv. Office Wait Time - Enrollee complaint about length of time waiting for the provider during a scheduled appointment.

v. Provider Directory Error - Enrollee complaint that information listed in provider directory is inaccurate (address, phone, accepting new patients, accepting enrollee's plan, etc.).

vi. Provider Not Taking New Patients - Enrollee complaint that provider is not accepting new patients.

vii. Telephone Access Plan - Enrollee complaint regarding difficulty reaching a live person to talk to at the health plan during or after office hours.

viii. Telephone Access Provider - Enrollee complaint regarding difficulty reaching a live person to talk to at the provider office during or after office hours.

ix. Timely Access - Enrollee complaint regarding difficulty obtaining a timely appointment with a network provider.

x. Timely Authorization - Enrollee complaint regarding difficulty obtaining a timely authorization for a network provider.

b. "Nature of Resolution" means the action taken by the health plan to resolve the grievance. Resolution methods may include:

i. Authorization Approved - The health plan, or delegated provider, approves an authorization for an appointment with a specialist, hospital, or other type of provider.

ii. Authorization Denied - The health plan, or delegated provider, denies an authorization for an appointment with a specialist, hospital, or other type of provider.

iii. Change Medical Group - The health plan assists the enrollee with assignment to a different Medical Group or IPA.

iv. Change PCP - The health plan assigns the enrollee to a different PCP.

v. Change Specialist - The health plan identifies a different specialist for the enrollee.

vi. Enrollee Educated - The health plan educates enrollee regarding access rules, network rules, etc.

vii. No Confirmed Access Issue - The health plan researches enrollee grievance. Grievance determined not to involve an access issue. No assistance is provided to secure timely appointment and no additional communication/education is provided to enrollee or provider.

viii. Out-of-Network Referral - The health plan authorizes an out-of-network referral to meet the enrollee's needs.

ix. Provider Educated - The health plan educates/informs provider of access responsibilities.

x. Re-adjudicated claim - The health plan re-processes a claim for services previously received to reflect in-network benefits.

xi. Updated Provider Directory - The health plan researched and/or updated its provider directory as a result of enrollee grievance.

xii. Secured Timely Appointment - The health plan secures a timely appointment for the enrollee.

c. "Resolution Determination" means the ultimate outcome of the health plan's resolution of the grievance. Resolution determinations may be made as follows:

i. Enrollee Favor - The health plan's decision is wholly in the enrollee's favor; the health plan agrees to grant the entirety of the enrollee's request(s).

ii. Partial Enrollee Favor - A portion of the health plan's decision is in the enrollee's favor; health plan agrees to grant part of the enrollee's request and denies part of the enrollee's request.

iii. Health Plan Favor - The health plan's decision is wholly in its favor; the health plan denies the enrollee's request in whole.

9. "Individual provider" means a single individual who delivers health care services to patients.

10. "Name" when referring to a network provider, means the name appearing on the network provider's state license or certificate issued to provide health care services. For network providers for which licensure or certification is not required, "name" means the professional name used by the network provider to deliver health care services.

11. "National Provider Identifier" (NPI) means the number(s) associated with a network provider, as registered through the National Plan and Provider Enumeration System.

12. "Network" shall have the definition set forth in Rule 1300.67.2.2(b)(4).

13. "Network capture date" shall have the definition set forth in Rule 1300.67.2.2(b)(6).

14. "Network identifier" shall have the definition set forth in Rule 1300.67.2.2(b)(7).

15. "Network name" shall have the definition set forth in Rule 1300.67.2.2(b)(8).

16. "Network provider" shall have the definition set forth in Rule 1300.67.2.2(b)(9).

17. "Network service area" shall have the definition set forth in Rule 1300.67.2.2(b)(10).

18. "Network tier" means a set of network providers made available at the same cost-share level, within a tiered network. A network tier does not include providers accessible to enrollees through an out-of-network benefit.

a. A "tiered network" means a network in which network providers in the same practice area of specialty or expertise are available to enrollees at different cost share levels.

19. "Number of enrollees assigned to a network provider" means the sum of all enrollees within the network that the health plan, its subcontracted plan, or its delegated provider group has assigned to a network provider, across all of the network provider's locations within the health plan network.

20. "Part-time" means the network provider dedicates less than 32 hours per week to providing health care services to patients within the network provider's practice area.

21. "Plan-to-plan contract" shall have the definition set forth in Rule 1300.67.2.2(b)(12).

22. "Practice address" and "practice location or locations" means the physical location(s) where the network provider delivers health care services.

23. "Primary care physician" shall have the definition set forth in Rule 1300.45(m).

24. "Primary plan" shall have the definition set forth in Rule 1300.67.2.2(b)(12)(A).

25. "Product line" shall have the definition set forth in Rule 1300.67.2.2(b)(13).

26. "Provider group" shall have the definition set forth in Rule 1300.67.2.2(b)(14).

27. "Subcontracted plan" shall have the definition set forth in Rule 1300.67.2.2(b)(12)(B).

28. "Reporting plan" shall have the definition set forth in Rule 1300.67.2.2(b)(16).

29. "Specialty" or "subspecialty" means the primary specialty or subspecialty type(s) that the network provider currently practices in the identified network, and for which the network provider has been credentialed by the health plan.

30. "Telehealth" shall have the definition set forth in Business and Professions Code section 2290.5.

31. "Telehealth modality" means the method by which an enrollee receives telehealth services. Telehealth modality may include direct patient care or provider-to-provider services, in a synchronous or asynchronous interaction.

a. Telehealth modalities may include live two-way video or audio interactions, e-consults, remote patient monitoring, store and forward interactions, remote clinician advice or triage services, or other methods of delivering treatment that meet the definition of "telehealth."

32. Telehealth "patient location" means the location where a patient may receive telehealth services. The patient location may include a medical facility, the patient's personal residence, or a personal mobile device.

33. "Tertiary services" means highly specialized or complex medical care performed by specialists and subspecialists, often using advanced technology in state of the art facilities, including intensive care facilities, for patients with unusually severe, complex or uncommon health problems.

34. "Unscheduled urgent services" means services available to enrollees on a same-day, in-person walk-in basis to diagnose and treat illnesses and injuries that, in accordance with clinical appropriateness requirements set forth in section 1367.01(h)(2) and Rule 1300.67.2.2(c)(1), require care earlier than the scheduled appointment timeframes in Rule 1300.67.2.2(c)(5)(A) and (B), or earlier than the actual appointment timeframes available to enrollees within the network. Unscheduled urgent services shall include physician or non-physician providers who:

a. Provide urgent services which can reasonably be performed on an outpatient basis in a practitioner's office, urgent care facility or otherwise outside of the emergency room setting, in accordance with Rule 1300.67(c);
b. Have basic diagnostic services onsite, for use during the hours of operation; and
c. Provide the unscheduled urgent services through expanded hours, or at a location with hours of operation outside of the traditional business hours of 9:00 a.m. to 5:00 p.m., Monday through Friday.

I. Instructions for Required Annual Reporting

All health plans subject to reporting requirements under Rules 1300.67.2.2(a)(1) and (h)(1)(A) shall submit annually a Timely Access Compliance Report and an Annual Network Report, as set forth in Rules 1300.67.2.2(h)(2), (h)(6), (h)(7) and (h)(8). To complete the submission of both reports, health plans shall complete or update required information within the network access profile, and submit required annual report forms within the Department's web portal. (Rule 1300.67.2.2(h)(2).)[2] Health plans subject to reporting requirements under Rules 1300.67.2.2(a)(2) and (h)(1)(B) shall complete and submit information within the Network Access Profile within the web portal, set forth in Rule 1300.67.2.2(h)(8).The health plan designee shall verify the accuracy of the information provided to the Department within the annual submission. (Rule 1300.67.2.2(h)(2).)

A. Report Form Submission Requirements (Rules 1300.67.2.2(h)(6) and (h)(7))

Report forms provided by the Department in the web portal are the only allowable format for a health plan to submit required data for the Timely Access Compliance Report and the Annual Network Report. Required report forms include the following:

1. Provider Appointment Availability Survey Report Forms (Form Nos.: 40-254 through 40-264), required for Provider Appointment Availability Survey (PAAS) data.
2. Annual Network Report Forms (Form Nos.: 40-265 through 40-272), required for Annual Network data.
3. Annual Out-of-Network Payment Report Form (Form No. 40-273), required for health plans that do not exclusively contract with the Medi-Cal program. (See section 1371.31(a)(4).)

1. Validation (Rule 1300.67.2.2(h)(9))

To submit the report forms and satisfy annual reporting requirements, the health plan shall complete the network access profile and upload all required report forms into the web portal. Prior to submission, the uploaded report forms shall pass the Department's automated validation for completeness and accuracy, as described in Rule 1300.67.2.2(h)(9).[3] The

[2] A health plan's annual submission within the Department's web portal does not amend or modify the health plan's original licensing documents, or serve as a request for approval of an amendment or material modification to a health plan's license.

[3] The Department's validation does not ensure that a health plan's report form submissions are free from errors, omissions, conflicting data or data submitted contrary to instructions. The Department may further identify inaccuracies, inconsistencies or omissions in the submission, and require the health plan to correct the submitted data, or make a finding of non-compliance under Rule 1300.67.2.2(i).

report form may not pass validation and the submission may fail under the following circumstances:

1. The report form fields contain information or data that conflicts with the requirements set forth in Rule 1300.67.2.2 or the Field Instructions set forth in the Annual Network Report Forms and Provider Appointment Availability Survey (PAAS) Report Form Instructions sections of this Instruction Manual;
2. The report form is missing information or data that is required under Rule 1300.67.2.2 or this Instruction Manual;
3. The report form contains information that conflicts with standardized terminology requirements, described in Rule 1300.67.2.2(h)(8)(D);
4. The report form contains information or data that conflicts with other information or data reported by the health plan through the Department's web portal, including the following:
    i. Network Identifiers, Network Names, Product Lines, and plan-to-plan contracts specified in the network access profile conflict or are not included in the appropriate fields of the Annual Network Report Forms or PAAS Report Forms;
    ii. The health plan used a crosswalk table to associate the health plan's internal terminology to the Department's required standardized terminology, but did not report data using the same terms it entered within the crosswalk tables; or
    iii. Counties identified as part of the network service area in the network access profile are not consistent with the counties and ZIP Codes reported in the Network Service Area Report Form
5. The report form contains information that conflicts with established sources such as the NPI Registry, the California Department of Consumer Affairs, or the United States Postal System, and other sources as set forth in Rule 1300.67.2.2(h)(8)(D). The validation will identify deactivated NPI or California license numbers, and prevent the report form from passing validation.
6. The health plan did not include at least one row of data in the Enrollment Report Form.

Additionally, the health plan's submission will not pass validation if the submission does not contain all report forms identified by the health plan as comprising the entirety of the health plan's Annual Network and Timely Access Report in the network access profile. A health plan's submission will not pass validation if it does not include a Network Service Area – Report Form.

B. Network Access Profile Requirements (Rule 1300.67.2.2(h)(8))

All health plans subject to reporting requirements under Rule 1300.67.2.2(a)(1) and (2) shall complete or update the network access profile within the Department's web portal prior to submitting the required annual report forms, as described in Rules 1300.67.2.2(h)(1) and (h)(8). Failure to provide complete and accurate information within

the network access profile may cause the health plan's annual submission to fail, requiring the health plan to correct or complete the network access profile data and resubmit corresponding report forms, if applicable.

On an annual basis, health plans subject to reporting requirements under Rules 1300.67.2.2(a)(1) and (h)(1)(A) shall complete or update the information within the health plan's network access profile for each reported network, as set forth in items 1 through 8 below. Health plans subject to reporting requirements under Rules 1300.67.2.2(a)(2) and (h)(1)(B) shall annually complete or update the information within the health plan's network access profile for each reported network, as set forth in items 1 through 5, and 8 below:

1. **Network Identifier** (Rule 1300.67.2.2(h)(8)(B))

The health plan shall report each network by listing the Department's assigned network identifier for the network, consistent with the definition of these terms in Rules 1300.67.2.2(b)(4) and (b)(7). The Department will provide an updated list of networks and network identifiers within the web portal on an annual basis. If, since the previous network capture date, a health plan has removed, added or otherwise changed the network in a manner that would require a filing under section 1352 and Rules 1300.51 or 1300.52.4, the health plan shall list the network identifier and provide the filing number verifying the change, and other available information describing the reason for the change. The health plan shall identify whether the reported network had enrollment as of the network capture date, and if not, the last date of enrollment within the network.

2. **Network Name** (Rule 1300.67.2.2(h)(8)(B))

The health plan shall report the network name for the network, consistent with the definition of these terms in Rule 1300.67.2.2(b)(4) and (b)(8). (See Rule 1300.67.2.2(h)(8)(B).) The health plan shall indicate the Department's assigned network identifier associated with the reported network name.

3. **Product Lines** (Rule 1300.67.2.2(h)(8)(C))

For each health plan network, the health plan shall report all product lines consistent with the standardized terminology in Appendix A. (Rules 1300.67.2.2(h)(8)(C) and (h)(8)(D).) If the health plan identifies a product line as large group, in-home supportive services (IHSS), healthy kids, or employer, the health plan shall identify whether the Evidence of Coverage (EOC) covers services for which the health plan is required to offer coverage to a group subscriber. These services include Alcohol and Other Drugs services, pharmacy services, and orthotics and prosthetics.

4. **Network Service Area** (Rule 1300.67.2.2(h)(8)(C))

The health plan shall specify the network service area for the reported network. Within the network access profile, the health plan shall identify all counties within the approved network service area of the identified network, including counties for which the network service area includes only a portion of the county.

5. **Source of Network Providers and Plan-to-Plan Contracts** (Rule 1300.67.2.2(h)(8)(C))

For each reported network, the health plan shall identify and provide information concerning the source of network providers, including plan-to-plan contracts that contribute network providers to the network.

a. Within the web portal, the health plan shall specify all the following that apply:

   1. Network Providers are Directly Employed or Contracted with the Health Plan: Some or all of the network providers within the identified network meet the criteria set forth in Rule 1300.67.2.2(b)(9)(B)(i)-(iii) (contracted directly with the health plan, employed by the health plan, or are available through an association, provider group or other entity that is contracted directly with the health plan).

   2. Plan-to-Plan Contract – Network Serves as Primary Plan: The identified network includes at least one network provider that is made available to the health plan's enrollees through a plan-to-plan contract with a subcontracted plan, as defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12).

   3. Plan-to Plan Contract – Network Serves as Subcontracted Plan: The identified network includes at least one network provider that is made available to another health plan's network through a plan-to-plan contract with the primary plan, as defined in Rule 1300.67.2.2(b)(12).

b. A health plan that selects "Plan-to-Plan Contract – Network Serves as Primary Plan" shall identify all full-service and specialized subcontracted plans that contribute network providers to the network. For each subcontracted plan that contributes network providers to the network, the health plan shall identify:

   1. The name and license number of the subcontracted plan. The Department will provide an updated list of health plan names and license numbers within the web portal.

   2. Network name and network identifier of the subcontracted plan's network that is available, in whole or in part, to the primary plan's network. The Department will provide an updated list of network names and identifiers within the web portal.

   3. Whether the plan-to-plan contract includes a delegation of duties, or no delegation of duties:

      (i) Delegation: The primary plan has delegated some or all of its health plan functions to the subcontracted plan within the scope of the subcontracted plan's license, as allowable under the Knox-Keene Act; or

(ii) No Delegation: The subcontracted plan makes network providers available to the primary plan but the primary plan has not delegated health plan functions to the subcontracted plan.

c. A health plan that selects "Plan-to-Plan Contract – Network Serves as Subcontracted Plan" shall identify all primary plans that use the health plan's network through a plan-to-plan contract. For each primary plan that uses some or all network providers within the health plan's network, the health plan shall identify:

1. The name and license number of the primary plan. The Department will provide an updated list of health plan names and license numbers within the web portal.
2. Whether all of the network providers, or only some of the network providers in the network are available to each primary plan network.
3. Whether the plan-to-plan contract includes a delegation of duties, or no delegation of duties:
(i) Delegation: The primary plan has delegated health plan functions to the health plan within the scope of the health plan's license, as allowable under the Knox-Keene Act; or
(ii) No Delegation: The health plan makes network providers available to the primary plan but the primary plan has not delegated health plan functions to the health plan.

6. **Report Form Identification** (Rule 1300.67.2.2(h)(2))

The health plan shall identify the title of each report form that it will submit for each reported network. Report forms that are applicable to the health plan's reported network(s) shall be completed, uploaded and submitted to the Department within the web portal.

7. **Standardized Terminology and Crosswalk Tables** (Rule 1300.67.2.2(h)(8)(D))

The health plan shall use the Department's standardized terminology when reporting data in the categories listed in Rules 1300.67.2.2(h)(8)(D)(i)-(ix). The Department's standardized terminology for the data listed in Rules 1300.67.2.2(h)(8)(D)(ii)-(iv), (vi) and (ix) are set forth in appendices A-F. The Department's standardized terminology for the data listed in Rules 1300.67.2.2(h)(8)(D)(i), (v), (vii) and (viii) are available within the Department's web portal. As available, health plans may use crosswalk tables provided within the network access profile of the web portal to report standardized terminology by connecting the health plan's own terminology to the standardized terminology via the crosswalk tables. See the Reporting with Standardized Terminology section within this Manual for more information.

8. **Verification**

Prior to submission of the network access profile or report forms, the designee for the health plan responsible for reviewing and submitting the reports shall verify the accuracy

and correctness of the annual submission, in accordance with Rule 1300.67.2.2(h)(2).

II. General Instructions Applicable to All Required Report Forms (Rule 1300.67.2.2(h)(6) and (7))

Attention: Review these instructions before populating any report forms for submission in the Timely Access Compliance Report or Annual Network Report.

The general instructions below are applicable to the report forms health plans are required to submit annually as part of the Timely Access Compliance Report and the Annual Network Report. (Rules 1300.67.2.2(h)(1),(2),(6) and (7).)

A. Reporting Data from Subcontracted Plans

The primary plan in a plan-to-plan contract for a reported network is responsible for submitting all data for the network, as described in Rule 1300.67.2.2(h)(1)(A), including required report forms for the Timely Access Compliance Report and the Annual Network Report, as described in Rule 1300.67.2.2(h)(3). Subcontracted plans are responsible for submitting the information described in Rule 1300.67.2.2(h)(1)(B). The data included in the primary plan's submission shall represent all network providers, including those made available to the network through a plan-to-plan contract as defined in Rule 1300.67.2.2(b)(12).

B. Reporting Multiple Entries for the Same Data Field

When reporting network providers within the Annual Network Report Forms and Contact List Report Form, the health plan shall report all responsive data for the network provider. When applicable, the health plan shall report more than one entry for the same data field (e.g., a network provider practices at multiple addresses, has multiple specialty types or participates in multiple provider groups). To report more than one entry for the same data field for a network provider, the health plan shall create a new record (i.e., populate an additional row) for the network provider. The new record shall contain the data entered in all fields that do not vary, as well as the new entry in the data field that varies. For each network provider, the health plan shall report the number of records needed to describe all possible combinations of required data applicable to the network provider.

Examples of fields that may require multiple entries for a network provider are:

1. Specialty Type: The network provider may practice in both a specialty and a subspecialty or in multiple specialties.
2. Type of License or Certificate: The network provider may hold more than one license or certificate.
3. Practice Address: The network provider may practice at more than one address.
4. Facility Name: The network provider may hold privileges or admit patients at more than one facility.
5. Accepting New Patients: The network provider may practice at multiple addresses, but accept new patients at only one practice address.

6. Provider Group: The network provider may participate in more than one provider group.

When reporting network service area and enrollment data within the Network Service Area and Enrollment Report Form, the health plan shall report all responsive data for the network. When applicable, the health plan shall report more than one entry for the same data field, such as enrollees that are delegated to more than one subcontracted plan within the same network, product line, county and ZIP Code. To report more than one entry for the same data field, the health plan shall create a new record. The new record shall contain the new entry in the data field that varies, and the health plan shall repeat the data entered in all fields that do not vary, except for the "number of network enrollees" field. The health plan shall not report duplicate data entries for enrollment counts within the data field "number of network enrollees." If multiple records apply to the same count of enrollees within a reported network, product line, county and ZIP Code, once the health plan has reported the count of enrollees, the health plan shall leave the "number of network enrollees" field blank for each subsequent record. For more information about the reporting of enrollment data, please see the instructions in the Network Service Area and Enrollment Report Form section of this Manual.

C. Reporting With Standardized Terminology (Rule 1300.67.2.2(h)(8)(D))

Health plans shall report data according to the Department's standardized terminology, either directly within the report forms, or by associating the health plan's own terminology to the standardized terminology by using the available crosswalk tables in the web portal. Standardized terminology is described in Appendices A-F of this Instruction Manual, or in the web portal, as set forth in Rule 1300.67.2.2(h)(8)(D)(i)-(ix). The health plan shall use the Department's standardized terminology in the following fields within the report forms:

1. Hospital and Other Inpatient Provider Names – Health plans shall report each hospital and other inpatient provider names using the terminology made available on the web portal, as described in Rule 1300.67.2.2(h)(8)(D)(i).

2. Product Line Categories – The standardized terminology for product line is set forth in **Appendix A** of this Manual.

3. Provider Types – The standardized terminology for provider types is set forth in **Appendix B** of this Manual. The provider type terminology includes standardized terminology to describe physician and other individual provider specialties and to describe the services delivered by facility and other entity providers. The Provider Types Appendix includes standardized terminology for the following fields:

    a. Primary Care Physician (PCP) Specialty Type
    b. Specialist Physician Specialty Type
    c. Non-Physician Medical Practitioner (NPMP) Specialty Type
    d. Mental Health Facility Type
    e. Non-Physician Mental Health Professional Specialty Type

f. Other Outpatient Provider Type
g. Hospital and Other Inpatient Provider Type
h. Clinic Type

4. Provider Languages – The standardized terminology for provider language is set forth in **Appendix C** of this Manual.

5. Provider Group Names – Health plans shall report each provider group using the terminology made available on the web portal, as described in Rule 1300.67.2.2(h)(8)(D)(v).

6. Type of License and Certificate – The standardized terminology for a provider's type of license or certificate is set forth in **Appendix D** of this Manual. The Type of License and Certificate Appendix includes standardized terminology for the following fields:

a. PCP Licensure Type
b. NPMP Licensure Type
c. NPMP Certificate Type
d. Specialist Licensure Type
e. Mental Health Professional Licensure Type
f. Hospital License Category
g. Clinic License Category

7. ZIP Code by County – Health plans shall report each county and ZIP Code as described in Rule 1300.67.2.2(h)(8)(D)(vii) and made available on the web portal.

8. California License Number and National Provider Identifier (NPI) -- Health plans shall report each California License Number and NPI as described in Rule 1300.67.2.2(h)(8)(D)(viii) and made available on the web portal.

9. Telehealth Terminology – The standardized terminology for reporting patient location and telehealth modality data is set forth in **Appendix E** of this Manual. The Telehealth Terminology Appendix includes standardized terminology for the following fields:

a. Patient Location Category
b. Telehealth Delivery Modality Category

10. Grievance Field Values – The standardized terminology for reporting grievance data is set forth in **Appendix F** of this Manual. The Grievance Field Values Appendix includes standardized terminology for the following fields:

a. Complaint Category
b. Provider Category
c. Resolution Methods
d. Resolution Determination

III. Timely Access Compliance Report (Rule 1300.67.2.2(h)(6))

Health plans are required to submit to the Department, on an annual basis, a Timely Access Compliance Report, which consists of the items set forth in subsection (h)(6) of Rule 1300.67.2.2. Each health plan shall submit its Timely Access Compliance Report, as set forth below, for the applicable measurement year. The instructions below describe where, within the Department's web portal, each required item shall be submitted. Health plans may submit multiple documents for any particular section; however, each document uploaded shall be labeled appropriately so that the Department can easily identify the document responsive to each requirement.

A. Timely Access Policies and Procedures (Rule 1300.67.2.2(h)(6)(A))

Health plans are required to submit Timely Access Policies and Procedures in the annual Timely Access Compliance Report, pursuant to Rule 1300.67.2.2(h)(6)(A). The Timely Access Policies and Procedures submitted to the Department shall be the relevant policies and procedures that were in effect with the health plan during the applicable measurement year. The health plan may only submit policies and procedures in the Timely Access Compliance Report that have already been filed with the Department as an Amendment or Material Modification to its original licensing application, pursuant to sections 1351 or 1352. The health plan shall identify the page numbers in the relevant filings setting forth the information required by Rule 1300.67.2.2(h)(6)(A)(i) to be submitted.

Under the Timely Access Policies and Procedures section within the Department's web portal, the health plan shall submit the following information in each of the applicable sections of the Department's web portal:

1. **Timely Access Policies and Procedures setting forth each Time-Elapsed Standard** (Rule 1300.67.2.2(h)(6)(A)(i))

In the Time-Elapsed Standards section of the Department's web portal, submit the policies and procedures used by the health plan that set forth each of the timely access standards in Rule 1300.67.2.2(c).

2. **Timely Access Policies and Procedures setting forth Approved Alternative Access Standards** (Rule 1300.67.2.2(h)(6)(A)(i))

If applicable, in the Approved Alternative Access Standards section of the Department's web portal, submit the policies and procedures setting forth any alternative time-elapsed standards, alternatives to time-elapsed standards, or alternative to the threshold rate of compliance for which the health plan obtained the Department's prior approval by Order of the Director pursuant to Health and Safety Code section 1352.

B. Quality Assurance Monitoring Policies and Procedures (Rule 1300.67.2.2(h)(6)(A)(ii))

Health plans are required to submit Quality Assurance Monitoring Policies and Procedures related to timely access, pursuant to Rule 1300.67.2.2(h)(6)(A)(ii), via the applicable sections of the Department's web portal. The Quality Assurance Monitoring Policies and Procedures submitted to the Department as part of this report shall be the relevant policies and procedures that were in effect during the applicable measurement year, that are on file with the Department as part of the health plan's original licensing application, or amendments or modifications to the license pursuant to section 1351 or 1352. The health plan shall identify the page numbers in the relevant filings setting forth the information required by Rule 1300.67.2.2(h)(6)(A)(ii) to be submitted.

Health plans shall submit the following Quality Assurance Monitoring Policies and Procedures:

1. **Quality Assurance Monitoring Policies and Procedures related to Appointment Time-Elapsed Standards** (Rule 1300.67.2.2(h)(6)(A)(ii))

Within the applicable section of the Department's web portal, submit the health plan's policies and procedures setting forth its Quality Assurance Program process for monitoring compliance with each of the appointment time-elapsed standards set forth in Rule 1300.67.2.2(c)(5). The policies and procedures shall include all of relevant quality assurance program requirements, including those set forth in Rule 1300.67.2.2(d), used to monitor the time-elapsed standards set forth in Rule 1300.67.2.2(c)(5). In addition, consistent with Rule 1300.67.2.2(f), the policies and procedures shall indicate that the health plan uses the Provider Appointment Availability Survey (PAAS) Manual to administer the annual PAAS, and to develop and calculate its annual rate of compliance with the time-elapsed standards set forth in Rule 1300.67.2.2(c)(5). The health plan shall also submit the survey used by the health plan to administer the PAAS. The health plan's survey shall identify any changes made to the Survey Tool set forth in Appendix 2 of the PAAS Manual.

2. **Quality Assurance Monitoring Policies and Procedures Related to All Other Timely Access Standards** (Rule 1300.67.2.2(h)(6)(A)(ii))

Within the applicable section of the Department's web portal, submit the health plan's policies and procedures setting forth its Quality Assurance Program process for monitoring network compliance with the timely access standards set forth in Rule 1300.67.2.2(c)(1)-(4) and (c)(6)-(10). The policies and procedures shall include all relevant quality assurance program requirements used to monitor the time-elapsed standards, as set forth in Rule 1300.67.2.2(d).

3. **Oversight of Plan-to-Plan Contracts - Policies and Procedures** (Rule 1300.67.2.2(h)(6)(A)(ii))

Within the applicable section of the Department's web portal, submit the health plan's policies and procedures setting forth the health plan's oversight procedures for ensuring all subcontracted plans and other delegated entities comply with Rule 1300.67.2.2(c). The submitted policies and procedures shall include any periodic reporting requirements included in the plan-to-plan contracts. (See Rules 1300.67.2.2(a)(3) and (h)(6)(A)(iii).)

C. Provider Appointment Availability Survey Report Forms (Rule 1300.67.2.2(f) and (h)(6)(B))

The health plan shall provide the name of the entity administering the Provider Appointment Availability Survey on its behalf (if applicable), and submit the following information in each of the applicable sections of the Department's web portal, consistent with Rule 1300.67.2.2(h)(6)(B).

1. **Contact List Report Forms** - The completed Contact List Report Forms for each Provider Survey Type, as defined in Rule 1300.67.2.2(b)(15):

   a. Primary Care Providers Contact List Report Form
   b. Non-Physician Mental Health Care Providers Contact List Report Form
   c. Specialist Physicians Contact List Report Form
   d. Psychiatrists Contact List Report Form
   e. Ancillary Service Providers Contact List Report Form

2. **Raw Data Report Forms** - The completed Raw Data Report Forms for each Provider Survey Type, as defined in Rule 1300.67.2.2(b)(15):

   a. Primary Care Providers Raw Data Report Form
   b. Non-Physician Mental Health Care Providers Raw Data Report Form
   c. Specialist Physicians Raw Data Report Form
   d. Psychiatrists Raw Data Report Form
   e. Ancillary Service Providers Raw Data Report Form

3. **Results Report Form** - The completed Results Report Form, which includes:

   a. Primary Care Providers Results Tab
   b. Non-Physician Mental Health Care Providers Results Tab
   c. Specialist Physicians Results Tab
   d. Psychiatrists Results Tab
   e. Ancillary Service Providers Results Tab
   f. Summary of Rates of Compliance Tab
   g. Network by Provider Survey Type Tab

D. Patterns of Non-Compliance or Incidents of Non-Compliance (Rule 1300.67.2.2(h)(6)(C))

The health plan shall submit the following information related to its process for identifying and addressing patterns or incidents of non-compliance with the standards set forth in Rule 1300.67.2.2(c) in the applicable sections of the Department's web portal, consistent with Rule 1300.67.2.2(h)(6)(C):

1. **Procedure** (Rule 1300.67.2.2(h)(6)(C)(i))

Submit a description of the health plan's procedure for identifying any patterns of non-compliance with the timely access standards and incidents of non-compliance with the timely access standards resulting in substantial harm to an enrollee. The description shall include definitions, the monitoring mechanism used by the health plan, and the data sources relied upon by the health plan.

2. **Incidents of Non-Compliance Resulting in Substantial Harm to an Enrollee** (Rule 1300.67.2.2(h)(6)(C)(ii)-(iv))

Submit a description indicating whether the health plan, during the measurement year, identified any incidents of non-compliance with the standards developed pursuant to section 1367.03 resulting in substantial harm to an enrollee. If so, provide a description of the identified non-compliance, the health plan's responsive investigation, determination, and corrective action.

3. **Patterns of Non-Compliance** (Rule 1300.67.2.2(h)(6)(C)(ii)-(iv))

Submit a description indicating whether the health plan identified, during the measurement year, any patterns of non-compliance as defined in Rule 1300.67.2.2(b)(11). If so, provide a description of the identified non-compliance, the health plan's responsive investigation, determination, and corrective action.

4. **Prior Incidents or Patterns of Non-Compliance Not Previously Submitted** (Rule 1300.67.2.2(h)(6)(C)(v))

Submit a description indicating whether the health plan identified any (1) incidents of non-compliance with the standards developed pursuant to section 1367.03 resulting in substantial harm to an enrollee, or (2) patterns of non-compliance as defined in Rule 1300.67.2.2(b)(11) that occurred in a prior measurement year that were not previously submitted to the Department in a Timely Access Compliance Report. If so, provide a description of the identified non-compliance, the health plan's responsive investigation, determination, and corrective action.

E. Policies and Procedures for Advanced Access Program Verification (Rule 1300.67.2.2(h)(6)(D))

Within the applicable sections of the Department's web portal, submit the policies and procedures used by the health plan to verify that its network providers and provider groups schedule appointments in accordance with the definition of Advanced Access. (See Rule 1300.67.2.2(d)(2)(E).) The health plan shall identify the page numbers in the relevant filings setting forth the information required by Rule 1300.67.2.2(h)(6)(D) to be submitted.

The list of all network provider and provider groups utilizing advanced access appointment scheduling shall be submitted to the Department in the Primary Care Provider Contact List by completing the "Advanced Access Provider" field consistent with Rule 1300.67.2.2(h)(6)(D).

F. Health Plan and Contractor Use of Triage, Telemedicine, and Health Information Technology (I.T.) (Rule 1300.67.2.2(h)(6)(E))

The health plan shall submit the following information in each of the applicable sections of the Department's web portal, consistent with Rule 1300.67.2.2(h)(6)(E):

1. **Triage** – Submit a description of the implementation and use of triage services to provide timely access to care by the health plan and its network providers.

2. **Telemedicine** – Submit a description of the implementation and use of telemedicine services to provide timely access to care by the health plan and its network providers.

3. **Health I.T.** – Submit a description of the implementation and use of health information technology to provide timely access to care by the health plan and its network providers. Health plans may include in the description information regarding new and innovative technology used to ensure enrollees receive timely access to health care services.

G. Provider Satisfaction Survey and Enrollee Experience Survey (Rule 1300.67.2.2(h)(6)(F))

The health plan shall submit the following information in each of the applicable sections of the Department's web portal, consistent with Rule 1300.67.2.2(h)(6)(F).

1. Provider Satisfaction Survey Methodology

The Provider Satisfaction Survey Methodology submission shall include all of the following items:

a. The health plan's policies and procedures used to administer the annual Provider Satisfaction Survey. The health plan shall identify the page numbers in the

relevant filings setting forth the information required by Rule 1300.67.2.2(h)(6)(F) to be submitted.

b. A copy of the survey tool developed and used by the health plan to conduct the Provider Satisfaction Survey. The survey tool shall set forth the survey questions used to survey network providers.
c. The methodology used to administer the survey and analyze the results.

2. Provider Satisfaction Survey Results

The Provider Satisfaction Survey Results submission shall include all of the following items:

a. The results of the Provider Satisfaction Survey(s) for the measurement year.
b. A narrative description that includes information regarding how the survey results for the current year compare with results of the prior year's survey(s), including a discussion of the relative change in survey results.

3. Enrollee Experience Survey Methodology

The Enrollee Experience Survey Methodology submission shall include all of the following items:

a. The health plan's policies and procedures used to administer the annual Enrollee Experience Survey. The health plan shall identify the page numbers in the relevant filings setting forth the information required by Rule 1300.67.2.2(h)(6)(F) to be submitted.
b. A copy of the survey tool developed and used by the health plan to conduct the Enrollee Experience Survey. The survey tool shall set forth the survey questions used to survey the health plan’s enrollees.
c. The methodology used to administer the survey and analyze the results.

4. Enrollee Experience Survey Results

The Enrollee Experience Survey Results submission shall include the following items:

a. The results of the Enrollee Experience Survey(s) for the measurement year.
b. A narrative description that includes information regarding how the survey results for the current year compare with results of the prior year's survey(s), including a discussion of the relative change in survey results.

H. Quality Assurance Report (Rule 1300.67.2.2(h)(6)(G))

Within the applicable section of the Department’s web portal, the health plan shall provide the name of the external vendor conducting the quality assurance review set forth in Rule 1300.67.2.2(f)(3)-(4) and the PAAS Manual. In addition, the health plan shall submit its Quality Assurance Report, setting forth all required information in Rule 1300.67.2.2(f)(3)-(4) and the PAAS Manual. (Rule 1300.67.2.2(h)(6)(G).)

IV. Provider Appointment Availability Survey Report Form Instructions (Rule 1300.67.2.2(f) and (h)(6)(B))

Review each of the Provider Appointment Availability Survey (PAAS) Report Form Instructions, the PAAS Manual, and section II of this Instruction Manual, regarding the General Instructions Applicable to All Report Forms before populating each report form. The following PAAS Report Forms are available within the Department's web portal:

1. Primary Care Providers Contact List Report Form (Form No. 40-254).
2. Non-Physician Mental Health Care Providers Contact List Report Form (Form No. 40-255).
3. Specialist Physicians Contact List Report Form (Form No. 40-256).
4. Psychiatrists Contact List Report Form (Form No. 40-257).
5. Ancillary Service Providers Contact List Report Form (Form No. 40-258).
6. Primary Care Providers Raw Data Report Form (Form No. 40-259).
7. Non-Physician Mental Health Care Providers Raw Data Report Form (Form No. 40-260).
8. Specialist Physicians Raw Data Report Form (Form No. 40-261).
9. Psychiatrists Raw Data Report Form (Form No. 40-262).
10. Ancillary Service Providers Raw Data Report Form (Form No. 40-263).
11. Results Report Form (Form No. 40-264), which includes the following information:
    a. Primary Care Providers Results Tab;
    b. Non-Physician Mental Health Care Providers Results Tab;
    c. Specialist Physicians Results Tab;
    d. Psychiatrists Results Tab;
    e. Ancillary Service Providers Results Tab;
    f. Summary of Rates of Compliance Tab; and
    g. Network by Provider Survey Type Tab.

In accordance with the PAAS Manual and PAAS Report Form Instructions set forth below, the health plan shall:

1. Complete a Contact List Report Form for each Provider Survey Type. The health plan shall use each Contact List Report Form to select the unique providers in each county from each network (County/Network) to survey.
2. Conduct the PAAS and enter the responses to the PAAS on the Raw Data Report Form for each Provider Survey Type.
3. Summarize the results of the PAAS on the Results Tab for each Provider Survey Type in the Results Report Form. The Summary of Rates of Compliance Tab and the Network by Provider Survey Type Tab are programmed to auto-calculate the information that is required to be reported to the Department based on the information the health plan enters on the Results Tabs for each of the Provider Survey Types.
4. Complete the Health Plan Information Tab of each PAAS Report Form.

The health plan shall complete all PAAS Report Forms with information related only to network providers who meet all the criteria listed in the PAAS Manual. Health plans that do not complete the PAAS Report Forms according to the instructions in this manual and the PAAS Manual may be found non-compliant pursuant to Rule 1300.67.2.2(f) and (i).

A. Health Plan Information Tab

In each of the PAAS Report Forms, enter the following information on the Health Plan Information Tab:

1. Reporting Plan Name*:* Enter the reporting plan's legal name (and DBA if applicable).
2. Subcontracted Plan Name*:* Enter the name of all subcontracted plans for which the reporting plan is submitting data, if applicable.
3. Measurement Year*:* Enter the measurement year for which the range of data is being reported.
4. Name of Survey Administrator*:* Enter the name of the entity conducting the Provider Appointment Availability Survey for the reporting plan.
5. Name of Quality Assurance Vendor*:* Enter the name of the entity conducting the quality assurance process and drafting the health plan's quality assurance report.
6. Date Contact List Generated*:* Enter the date on which the reporting plan created its Contact List. (This field only applies Contact List Report Forms.)

B. Contact List Report Forms – Instructions

The health plan shall use the PAAS Manual and the instructions set forth below to enter the required information in each field on the Contact List Report Form for the applicable Provider Survey Type. The health plan shall complete all required fields, but is not required to complete requested fields. Each Contact List Report Form shall include only the network providers who meet all the criteria listed in the PAAS Manual.

Primary Care Providers Contact List Report Form (Form No. 40-254)

Field Name	***Field Instructions - Primary Care Providers Contact List Report Form***
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Network Information	
Network Name	Enter the network name within which the reported provider serves as a network provider, as defined in Rule 1300.67.2.2(b)(8).

Field Name	***Field Instructions - Primary Care Providers Contact List Report Form***
Network ID	Enter the network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Subcontracted Plan Information	
Subcontracted Plan License Number	Enter the subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). Each health plan's license number is available on the Department's web portal.
Subcontracted Plan Network ID	Enter the subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12).
Network Provider Information	
Last Name	Enter the last name of the network provider.
First Name	Enter the first name of the network provider.
FQHC/RHC Name	Enter the name of the FQHC/RHC network provider.
NPI	Enter the unique National Provider Identifier (NPI) assigned to the network provider, active on the network capture date.
CA License	Enter the California license number of the network provider, active on the network capture date.
Non-CA License	Enter the license number issued outside of the state of California, active on the network capture date.
Non-CA License State	Enter the state in which the non-California license was issued.
License Type	Enter the network provider's type of license.
Specialty	Enter the network provider's specialty or subspecialty as of the network capture date.
NPI of Supervising PCP	Enter the unique National Provider Identifier (NPI) of the reported primary care physician (PCP) who supervises the non-physician medical practitioner.
Board Certified / Eligible	For each reported specialty or subspecialty, indicate whether the network provider is board-certified or board-eligible.
Provider Group	Enter the name of the provider group affiliated with the network provider, if applicable.
Network Provider Practice Location and Associated Information	

Field Name	***Field Instructions - Primary Care Providers Contact List Report Form***
Practice Address	Enter the street number and street name of the practice address. If the network provider also serves as a telehealth provider, report only the physical location at which the network provider delivers in-person health care services.
Practice Address 2	Enter the number of the office, suite, building or other location identifier for the practice address, if applicable.
City	Enter the city in which the practice address is located.
County	Enter the county in which the practice address is located.
State	Enter the state in which the practice address is located.
Zip Code	Enter the ZIP Code in which the practice address is located.
Phone Number 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Phone Number 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Phone Number 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.

Field Name	***Field Instructions - Primary Care Providers Contact List Report Form***
Displayed in Provider Directory	Identify whether, on the network capture date, the network provider was displayed in the health plan's online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network, location, and service type identified in the corresponding fields of this report form.
Unique Provider	Enter "Y" if this network provider was identified as a unique provider after conducting the unique provider and duplicate record identification process described in paragraphs 15-19 of the PAAS Manual. Enter "N" if this entry was identified as a duplicate provider.
Advanced Access Provider	Enter "Y" if this network provider participates in an Advanced Access Program. (See paragraphs 54-57 of the PAAS Manual and Rules 1300.67.2.2(b)(1), (c)(5)(I), (d)(2)(E), and (h)(6)(D) for further information related to submission requirements.)
Qualified Advanced Access Provider	Enter "Y" if the health plan identified this network provider as a Qualified Advanced Access Provider. (See paragraphs 54-57 of the PAAS Manual and Rule 1300.67.2.2(c)(5)(I), and (d)(2)(E) for further details regarding verification of Advanced Access Providers.)
PAAS Information	
Provider Survey Type	For each network provider, enter "Primary Care Providers" in this field.
REQUESTED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Comments 1	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.
Comments 2	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.

Non-Physician Mental Health Care Providers Contact List Report Form (Form No. 40-255)

Field Name	***Field Instructions - NPMH Care Providers Contact List Report Form***
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*

Field Name	***Field Instructions - NPMH Care Providers Contact List Report Form***
Network Information	
Network Name	Enter the network name within which the reported provider serves as a network provider, as defined in Rule 1300.67.2.2(b)(8).
Network ID	Enter the network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Subcontracted Plan Information	
Subcontracted Plan License Number	Enter the subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). Each health plan's license number is available on the Department's web portal.
Subcontracted Plan Network ID	Enter the subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12).
Network Provider Information	
Last Name	Enter the last name of the network provider.
First Name	Enter the first name of the network provider.
FQHC/RHC Name	Enter the name of the FQHC/RHC network provider.
NPI	Enter the unique National Provider Identifier (NPI) assigned to the network provider, active on the network capture date.
CA License / Certificate	Enter the California license or certificate identifier, active on the network capture date.
Non-CA License / Certificate	Enter the license number or certificate identifier issued outside of the state of California, active on the network capture date.
Non-CA License / Certificate State	Enter the state in which the non-California license or certificate was issued.
Type of License / Certificate	Enter the network provider's type of license or certificate.
Specialty	Enter the network provider's specialty as of the network capture date.
Provider Group	Enter the name of the provider group affiliated with the network provider, if applicable.
Network Provider Practice Location and Associated Information	

Field Name	***Field Instructions - NPMH Care Providers Contact List Report Form***
Practice Address	Enter the street number and street name of the practice address. If the network provider also serves as a telehealth provider, report only the physical location at which the network provider delivers in-person health care services.
Practice Address 2	Enter the number of the office, suite, building or other location identifier for the practice address, if applicable.
City	Enter the city in which the practice address is located.
County	Enter the county in which the practice address is located.
State	Enter the state in which the practice address is located.
Zip Code	Enter the ZIP Code in which the practice address is located.
Phone Number 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Phone Number 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Phone Number 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.

Field Name	***Field Instructions - NPMH Care Providers Contact List Report Form***
Displayed in Provider Directory	Identify whether, on the network capture date, the network provider was displayed in the health plan's online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network, location, and service type identified in the corresponding fields of this report form.
Unique Provider	Enter "Y" if this network provider was identified as a unique provider after conducting the unique provider and duplicate record identification process described in paragraphs 15-19 of the PAAS Manual. Enter "N" if this entry was identified as a duplicate provider.
PAAS Information	
Provider Survey Type	For each network provider, enter "Non-Physician Mental Health Care Providers" in this field.
REQUESTED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Comments 1	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.
Comments 2	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.

Specialist Physicians Contact List Report Form (Form No. 40-256)

Field Name	***Field Instructions - Specialist Physicians Contact List Report Form***
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Network Information	
Network Name	Enter the network name within which the reported provider serves as a network provider, as defined in Rule 1300.67.2.2(b)(8).
Network ID	Enter the network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Subcontracted Plan Information	

Field Name	***Field Instructions - Specialist Physicians Contact List Report Form***
Subcontracted Plan License Number	Enter the subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). Each health plan's license number is available on the Department's web portal.
Subcontracted Plan Network ID	Enter the subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12).
Network Provider Information	
Last Name	Enter the last name of the network provider.
First Name	Enter the first name of the network provider.
FQHC/RHC Name	Enter the name of the FQHC/RHC network provider.
NPI	Enter the unique National Provider Identifier (NPI) assigned to the network provider, active on the network capture date.
CA License	Enter the California license number of the network provider, active on the network capture date.
Non-CA License	Enter the license number issued outside of the state of California, active on the network capture date.
Non-CA License State	Enter the state in which the non-California license was issued.
License Type	Enter the network provider's type of license.
Specialty	Enter the network provider's specialty or subspecialty as of the network capture date.
Board Certified / Eligible	For each reported specialty or subspecialty, indicate whether the network provider is board-certified or board-eligible.
Provider Group	Enter the name of the provider group affiliated with the network provider, if applicable.
Network Provider Practice Location and Associated Information	
Practice Address	Enter the street number and street name of the practice address. If the network provider also serves as a telehealth provider, report only the physical location at which the network provider delivers in-person health care services.

Field Name	***Field Instructions - Specialist Physicians Contact List Report Form***
Practice Address 2	Enter the number of the office, suite, building or other location identifier for the practice address, if applicable.
City	Enter the city in which the practice address is located.
County	Enter the county in which the practice address is located.
State	Enter the state in which the practice address is located.
Zip Code	Enter the ZIP Code in which the practice address is located.
Phone Number 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Phone Number 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Phone Number 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Displayed in Provider Directory	Identify whether, on the network capture date, the network provider was displayed in the health plan's online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network, location, and service type identified in the corresponding fields of this report form.

Field Name	***Field Instructions - Specialist Physicians Contact List Report Form***
Unique Provider	Enter "Y" if this network provider was identified as a unique provider after conducting the unique provider and duplicate record identification process described in paragraphs 15-19 of the PAAS Manual. Enter "N" if this entry was identified as a duplicate provider.
PAAS Information	
Provider Survey Type	For each network provider, enter "Specialist Physicians" in this field.
REQUESTED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Comments 1	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.
Comments 2	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.

Psychiatrists Contact List Report Form (Form No. 40-257)

Field Name	***Field Instructions - Psychiatrists Contact List Report Form***
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Network Information	
Network Name	Enter the network name within which the reported provider serves as a network provider, as defined in Rule 1300.67.2.2(b)(8).
Network ID	Enter the network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Subcontracted Plan Information	
Subcontracted Plan License Number	Enter the subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). Each health plan's license number is available on the Department's web portal.

Field Name	***Field Instructions - Psychiatrists Contact List Report Form***
Subcontracted Plan Network ID	Enter the subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12).
Network Provider Information	
Last Name	Enter the last name of the network provider.
First Name	Enter the first name of the network provider.
FQHC/RHC Name	Enter the name of the FQHC/RHC network provider.
NPI	Enter the unique National Provider Identifier (NPI) assigned to the network provider, active on the network capture date.
CA License	Enter the California license number of the network provider, active on the network capture date.
Non-CA License	Enter the license number issued outside of the state of California, active on the network capture date.
Non-CA License State	Enter the state in which the non-California license was issued.
License Type	Enter the network provider's type of license.
Specialty	Enter the network provider's specialty or subspecialty as of the network capture date.
Board Certified / Eligible	For each reported specialty or subspecialty, indicate whether the network provider is board-certified or board-eligible.
Provider Group	Enter the name of the provider group affiliated with the network provider, if applicable.
Network Provider Practice Location and Associated Information	
Practice Address	Enter the street number and street name of the practice address. If the network provider also serves as a telehealth provider, report only the physical location at which the network provider delivers in-person health care services.
Practice Address 2	Enter the number of the office, suite, building or other location identifier for the practice address, if applicable.
City	Enter the city in which the practice address is located.
County	Enter the county in which the practice address is located.
State	Enter the state in which the practice address is located.
Zip Code	Enter the ZIP Code in which the practice address is located.

Field Name	***Field Instructions - Psychiatrists Contact List Report Form***
Phone Number 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Phone Number 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Phone Number 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Displayed in Provider Directory	Identify whether, on the network capture date, the network provider was displayed in the health plan's online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network, location, and service type identified in the corresponding fields of this report form.
Unique Provider	Enter "Y" if this network provider was identified as a unique provider after conducting the unique provider and duplicate record identification process described in paragraphs 15-19 of the PAAS Manual. Enter "N" if this entry was identified as a duplicate provider.
PAAS Information	

Field Name	***Field Instructions - Psychiatrists Contact List Report Form***
Provider Survey Type	For each network provider, enter "Psychiatrists" in this field.
REQUESTED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Comments 1	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.
Comments 2	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.

Ancillary Service Providers Contact List Report Form (Form No. 40-258)

Field Name	***Field Instructions - Ancillary Service Providers Contact List Report Form***
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Network Information	
Network Name	Enter the network name within which the reported provider serves as a network provider, as defined in Rule 1300.67.2.2(b)(8).
Network ID	Enter the network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Subcontracted Plan Information	
Subcontracted Plan License Number	Enter the subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). Each health plan's license number is available on the Department's web portal.
Subcontracted Plan Network ID	Enter the subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12).
Network Provider Information	
Entity or Facility Name	Enter the name of the entity or facility providing the ancillary service.
DBA	Enter the "Doing-Business-As" name of the network provider, if applicable.

Field Name	***Field Instructions - Ancillary Service Providers Contact List Report Form***
FQHC/RHC Name	Enter the name of the FQHC/RHC network provider.
NPI	Enter the unique National Provider Identifier (NPI) assigned to the entity or facility, active on the network capture date.
Provider Type	Enter the provider type, as set forth in Appendix B that describes the individual the entity or facility network provider's area of practice.
Provider Group	Enter the name of the provider group affiliated with the network provider, if applicable.
Network Provider Practice Location and Associated Information	
Practice Address	Enter the street number and street name of the practice address. If the network provider also serves as a telehealth provider, report only the physical location at which the network provider delivers in-person health care services.
Practice Address 2	Enter the number of the office, suite, building or other location identifier for the practice address, if applicable.
City	Enter the city in which the practice address is located.
County	Enter the county in which the practice address is located.
State	Enter the state in which the practice address is located.
Zip Code	Enter the ZIP Code in which the practice address is located.
Phone Number 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Phone Number 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Phone Number 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.

Field Name	***Field Instructions - Ancillary Service Providers Contact List Report Form***
Email Address 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Displayed in Provider Directory	Identify whether, on the network capture date, the network provider was displayed in the health plan's online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network, location, and service type identified in the corresponding fields of this report form.
Unique Provider	Enter "Y" if this network provider was identified as a unique provider after conducting the unique provider and duplicate record identification process described in paragraphs 15-19 of the PAAS Manual. Enter "N" if this entry was identified as a duplicate provider.
PAAS Information	
Provider Survey Type	For each network provider, enter "Ancillary Service Providers" in this field.
REQUESTED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Comments 1	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.
Comments 2	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.

C. Raw Data Report Forms – Instructions

The health plan shall use the PAAS Manual and the instructions set forth below to enter information related to the unique providers that the health plan selected to survey from the appropriate Contact List onto the Raw Data Report Form. (See paragraphs 15-34 in the PAAS Manual for identification of unique providers, the sample selection instructions and further details.) Conduct the PAAS and use the information from the PAAS to populate the fields designated with an asterisk. The health plan shall complete all required fields, but is

not required to complete the requested fields.

The health plan shall use the responses on the Raw Data Report Form to report the information required on the Results Report Form to the Department. By incorporating data obtained through Extraction into the Raw Data Report Form, the health plan affirms that it has met all specifications related to Extraction set forth in the PAAS Manual in paragraphs 43-45.

Primary Care Providers Raw Data Report Form (Form No. 40-259)

Field Name	***Field Instructions - Primary Care Providers Raw Data Report Form***
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Network Information	
Network Name	Enter the network name within which the reported provider serves as a network provider, as defined in Rule 1300.67.2.2(b)(8).
Network ID	Enter the network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Subcontracted Plan Information	
Subcontracted Plan License Number	Enter the subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). Each health plan's license number is available on the Department's web portal.
Subcontracted Plan Network ID	Enter the subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12).
Network Provider Information	
Last Name	Enter the last name of the network provider.
First Name	Enter the first name of the network provider.
FQHC/RHC Name	Enter the name of the FQHC/RHC network provider.
NPI	Enter the unique National Provider Identifier (NPI) assigned to the network provider, active on the network capture date.
CA License	Enter the California license number of the network provider, active on the network capture date.

Field Name	***Field Instructions - Primary Care Providers Raw Data Report Form***
Non-CA License	Enter the license number issued outside of the state of California, active on the network capture date.
Non-CA License State	Enter the state in which the non-California license was issued.
License Type	Enter the network provider's type of license.
Specialty	Enter the network provider's specialty or subspecialty as of the network capture date.
NPI of Supervising PCP	Enter the unique National Provider Identifier (NPI) of the reported primary care physician (PCP) who supervises the non-physician medical practitioner.
Board Certified / Eligible	For each reported specialty or subspecialty, indicate whether the network provider is board-certified or board-eligible.
Provider Group	Enter the name of the provider group affiliated with the network provider, if applicable.
Network Provider Practice Location and Associated Information	
Practice Address	Enter the street number and street name of the practice address.
Practice Address 2	Enter the number of the office, suite, building or other location identifier for the practice address, if applicable.
City	Enter the city in which the practice address is located.
County	Enter the county in which the practice address is located.
State	Enter the state in which the practice address is located.
Zip Code	Enter the ZIP Code in which the practice address is located.
Phone Number 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Phone Number 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Phone Number 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.

Field Name	***Field Instructions - Primary Care Providers Raw Data Report Form***
Fax Number 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Qualified Advanced Access Provider	Enter "Y" if the health plan identified this network provider as a Qualified Advanced Access Provider. (See paragraphs 54-57 of the PAAS Manual and Rule 1300.67.2.2(c)(5)(I) and (d)(2)(E) for further details regarding verification of Advanced Access Providers.)
PAAS Information	
Provider Survey Type	For each network provider, enter "Primary Care Providers" in this field.
Survey Modality	Enter the survey administration modality used by the health plan to obtain the network provider's response to the PAAS using the following values: • "Three Step Protocol" • "Qualified Advanced Access Provider" • "Extraction" Review paragraphs 42-55 of the PAAS Manual for further information related to PAAS modalities. The Qualified Advanced Access Provider modality may only be used for Primary Care Providers.
Sample Type	Enter "Random Sample" if the health plan administered the survey to a randomly selected sample of network providers in the County/Network. Enter "Census" if the health plan conducted a census (surveyed all the network providers) in the County/Network.

Field Name	***Field Instructions - Primary Care Providers Raw Data Report Form***
Outcome*	Indicate the network provider's PAAS outcome, based on the criteria set forth in the PAAS Manual, by entering one of the following values: • "Eligible – Completed Survey" • "Refused – Refused/Declined to Respond" • "Refused – No Response" • "Ineligible – Provider Not in Health Plan Network" • "Ineligible – Provider Not in County" • "Ineligible – Provider Retired or Ceasing to Practice" • "Ineligible – Provider Listed Under Incorrect Specialty" • "Ineligible – Contact Information Issue (Incorrect Phone or Fax Number/Email)" • "Ineligible – Provider Does Not Offer Appointments" (See paragraphs 58-60 and 63 of the PAAS Manual for further information related to PAAS Outcomes.)
Survey Completed via*	Indicate whether the survey was completed via: • "Phone" • "Fax" • "Email/Online" • "Extraction – Electronic" • "Extraction – Manual" • "Qualified Advanced Access Provider" For non-responding and ineligible providers, enter the last method the health plan used in attempting to survey the network provider.
Date Survey Initiated*	Enter the date the survey was initiated via Email, Electronic Communication, Fax or Extraction. If the survey was not initiated by Email, Electronic Communication, Fax or Extraction (e.g., this contact information was not available), and as a result the survey was initiated by telephone, enter the date of the first telephone call made to the network provider in attempting to initiate the survey. For a Qualified Advanced Access Provider enter "NA."
Date Survey Completed*	Enter the date the response was completed or the date the appointment data was extracted (mm/dd/yy). Enter "NA" if the network provider declined to respond, was ineligible, or is a Qualified Advanced Access Provider.

Timely Access and Annual Network Submission Instruction Manual

Field Name	***Field Instructions - Primary Care Providers Raw Data Report Form***
Time Survey Completed*	Enter the time the response was completed or the time the appointment data was extracted (hh:mm am/pm). Enter "NA" if the network provider declined to respond, was ineligible or is a Qualified Advanced Access Provider.
Name of Individual Conducting the Survey*	If conducting the PAAS using a telephone call, enter the first name and first initial of the surveyor's last name (the person who made the call on behalf of the health plan). If the name of the surveyor is unavailable to the health plan, a unique ID may be used to identify the surveyor. Enter "NA" if the survey was not completed by telephone.
Person Spoken to*	Enter the name of the person who responded to the PAAS on behalf of the network provider, if applicable.
Question 1 and 2 - Date ***When is the next available appointment date with [Provider Name] for [an urgent care or a non-urgent appointment]?****	Based on the network provider's response to the PAAS questions regarding the next available urgent care appointment (Question 1) or non-urgent appointment (Question 2) (or the appointment data obtained in response to these questions through Extraction), enter the date of the network provider's next available appointment (e.g. mm/dd/yy) in the field applicable to the appointment type. Enter "NA" if the network provider indicated that this appointment type is not applicable, the network provider is a non-responder, ineligible or a Qualified Advanced Access Provider. (See paragraphs 54-60 of the PAAS Manual.) Enter "Unknown" if the network provider is not scheduling appointments at the time of the survey because the network provider is out of the office (e.g., vacation, maternity leave, etc.).
Question 1 and 2 - Time ***When is the next available appointment time with [Provider Name] for [an urgent care or a non-urgent appointment]?****	Based on the network provider's response to the PAAS questions regarding the next available urgent care appointment (Question 1) or non-urgent appointment (Question 2) (or the appointment data obtained in response to these questions through Extraction), enter the time of the network provider's next available appointment (hh:mm am/pm) in the field applicable to the appointment type. Enter "NA" if the network provider indicated that this appointment type is not applicable or the network provider is a non-responder, ineligible or a Qualified Advanced Access Provider. (See paragraphs 54-60 of the PAAS Manual.) Enter "Unknown" if the network provider is not scheduling appointments at the time of the survey because the network provider is out of the office (e.g., vacation, maternity leave, etc.).

Field Name	***Field Instructions - Primary Care Providers Raw Data Report Form***
Calculation 1 and 2 ***Yes, there is an available appointment within [applicable time-elapsed standard].*** ***No, there is no available appointment within [applicable time-elapsed standard].******	Calculation 1 refers to the network provider's next available urgent care appointment. Calculation 2 refers to the network provider's next available non-urgent appointment. Indicate whether the network provider's next available appointment falls within the applicable standard for Calculation 1 and Calculation 2 by entering: • "Y" to indicate "Yes, there is an available appointment within [applicable time-elapsed standard]." (If the health plan has identified this provider as a Qualified Advanced Access Provider, enter "Y" for all applicable appointment types.) • "N" to indicate "No, there is no available appointment within [applicable time-elapsed standard]." (If "Unknown" is entered into the next available appointment date and time response fields, no appointment is available with this network provider within the applicable time-elapsed standard.) • "NA" if the appointment type is not applicable to this network provider, the network provider is a non-responder, or the network provider is ineligible. Each Raw Data Report Form sets forth the applicable timeframe for the Provider Survey Type, based on the time-elapsed standards set forth in Rule 1300.67.2.2(c). Refer to paragraphs 68-70 of the PAAS Manual and the Survey Tool, set forth in Appendix 2 of the PAAS Manual for specific instructions regarding each calculation.
REQUESTED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Comments 1	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.
Comments 2	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.
Comments 3	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.

Non-Physician Mental Health Care Providers Raw Data Report Form (Form No. 40-260)

Field Name	***Field Instructions - NPMH Care Providers Raw Data Report Form***
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Network Information	
Network Name	Enter the network name within which the reported provider serves as a network provider, as defined in Rule 1300.67.2.2(b)(8).
Network ID	Enter the network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Subcontracted Plan Information	
Subcontracted Plan License Number	Enter the subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). Each health plan's license number is available on the Department's web portal.
Subcontracted Plan Network ID	Enter the subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12).
Network Provider Information	
Last Name	Enter the last name of the network provider.
First Name	Enter the first name of the network provider.
FQHC/RHC Name	Enter the name of the FQHC/RHC network provider.
NPI	Enter the unique National Provider Identifier (NPI) assigned to the network provider, active on the network capture date.
CA License / Certificate	Enter the California license or certificate identifier, active on the network capture date.
Non-CA License / Certificate	Enter the license number or certificate identifier issued outside of the state of California, active on the network capture date.
Non-CA License / Certificate State	Enter the state in which the non-California license or certificate was issued.
Type of License /	Enter the network provider's type of license or certificate.

Field Name	***Field Instructions - NPMH Care Providers Raw Data Report Form***
Certificate	
Specialty	Enter the network provider's specialty as of the network capture date.
Provider Group	Enter the name of the provider group affiliated with the network provider, if applicable.
Network Provider Practice Location and Associated Information	
Practice Address	Enter the street number and street name of the practice address.
Practice Address 2	Enter the number of the office, suite, building or other location identifier for the practice address, if applicable.
City	Enter the city in which the practice address is located.
County	Enter the county in which the practice address is located.
State	Enter the state in which the practice address is located.
Zip Code	Enter the ZIP Code in which the practice address is located.
Phone Number 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Phone Number 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Phone Number 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the

Field Name	***Field Instructions - NPMH Care Providers Raw Data Report Form***
	Department in this report form.
PAAS Information	
Provider Survey Type	For each network provider, enter "Non-Physician Mental Health Care Providers" in this field.
Survey Modality	Enter the survey administration modality used by the health plan to obtain the network provider's response to the PAAS using the following values: • "Three Step Protocol" • "Extraction" Review paragraphs 42-53 of the PAAS Manual for further information related to PAAS modalities. The Qualified Advanced Access Provider modality only be used for Primary Care Providers.
Sample Type	Enter "Random Sample" if the health plan administered the survey to a randomly selected sample of network providers in the County/Network. Enter "Census" if the health plan conducted a census (surveyed all the network providers) in the County/Network.
Outcome*	Indicate the network provider's PAAS outcome, based on the criteria set forth in the PAAS Manual, by entering one of the following values: • "Eligible – Completed Survey" • "Refused – Refused/Declined to Respond" • "Refused – No Response" • "Ineligible – Provider Not in Health Plan Network" • "Ineligible – Provider Not in County" • "Ineligible – Provider Retired or Ceasing to Practice" • "Ineligible – Provider Listed Under Incorrect Specialty" • "Ineligible – Contact Information Issue (Incorrect Phone or Fax Number/Email)" • "Ineligible – Provider Does Not Offer Appointments" (See paragraphs 58-60 and 63 of the PAAS Manual for further information related to PAAS Outcomes.)

Field Name	***Field Instructions - NPMH Care Providers Raw Data Report Form***
Survey Completed via*	Indicate whether the survey was completed via: • "Phone" • "Fax" • "Email/Online" • "Extraction – Electronic" • "Extraction – Manual" For non-responding and ineligible providers, enter the last method the health plan used in attempting to survey the network provider.
Date Survey Initiated*	Enter the date the survey was initiated via Email, Electronic Communication, Fax or Extraction. If the survey was not initiated by Email, Electronic Communication, Fax or Extraction (e.g., this contact information was not available), and as a result the survey was initiated by telephone, enter the date of the first telephone call made to the network provider in attempting to initiate the survey.
Date Survey Completed*	Enter the date the response was completed or the date the appointment data was extracted (mm/dd/yy). Enter "NA" if the network provider declined to respond or was ineligible.
Time Survey Completed*	Enter the time the response was completed or the time the appointment data was extracted (hh:mm am/pm). Enter "NA" if the network provider declined to respond or was ineligible.
Name of Individual Conducting the Survey*	If conducting the PAAS using a telephone call, enter the first name and first initial of the surveyor's last name (the person who made the call on behalf of the health plan). If the name of the surveyor is unavailable to the health plan, a unique ID may be used to identify the surveyor. Enter "NA" if the survey was not completed by telephone.
Person Spoken to*	Enter the name of the person who responded to the PAAS on behalf of the network provider, if applicable.

Field Name	***Field Instructions - NPMH Care Providers Raw Data Report Form***
Question 1 and 2 - Date ***When is the next available appointment date with [Provider Name] for [an urgent care or a non-urgent appointment]?******	Based on the network provider's response to the PAAS questions regarding the next available urgent care appointment (Question 1) or non-urgent appointment (Question 2) (or the appointment data obtained in response to these questions through Extraction), enter the date of the network provider's next available appointment (e.g. mm/dd/yy) in the field applicable to the appointment type. Enter "NA" if the network provider indicated that this appointment type is not applicable or the network provider is a non-responder or ineligible. (See paragraphs 58-60 of the PAAS Manual.) Enter "Unknown" if the network provider is not scheduling appointments at the time of the survey because the network provider is out of the office (e.g., vacation, maternity leave, etc.).
Question 1 and 2 - Time ***When is the next available appointment time with [Provider Name] for [an urgent care or a non-urgent appointment]?******	Based on the network provider's response to the PAAS questions regarding the next available urgent care appointment (Question 1) or non-urgent appointment (Question 2) (or the appointment data obtained in response to these questions through Extraction), enter the time of the network provider's next available appointment (e.g. hh/mm am/pm) in the field applicable to the appointment type. Enter "NA" if the network provider indicated that this appointment type is not applicable, or the network provider is a non-responder or ineligible. (See paragraphs 58-60 of the PAAS Manual.) Enter "Unknown" if the network provider is not scheduling appointments at the time of the survey because the network provider is out of the office (e.g., vacation, maternity leave, etc.).
Calculation 1 and 2 ***Yes, there is an available appointment within [applicable time-elapsed standard].*** ***No, there is no available appointment within [applicable time-elapsed standard].****	Calculation 1 refers to the network provider's next available urgent care appointment. Calculation 2 refers to the network provider's next available non-urgent appointment. Indicate whether the network provider's next available appointment falls within the applicable standard for Calculation 1 and Calculation 2 by entering: • "Y" to indicate "Yes, there is an available appointment within [applicable time-elapsed standard]"; • "N" to indicate "No, there is no available appointment within [applicable time-elapsed standard]." (If "Unknown" is entered into the next available appointment date and time response fields, no appointment is available within the applicable time-elapsed standard.)

Field Name	***Field Instructions - NPMH Care Providers Raw Data Report Form***
	• "NA" if the appointment type is not applicable to this network provider, the network provider is a non-responder, or the network provider is ineligible. Each Raw Data Report Form sets forth the applicable timeframe for the Provider Survey Type, based on the time-elapsed standards set forth in Rule 1300.67.2.2(c). Refer to paragraphs 68-70 of the PAAS Manual and the Survey Tool, set forth in Appendix 2 of the PAAS Manual for specific instructions regarding each calculation.
REQUESTED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Comments 1	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.
Comments 2	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.
Comments 3	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.

Specialist Physicians Raw Data Report Form (Form No. 40-261)

Field Name	***Field Instructions - Specialist Physicians Raw Data Report Form***
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Network Information	
Network Name	Enter the network name within which the reported provider serves as a network provider, as defined in Rule 1300.67.2.2(b)(8).
Network ID	Enter the network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Subcontracted Plan Information	

Field Name	***Field Instructions - Specialist Physicians Raw Data Report Form***
Subcontracted Plan License Number	Enter the subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). Each health plan's license number is available on the Department's web portal.
Subcontracted Plan Network ID	Enter the subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12).
Network Provider Information	
Last Name	Enter the last name of the network provider.
First Name	Enter the first name of the network provider.
FQHC/RHC Name	Enter the name of the FQHC/RHC network provider.
NPI	Enter the unique National Provider Identifier (NPI) assigned to the network provider, active on the network capture date.
CA License	Enter the California license number of the network provider, active on the network capture date.
Non-CA License	Enter the license number issued outside of the state of California, active on the network capture date.
Non-CA License State	Enter the state in which the non-California license was issued.
License Type	Enter the network provider's type of license.
Specialty	Enter the network provider's specialty or subspecialty as of the network capture date.
Board Certified / Eligible	For each reported specialty or subspecialty, indicate whether the network provider is board-certified or board-eligible.
Provider Group	Enter the name of the provider group affiliated with the network provider, if applicable.
Network Provider Practice Location and Associated Information	
Practice Address	Enter the street number and street name of the practice address.
Practice Address 2	Enter the number of the office, suite, building or other location identifier for the practice address, if applicable.
City	Enter the city in which the practice address is located.
County	Enter the county in which the practice address is located.

Field Name	***Field Instructions - Specialist Physicians Raw Data Report Form***
State	Enter the state in which the practice address is located.
Zip Code	Enter the ZIP Code in which the practice address is located.
Phone Number 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Phone Number 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Phone Number 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
PAAS Information	
Provider Survey Type	For each network provider, enter "Specialist Physicians" in this field.

Field Name	***Field Instructions - Specialist Physicians Raw Data Report Form***
Survey Modality	Enter the survey administration modality used by the health plan to obtain the network provider's response to the PAAS using the following values: • "Three Step Protocol" • "Extraction" Review paragraphs 42-53 of the PAAS Manual for further information related to PAAS modalities. The Qualified Advanced Access Provider modality may only be used for Primary Care Providers.
Sample Type	Enter "Random Sample" if the health plan administered the survey to a randomly selected sample of network providers in the County/Network. Enter "Census" if the health plan conducted a census (surveyed all the network providers) in the County/Network.
Outcome*	Indicate the network provider's PAAS outcome, based on the criteria set forth in the PAAS Manual, by entering one of the following values: • "Eligible – Completed Survey" • "Refused – Refused/Declined to Respond" • "Refused – No Response" • "Ineligible – Provider Not in Health Plan Network" • "Ineligible – Provider Not in County" • "Ineligible – Provider Retired or Ceasing to Practice" • "Ineligible – Provider Listed Under Incorrect Specialty" • "Ineligible – Contact Information Issue (Incorrect Phone or Fax Number/Email)" • "Ineligible – Provider Does Not Offer Appointments" (See paragraphs 58-60 and 63 of the PAAS Manual for further information related to PAAS Outcomes.)

Field Name	***Field Instructions - Specialist Physicians Raw Data Report Form***
Survey Completed via*	Indicate whether the survey was completed via: • "Phone" • "Fax" • "Email/Online" • "Extraction – Electronic" • "Extraction – Manual" For non-responding and ineligible providers, enter the last method the health plan used in attempting to survey the network provider.
Date Survey Initiated*	Enter the date the survey was initiated via Email, Electronic Communication, Fax or Extraction. If the survey was not initiated by Email, Electronic Communication, Fax or Extraction (e.g., this contact information was not available), and as a result the survey was initiated by telephone, enter the date of the first telephone call made to the network provider in attempting to initiate the survey.
Date Survey Completed*	Enter the date the response was completed or the date the appointment data was extracted (mm/dd/yy). Enter "NA" if the network provider declined to respond or was ineligible.
Time Survey Completed*	Enter the time the response was completed or the time the appointment data was extracted (hh:mm am/pm). Enter "NA" if the network provider declined to respond or was ineligible.
Name of Individual Conducting the Survey*	If conducting the PAAS using a telephone call, enter the first name and first initial of the surveyor's last name (the person who made the call on behalf of the health plan). If the name of the surveyor is unavailable to the health plan, a unique ID may be used to identify the surveyor. Enter "NA" if the survey was not completed by telephone.
Person Spoken to*	Enter the name of the person who responded to the PAAS on behalf of the network provider, if applicable.
Question 1 and 2 - Date ***When is the next available appointment date with [Provider Name] for [an urgent care or a non-urgent***	Based on the network provider's response to the PAAS questions regarding the next available urgent care appointment (Question 1) or non-urgent appointment (Question 2) (or the appointment data obtained in response to these questions through Extraction), enter the date of the network provider's next available appointment (e.g. mm/dd/yy) in the field applicable to the appointment type. Enter "NA" if the network provider indicated that this appointment type is not applicable or the network provider is a non-responder or ineligible. (See paragraphs 58-60 of the PAAS Manual.) Enter "Unknown" if

Field Name	***Field Instructions - Specialist Physicians Raw Data Report Form***
appointment]?*	the network provider is not scheduling appointments at the time of the survey because the network provider is out of the office (e.g., vacation, maternity leave, etc.).
Question 1 and 2 - Time ***When is the next available appointment time with [Provider Name] for [an urgent care or a non-urgent appointment]?****	Based on the network provider's response to the PAAS questions regarding the next available urgent care appointment (Question 1) or non-urgent appointment (Question 2) (or the appointment data obtained in response to these questions through Extraction), enter the time of the network provider's next available appointment (e.g. hh/mm am/pm) in the field applicable to the appointment type. Enter "NA" if the network provider indicated that this appointment type is not applicable or the network provider is a non-responder or ineligible. (See paragraphs 58-60 of the PAAS Manual.) Enter "Unknown" if the network provider is not scheduling appointments at the time of the survey because the network provider is out of the office (e.g., vacation, maternity leave, etc.).
Calculation 1 and 2 ***Yes, there is an available appointment within [applicable time-elapsed standard].*** ***No, there is no available appointment within [applicable time-elapsed standard].****	Calculation 1 refers to the network provider's next available urgent care appointment. Calculation 2 refers to the network provider's next available non-urgent appointment. Indicate whether the network provider's next available appointment falls within the applicable standard for Calculation 1 and Calculation 2 by entering: • "Y" to indicate "Yes, there is an available appointment within [applicable time-elapsed standard]." • "N" to indicate "No, there is no available appointment within [applicable time-elapsed standard]." (If "Unknown" is entered into the next available appointment date and time response fields, no appointment is available with this network provider within the applicable time-elapsed standard.) • "NA" if the appointment type is not applicable to this network provider, the network provider is a non-responder, or the network provider is ineligible. Each Raw Data Report Form sets forth the applicable timeframe for the Provider Survey Type, based on the time-elapsed standards set forth in Rule 1300.67.2.2(c). Refer to paragraphs 68-70 of the PAAS Manual and the Survey Tool, set forth in Appendix 2 of the PAAS Manual for specific instructions regarding each calculation.

Field Name	***Field Instructions - Specialist Physicians Raw Data Report Form***
REQUESTED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Comments 1	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.
Comments 2	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.
Comments 3	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.

Psychiatrists Raw Data Report Form (Form No. 40-262)

Field Name	***Field Instructions - Psychiatrists Raw Data Report Form***
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Network Information	
Network Name	Enter the network name within which the reported provider serves as a network provider, as defined in Rule 1300.67.2.2(b)(8).
Network ID	Enter the network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Subcontracted Plan Information	
Subcontracted Plan License Number	Enter the subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). Each health plan's license number is available on the Department's web portal.
Subcontracted Plan Network ID	Enter the subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12).
Network Provider Information	
Last Name	Enter the last name of the network provider.
First Name	Enter the first name of the network provider.

Timely Access and Annual Network Submission Instruction Manual

Field Name	***Field Instructions - Psychiatrists Raw Data Report Form***
FQHC/RHC Name	Enter the name of the FQHC/RHC network provider.
NPI	Enter the unique National Provider Identifier (NPI) assigned to the network provider, active on the network capture date.
CA License	Enter the California license number of the network provider, active on the network capture date.
Non-CA License	Enter the license number issued outside of the state of California, active on the network capture date.
Non-CA License State	Enter the state in which the non-California license was issued.
License Type	Enter the network provider's type of license.
Specialty	Enter the network provider's specialty or subspecialty as of the network capture date.
Board Certified / Eligible	For each reported specialty or subspecialty, indicate whether the network provider is board-certified or board-eligible.
Provider Group	Enter the name of the provider group affiliated with the network provider, if applicable.
Network Provider Practice Location and Associated Information	
Practice Address	Enter the street number and street name of the practice address.
Practice Address 2	Enter the number of the office, suite, building or other location identifier for the practice address, if applicable.
City	Enter the city in which the practice address is located.
County	Enter the county in which the practice address is located.
State	Enter the state in which the practice address is located.
Zip Code	Enter the ZIP Code in which the practice address is located.
Phone Number 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Phone Number 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Phone Number 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.

Field Name	***Field Instructions - Psychiatrists Raw Data Report Form***
Fax Number 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
PAAS Information	
Provider Survey Type	For each network provider, enter "Psychiatrists" in this field.
Survey Modality	Enter the survey administration modality used by the health plan to obtain the network provider's response to the PAAS using the following values: • "Three Step Protocol" • "Extraction" Review paragraphs 42-53 of the PAAS Manual for further information related to PAAS modalities. The Qualified Advanced Access Provider modality may only be used for Primary Care Providers.
Sample Type	Enter "Random Sample" if the health plan administered the survey to a randomly selected sample of network providers in the County/Network. Enter "Census" if the health plan conducted a census (surveyed all the network providers) in the County/Network.

Timely Access and Annual Network Submission Instruction Manual

Field Name	***Field Instructions - Psychiatrists Raw Data Report Form***
Outcome*	Indicate the network provider's PAAS outcome, based on the criteria set forth in the PAAS Manual, by entering one of the following values: • "Eligible – Completed Survey" • "Refused – Refused/Declined to Respond" • "Refused – No Response" • "Ineligible – Provider Not in Health Plan Network" • "Ineligible – Provider Not in County" • "Ineligible – Provider Retired or Ceasing to Practice" • "Ineligible – Provider Listed Under Incorrect Specialty" • "Ineligible – Contact Information Issue (Incorrect Phone or Fax Number/Email)" • "Ineligible – Provider Does Not Offer Appointments" (See paragraphs 58-60 and 63 of the PAAS Manual for further information related to PAAS Outcomes.)
Survey Completed via*	Indicate whether the survey was completed via: • "Phone" • "Fax" • "Email/Online" • "Extraction – Electronic" • "Extraction – Manual" For non-responding and ineligible providers, enter the last method the health plan used in attempting to survey the network provider.
Date Survey Initiated*	Enter the date the survey was initiated via Email, Electronic Communication, Fax or Extraction. If the survey was not initiated by Email, Electronic Communication, Fax or Extraction (e.g., this contact information was not available), and as a result the survey was initiated by telephone, enter the date of the first telephone call made to the network provider in attempting to initiate the survey.
Date Survey Completed*	Enter the date the response was completed or the date the appointment data was extracted (mm/dd/yy). Enter "NA" if the network provider declined to respond or was ineligible.

Field Name	***Field Instructions - Psychiatrists Raw Data Report Form***
Time Survey Completed*	Enter the time the response was completed or the time the appointment data was extracted (hh:mm am/pm). Enter "NA" if the network provider declined to respond or was ineligible.
Name of Individual Conducting the Survey*	If conducting the PAAS using a telephone call, enter the first name and first initial of the surveyor's last name (the person who made the call on behalf of the health plan). If the name of the surveyor is unavailable to the health plan, a unique ID may be used to identify the surveyor. Enter "NA" if the survey was not completed by telephone.
Person Spoken to*	Enter the name of the person who responded to the PAAS on behalf of the network provider, if applicable.
Question 1 and 2 - Date ***When is the next available appointment date with [Provider Name] for [an urgent care or a non-urgent appointment]?****	Based on the network provider's response to the PAAS questions regarding the next available urgent care appointment (Question 1) or non-urgent appointment (Question 2) (or the appointment data obtained in response to these questions through Extraction), enter the date of the network provider's next available appointment (e.g. mm/dd/yy) in the field applicable to the appointment type. Enter "NA" if the network provider indicated that this appointment type is not applicable or the network provider is a non-responder or ineligible. (See paragraphs 58-60 of the PAAS Manual.) Enter "Unknown" if the network provider is not scheduling appointments at the time of the survey because the network provider is out of the office (e.g., vacation, maternity leave, etc.).
Question 1 and 2 - Time ***When is the next available appointment time with [Provider Name] for [an urgent care or a non-urgent appointment]?****	Based on the network provider's response to the PAAS questions regarding the next available urgent care appointment (Question 1) or non-urgent appointment (Question 2) (or the appointment data obtained in response to these questions through Extraction), enter the time of the network provider's next available appointment (e.g. hh/mm am/pm) in the field applicable to the appointment type. Enter "NA" if the network provider indicated that this appointment type is not applicable, or the network provider is a non-responder or ineligible. (See paragraphs 58-60 of the PAAS Manual.) Enter "Unknown" if the network provider is not scheduling appointments at the time of the survey because the network provider is out of the office (e.g., vacation, maternity leave, etc.).

Field Name	***Field Instructions - Psychiatrists Raw Data Report Form***
Calculation 1 and 2 ***Yes, there is an available appointment within [applicable time-elapsed standard].*** ***No, there is no available appointment within [applicable time-elapsed standard].******	Calculation 1 refers to the network provider's next available urgent care appointment. Calculation 2 refers to the network provider's next available non-urgent appointment. Indicate whether the network provider's next available appointment falls within the applicable standard for Calculation 1 and Calculation 2 by entering: • "Y" to indicate "Yes, there is an available appointment within [applicable time-elapsed standard]." • "N" to indicate "No, there is no available appointment within [applicable time-elapsed standard]." (If "Unknown" is entered into the next available appointment date and time response fields, no appointment is available with this network provider within the applicable time-elapsed standard.) • "NA" if the appointment type is not applicable to this network provider, the network provider is a non-responder, or the network provider is ineligible. Each Raw Data Report Form sets forth the applicable timeframe for the Provider Survey Type, based on the time-elapsed standards set forth in Rule 1300.67.2.2(c). Refer to paragraphs 68-70 of the PAAS Manual and the Survey Tool, set forth in Appendix 2 of the PAAS Manual for specific instructions regarding each calculation.
REQUESTED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Comments 1	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.
Comments 2	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.
Comments 3	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.

Ancillary Service Providers Raw Data Report Form (Form No. 40-263)

Field Name	***Field Instructions - Ancillary Service Providers Raw Data Report Form***
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Network Information	
Network Name	Enter the network name within which the reported provider serves as a network provider, as defined in Rule 1300.67.2.2(b)(8).
Network ID	Enter the network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Subcontracted Plan Information	
Subcontracted Plan License Number	Enter the subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). Each health plan's license number is available on the Department's web portal.
Subcontracted Plan Network ID	Enter the subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12).
Network Provider Information	
Entity or Facility Name	Enter the name of the entity or facility providing the ancillary service.
DBA	Enter the "Doing-Business-As" name of the network provider, if applicable.
FQHC/RHC Name	Enter the name of the FQHC/RHC network provider.
NPI	Enter the unique National Provider Identifier (NPI) assigned to the entity or facility, active on the network capture date.
Provider Type	Enter the provider type, as set forth in Appendix B that describes the individual the entity or facility network provider's area of practice.
Provider Group	Enter the name of the provider group affiliated with the network provider, if applicable.
Network Provider Practice Location and Associated Information	

Field Name	***Field Instructions - Ancillary Service Providers Raw Data Report Form***
Practice Address	Enter the street number and street name of the practice address.
Practice Address 2	Enter the number of the office, suite, building or other location identifier for the practice address, if applicable.
City	Enter the city in which the practice address is located.
County	Enter the county in which the practice address is located.
State	Enter the state in which the practice address is located.
Zip Code	Enter the ZIP Code in which the practice address is located.
Phone Number 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Phone Number 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Phone Number 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Fax Number 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 1	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 2	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
Email Address 3	This field is included for the health plan's use in conducting the PAAS only. This information shall not be submitted to the Department in this report form.
PAAS Information	
Provider Survey Type	For each network provider, enter "Ancillary Service Providers" in this field.

Timely Access and Annual Network Submission Instruction Manual

Field Name	***Field Instructions - Ancillary Service Providers Raw Data Report Form***
Survey Modality	Enter the survey administration modality used by the health plan to obtain the network provider's response to the PAAS using the following values: • "Three Step Protocol" • "Extraction" Review paragraphs 42-53 of the PAAS Manual for further information related to PAAS modalities. The Qualified Advanced Access Provider modality may only be used for Primary Care Providers.
Sample Type	Enter "Random Sample" if the health plan administered the survey to a randomly selected sample of network providers in the County/Network. Enter "Census" if the health plan conducted a census (surveyed all the network providers) in the County/Network.
Outcome*	Indicate the network provider's PAAS outcome, based on the criteria set forth in the PAAS Manual, by entering one of the following values: • "Eligible – Completed Survey" • "Refused – Refused/Declined to Respond" • "Refused – No Response" • "Ineligible – Provider Not in Health Plan Network" • "Ineligible – Provider Not in County" • "Ineligible – Provider Retired or Ceasing to Practice" • "Ineligible – Provider Listed Under Incorrect Specialty" • "Ineligible – Contact Information Issue (Incorrect Phone or Fax Number/Email)" • "Ineligible – Provider Does Not Offer Appointments" (See paragraphs 58-60 and 63 of the PAAS Manual for further information related to PAAS Outcomes.)

Field Name	***Field Instructions - Ancillary Service Providers Raw Data Report Form***
Survey Completed via*	Indicate whether the survey was completed via: • "Phone" • "Fax" • "Email/Online" • "Extraction – Electronic" • "Extraction – Manual" For non-responding and ineligible providers, enter the last method the health plan used in attempting to survey the network provider.
Date Survey Initiated*	Enter the date the survey was initiated via Email, Electronic Communication, Fax or Extraction. If the survey was not initiated by Email, Electronic Communication, Fax or Extraction (e.g., this contact information was not available), and as a result the survey was initiated by telephone, enter the date of the first telephone call made to the network provider in attempting to initiate the survey.
Date Survey Completed*	Enter the date the response was completed or the date the appointment data was Extracted (mm/dd/yy). Enter "NA" if the network provider declined to respond or was ineligible.
Time Survey Completed*	Enter the time the response was completed or the time the appointment data was extracted (hh:mm am/pm). Enter "NA" if the network provider declined to respond or was ineligible.
Name of Individual Conducting the Survey*	If conducting the PAAS using a telephone call, enter the first name and first initial of the surveyor's last name (the person who made the call on behalf of the health plan). If the name of the surveyor is unavailable to the health plan, a unique ID may be used to identify the surveyor. Enter "NA" if the survey was not completed by telephone.
Person Spoken to*	Enter the name of the person who responded to the PAAS on behalf of the network provider, if applicable.

Field Name	***Field Instructions - Ancillary Service Providers Raw Data Report Form***
Question 1 - Date ***When is the next available appointment date with [Provider Name] for a non-urgent appointment?******	Based on the network provider's response to the PAAS question regarding the next available non-urgent appointment (Question 1) (or the appointment data obtained in response to this question through Extraction), enter the date of the network provider's next available non-urgent appointment (e.g. mm/dd/yy) in this field. Enter "NA" if the network provider indicated that this appointment type is not applicable, the network provider is a non-responder or ineligible. (See paragraphs 54-60 of the PAAS Manual.) Enter "Unknown" if the network provider is not scheduling appointments at the time of the survey because the network provider is out of the office (e.g., vacation, maternity leave, etc.).
Question 1 - Time ***When is the next available appointment time with [Provider Name] for a non-urgent appointment?******	Based on the network provider's response to the PAAS question regarding the next available non-urgent appointment (Question 1) (or the appointment data obtained in response to this question through Extraction), enter the time of the network provider's next available appointment (e.g. hh:mm am/pm) in this field. Enter "NA" if the network provider indicated this appointment type is not applicable, or the network provider is a non-responder or ineligible. (See paragraphs 54-60 of the PAAS Manual.) Enter "Unknown" if the network provider is not scheduling appointments at the time of the survey because the network provider is out of the office (e.g., vacation, maternity leave, etc.).
Calculation 1 ***Yes, there is an available appointment within 15 Business Days.*** ***No, there is no available appointment within 15 Business Days.****	Indicate whether the network provider's next available non-urgent appointment falls within the applicable standard by entering: • "Y" to indicate "Yes, there is an available appointment within 15 Business Days." • "N" to indicate "No, there is no available appointment within 15 Business Days." (If "Unknown" is entered into the next available appointment date and time response fields, no appointment is available with this network provider within 15 Business Days.) • "NA" if the appointment type is not applicable to this network provider, the network provider is a non-responder, or the network provider is ineligible. Urgent care appointments questions are not applicable to Ancillary Service Providers in the PAAS Manual. Refer to paragraphs 68-70 of the PAAS Manual and the Survey Tool, set forth in Appendix 2 of the PAAS Manual for specific instructions regarding each calculation.

Field Name	***Field Instructions - Ancillary Service Providers Raw Data Report Form***
REQUESTED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Comments 1	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.
Comments 2	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.
Comments 3	In this optional field, the health plan may provide any explanations or notes to the Department regarding the information being reported.

D. Results Report Form – Instructions

The health plan shall use the PAAS Manual, the instructions set forth below, and the health plan's Raw Data Report Forms to complete each field, and calculate the PAAS results for each county in each network (County/Network) and for each Provider Survey Type in the applicable Results Tab in the Results Report Form (e.g., use the Primary Care Providers Raw Data Report Form to complete the Primary Care Providers Results Tab). The health plan shall enter information in the Results Report Form on the following report forms:

- 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.

The information entered by the health plan on each Results Tab is used to auto-populate and auto-calculate the Summary of Rates of Compliance Tab and the Network by Provider Survey Type Tab. In order for the auto-calculated fields to operate correctly, health plans shall include the PAAS results for all network providers in a single Results Report Form. The health plan shall complete all required fields.

Results Report Form: Results Tab (Form No. 40-264)

Field Name	***Field Instructions - Results Report Form: [Provider Survey Type] Results Tabs***
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Survey Information	

Field Name	***Field Instructions - Results Report Form: [Provider Survey Type] Results Tabs***
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Provider Survey Type	Enter the Provider Survey Type for which the health plan is reporting results: • "Primary Care Providers" • "Non-Physician Mental Health Care Providers" • "Specialist Physicians" • "Psychiatrists" • "Ancillary Service Providers"
Survey Modality	Enter the survey administration modality (or modalities) used to obtain the survey data for the Provider Survey Type in the County/Network using the following values: • "Three Step Protocol" • "Qualified Advanced Access Provider" • "Extraction" • "Three Step Protocol/Qualified Advanced Access Provider" • "Three Step Protocol/Extraction" • "Qualified Advanced Access Provider/Extraction" • "Three Step Protocol/Qualified Advanced Access Provider/Extraction" Review paragraphs 42-55 of the PAAS Manual for further information related to PAAS modalities. Health plans shall use the Qualified Advanced Access Provider modality only for Primary Care Providers.

Field Name	***Field Instructions - Results Report Form: [Provider Survey Type] Results Tabs***
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Sample Type	For each Provider Survey Type within the County/Network, indicate the sample type by entering: • "Random Sample" if the health plan administered the survey to a randomly selected sample of network providers but did not survey all network providers within the County/Network. • "Sample Exhaustion" if the health plan intended to administer the survey to a randomly selected sample of network providers but surveyed all network providers within the County/Network through the replacement of network providers from the oversample. • "Census" if the health plan conducted a census (surveyed all the network providers in the County/Network). (See Step 3 of PAAS Manual for further details related to selecting the network providers the health plan is required survey under the PAAS.)
Network Information	
Network Name	Enter the network name, as defined in Rule 1300.67.2.2(b)(8), for which the health plan is reporting results.
Network ID	Enter the network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Subcontracted Plan Information	
Subcontracted Plan License Number	If the health plan is reporting results for PAAS data obtained from a subcontracted plan, pursuant to paragraph 8b of the PAAS Manual, enter the subcontracted plan's license number. Each health plan's license number is available on the Department's web portal.
Subcontracted Plan Network ID	If the health plan is reporting results for PAAS data obtained from a subcontracted plan, pursuant to paragraph 8b of the PAAS Manual, enter the subcontracted plan network identifier.

Field Name	***Field Instructions - Results Report Form: [Provider Survey Type] Results Tabs***
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Geographic Information	
County	Enter the county for which the health plan is reporting results.
State	Enter the state for which the health plan is reporting results.
PAAS Results Information	
Number of Providers within County/Network	Enter the number of network providers that were identified as a unique provider in the health plan's Contact List Report Form for the Provider Survey Type in the County/Network. Unique providers are those providers with a "Y" in the "Unique Provider" field of the Contact List Report Form that were remaining after all duplicate entries have been identified. (See Step 2 in the PAAS Manual for further instructions and details regarding identification of unique providers.) The health plan will use the “Number of Providers within County/Network” to determine the "Required Sample Size."
Number of Providers Attempted to be Surveyed	Enter the total number of network providers the health plan attempted to survey via the Three Step Protocol, Extraction, and Qualified Advanced Access Provider for the Provider Survey Type in the County/Network. A survey attempt includes those network providers that responded, were ineligible and non-responders for the applicable County/Network. The “Number of Providers Attempted to be Surveyed” is identified by calculating the number of network providers in the "Outcome" field of the Raw Data Report Form as "Eligible," "Refused," and "Ineligible."

Field Name	***Field Instructions - Results Report Form: [Provider Survey Type] Results Tabs***
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Number of Providers Responded via Three Step Protocol	Enter the total number of network providers who responded to the applicable survey questions via the Three Step Protocol for the Provider Survey Type in the County/Network. Responding network providers include network providers that responded to the survey questions with appointment dates and times or indicated an appointment type (e.g., urgent care appointments) was not applicable to his/her practice. Responding network providers do not include non-responding providers, ineligible providers, network providers who responded via Extraction or as a Qualified Advanced Access Provider. Responding network providers are identified in the Raw Data Report Form by filtering the "Outcome" field for "Eligible – Completed Survey" and the "Survey Completed via" field for "Phone," "Fax," and "Email/Online."
Number of Providers Responded via Extraction	Enter the total number of network providers who responded to the applicable survey questions via Extraction for the Provider Survey Type in the County/Network. Responding network providers include providers that provided extracted data with appointment dates and times or indicated an appointment type (e.g., urgent care appointments) was not applicable to his/her practice. Responding network providers do not include the non-responding providers, ineligible providers or network providers that responded via the Three Step Protocol or as a Qualified Advanced Access Provider. The “Number of Providers Responded via Extraction” is identified by calculating from Raw Data Report Form the number of network providers identified in the "Outcome" field as "Eligible – Completed Survey" and the "Survey Completed via" field as "Extraction."

Field Name	***Field Instructions - Results Report Form: [Provider Survey Type] Results Tabs***
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Number of Providers Responded as a Qualified Advanced Access Provider ***(Primary Care Providers Results Tab Only)***	If the health plan selected a random sample, report the total number of primary care providers who were randomly selected to be surveyed and deemed compliant as Qualified Advanced Access Providers in the County/Network. (See paragraphs 54-57 of the PAAS Manual for further details regarding Qualified Advanced Access Providers.) If the health plan used census, report the total number of primary care providers who were deemed compliant as a Qualified Advanced Access Provider in the County/Network. Responding primary care providers are identified in the Raw Data Report Form by filtering the "Outcome" field for "Eligible – Completed Survey" and then filtering "Survey Completed via" field for "Qualified Advanced Access Providers."
Required Sample Size	Enter the required sample size necessary to achieve a statistically reliable sample for the Provider Survey Type in the County/Network. The required sample size is determined by using the "Number of Providers within County/Network" and the Sample Size Chart set forth in Appendix 1 of the PAAS Manual.
Required Sample Size Achieved	Enter "Y" if the health plan administered the survey to a randomly selected sample of network providers and was able to obtain a sufficient number of survey responses from network providers to reach the required sample size based on the "Required Sample Size" and the "Total Number of Providers Responded to Survey" fields. Enter "Y" if the health plan surveyed a census of network providers and was able to obtain a sufficient number of completed responses from network providers to reach or exceed the required sample size based on the "Required Sample Size" and the "Total Number of Providers Responded to Survey" fields. Enter "N" if the health plan was unable to meet the required sample size. (Even if the health plan was unable to meet the required sample size, the health plan shall still report all required information in the Results Report Form.)

Field Name	***Field Instructions - Results Report Form: [Provider Survey Type] Results Tabs***
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Number of Non-Responding Providers	Enter the number of network providers who did not respond to one or more applicable survey questions or declined to participate in the survey for the Provider Survey Type in the County/Network. The "Number of Non-Responding Providers" is identified by calculating the number of network providers identified in the "Outcome" field of the Raw Data Report Form as "Refused." (See paragraph 58 of the PAAS Manual for further information regarding non-responding providers.)
Number of Ineligible Providers	Enter the number of network providers who were identified as being ineligible for the Provider Survey Type in the County/Network. The "Number of Ineligible Providers" is identified by calculating the number of network providers identified in the "Outcome" field of the Raw Data Report Form as "Ineligible." (See paragraphs 59-60 of the PAAS Manual for further information regarding ineligible providers.)
Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care Appointment within [48 Hours or 96 Hours] ***(All Provider Survey Types Except Ancillary Service Providers)***	Enter the number of network providers who responded to the urgent care appointment question for the Provider Survey Type in the County/Network. Network providers that responded to the urgent care appointment question do not include ineligible providers, non-responding providers, or network providers that responded that urgent care appointments are not applicable. The "Number of Providers who Responded to the Question Regarding the Availability of an urgent care Appointment within [48 Hours or 96 Hours]", is identified by calculating from the Raw Data Report Form the number of network providers identified in the "Outcome" field as "Eligible - Completed Survey" and have a "Y" or "N" in the urgent care appointment "Calculation 1" field. If no network providers within a County/Network responded to the urgent care appointment standard, enter "NA" (e.g., there were only two network providers, and both were ineligible for the survey because they retired). "Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care Appointment within [48 Hours or 96 Hours]" is the denominator used to calculate the "Percentage of Providers with an Urgent Care Appointment Available within [48 Hours or 96 Hours]." (See paragraphs 70-72 of the PAAS Manual for further details.)

Field Name	***Field Instructions - Results Report Form: [Provider Survey Type] Results Tabs***
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
	(Ancillary Service Providers are not surveyed for urgent care appointments. This field is not applicable for Ancillary Service Providers.)
Number of Providers with an Urgent Care Appointment Available within [48 Hours or 96 Hours] ***(All Provider Survey Types Except Ancillary Service Providers)***	Enter the number of network providers who indicated an urgent care appointment was available within the applicable standard (48 hours for Primary Care Providers or 96 hours for NPMH, Specialist Physicians, and Psychiatrists) for this Provider Survey Type in the County/Network. The “Number of Providers with an Urgent Care Appointment Available within [48 Hours or 96 Hours]” is identified by calculating from the Raw Data Report Form the number of network providers identified in the "Outcome" field as "Eligible - Completed Survey" that have a "Y" in the urgent care appointment “Calculation 1” field. The “Number of Providers with an Urgent Care Appointment Available within [48 Hours or 96 Hours]” is the numerator used to calculate the “Percentage of Providers with an Urgent Care Appointment Available within [48 Hours or 96 Hours].” (See paragraphs 70-72 of the PAAS Manual for further details.) (Ancillary Service Providers are not surveyed for urgent care appointments. This field is not applicable for Ancillary Service Providers.)

Field Name	***Field Instructions - Results Report Form: [Provider Survey Type] Results Tabs***
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent Appointment within [10 Business Days or 15 Business Days]	Enter the number of network providers who responded to the non-urgent appointment question for the Provider Survey Type in the County/Network. Network providers who responded to the non-urgent appointment question do not include ineligible providers, non-responding providers, or network providers that responded that non-urgent appointments are not applicable. The "Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent Appointment within [10 Business Days or 15 Business Days]" is identified by calculating from the Raw Data Report Form the number of network providers identified in the "Outcome" field as "Eligible - Completed Survey" and have a "Y" or "N" in the non-urgent appointment "Calculation 2" field (for Ancillary Service Providers refer to the "Calculation 1" field). If no network providers within a County/Network responded to the non-urgent appointment standard, enter "NA" (e.g., there were only two network providers, and both were ineligible for the survey because they retired). This number is the denominator used to calculate the "Percentage of Providers with a Non-Urgent Appointment Available within [10 Business Days or 15 Business Days] (Unweighted)." (See paragraphs 70-72 of the PAAS Manual for further details.)
Number of Providers with a Non-Urgent Appointment Available within [10 Business Days or 15 Business Days]	Enter the number of network providers who indicated a non-urgent appointment was available within the applicable standard (10 business days for Primary Care Providers and NPMH or 15 business days for Specialist Physicians, Psychiatrists and Ancillary Service Providers) for the Provider Survey Type in the County/Network. The "Number of Providers with a Non-Urgent Appointment Available within [10 Business Days or 15 Business Days]" is identified by calculating from the Raw Data Report Form the number of network providers identified in the "Outcome" field as "Eligible - Completed Survey" that have a "Y" in the non-urgent appointment "Calculation 2" field (for Ancillary Service Providers refer to the "Calculation 1" field). The "Number of Providers with a Non-Urgent Appointment Available within [10 Business Days or 15

Field Name	***Field Instructions - Results Report Form: [Provider Survey Type] Results Tabs***
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
	Business Days]" is the numerator used to calculate the "Percentage of Providers with a Non-Urgent Appointment Available within [10 Business Days or 15 Business Days] (Unweighted)." (See paragraphs 70-72 of the PAAS Manual for further details.)
Total Number of Providers Responded to Survey	Verify the auto-calculated field is accurately reflected in the Results Report Form based on the numbers in the following fields for the Provider Survey Type in the County/Network. Report the sum of the following fields: "Number of Providers Responded via Three Step Protocol," "Number of Providers Responded via Extraction," and "Number of Providers Responded as a Qualified Advanced Access Provider."
Percentage of Non-Responding Providers	Verify the auto-calculated field is accurately reflected in the Results Report Form based on the numbers in the following fields for the Provider Survey Type in the County/Network. Use the "Number of Non-Responding Providers" field as the numerator. Add the "Number of Non-Responding Providers" field and "Total Number of Providers Responded to Survey" field to calculate the denominator. Divide the numerator by the denominator. Multiply this number (e.g., .89) by 100 to calculate and report a percentage (e.g., 89%) in this field. (See paragraphs 78-80 of the PAAS Manual for further information on calculating and reporting a percentage of non-responding providers.) $= \frac{\text{"Number of Non-Responding Providers"}}{(\text{"Number of Non-Responding Providers"} + \text{"Total Number of Providers Responded to Survey"})} * 100\%$

Field Name	***Field Instructions - Results Report Form: [Provider Survey Type] Results Tabs***
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Percentage of Ineligible Providers	Verify the auto-calculated field is accurately reflected in the Results Report Form based on the numbers in the following fields for the Provider Survey Type in the County/Network. Use the "Number of Ineligible Providers" field as the numerator. Add the "Number of Ineligible Providers" field, the "Number of Non-Responding Providers" field, and the "Total Number of Providers Responded to Survey" field to calculate the denominator. Divide the numerator by the denominator. Multiply this number (e.g., .89) by 100 to calculate and report a percentage (e.g., 89%) in this field. (See paragraphs 78-80 of the PAAS Manual for further information on calculating and reporting a percentage of ineligible providers.) $= \frac{\text{"Number of Ineligible Providers"}}{(\text{"Number of Ineligible Providers"} + \text{"Number of Non-Responding Providers"} + \text{"Total Number of Providers Responded to Survey"})} * 100\%$

Field Name	***Field Instructions - Results Report Form: [Provider Survey Type] Results Tabs***
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Percentage of Providers with an Urgent Care Appointment Available within [48 Hours or 96 Hours] (Unweighted) ***(All Provider Survey Types Except Ancillary Service Providers)***	Verify the auto-calculated fields are accurately reflected in the Results Report Form based on the numbers in the following fields for the Provider Survey Type in the County/Network. The "Percentage of Providers with an Urgent Care Appointment Available within [48 Hours or 96 Hours](Unweighted)" shall be reported for the Provider Survey Type in each County/Network. Divide the "Number of Providers with an Urgent Care Appointment Available within [48 Hours or 96 Hours]" field by the "Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care Appointment within [48 Hours or 96 Hours]" field. Multiply this number (e.g., .89) by 100 to calculate a percentage (e.g., 89%). Report the "Percentage of Providers with an Urgent Care Appointment Available within [48 Hours or 96 Hours] (Unweighted)" as a percentage (e.g., 89%). (Ancillary Service Providers are not surveyed for urgent care appointments. This field is not applicable for Ancillary Service Providers.) $$= \frac{\text{"Number of Providers with an Urgent Care Appointment Available within [48 Hours or 96 Hours]"}}{\text{"Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care Appointment within [48 Hours or 96 Hours]"}} * 100\%$$

Field Name	***Field Instructions - Results Report Form: [Provider Survey Type] Results Tabs***
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Percentage of Providers with a Non-Urgent Appointment Available within [10 Business Days or 15 Business Days] (Unweighted)	Verify the auto-calculated fields are accurately reflected in the Results Report Form based on the numbers in the following fields for the Provider Survey Type in the County/Network. The "Percentage of Providers with a Non-Urgent Appointment Available within [10 Business Days or 15 Business Days] (Unweighted)" shall be reported for the Provider Survey Type in each County/Network. Divide the "Number of Providers with a Non-Urgent Appointment Available within [10 Business Days or 15 Business Days]" field by the "Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent Appointment within [10 Business Days or 15 Business Days]" field for the non-urgent standard. Multiply this number (e.g., .89) by 100 to calculate a percentage (e.g., 89%). Report the "Percentage of Providers with a Non-Urgent Appointment Available within [10 Business Days or 15 Business Days] (Unweighted)" as a percentage (e.g., 89%). (Ancillary Service Providers are not surveyed for urgent care appointments. This field is not applicable for Ancillary Service Providers.) $$= \frac{\text{"Number of Providers with a Non-Urgent Appointment Available within [10 Business Days or 15 Business Days]"}}{\text{"Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent Appointment within [10 Business Days or 15 Business Days]"}} * 100\%$$
Number of Providers Weight Used for Calculating Aggregate Percentage of Providers with Timely Appointments for Urgent Care Appointments Rates of	Verify the auto-calculated fields are accurately reflected in the Results Report Form based on the numbers in the following fields for the Provider Survey Type in the County/Network. This field is used for the total number of network providers in the County/Network for the Provider Survey Type when calculating aggregate weighted "Percentage of Providers with Timely Appointments for Urgent Care Appointments (Weighted)" field in the Network by Provider Survey Type Tab. If no network providers in the County/Network responded to an urgent care appointment request, this

Field Name	***Field Instructions - Results Report Form: [Provider Survey Type] Results Tabs***
REQUIRED FIELD	***INSTRUCTIONS*** *Enter data in each field according to the instructions below.*
Compliance in Auto-Calculation Tabs ***(All Provider Survey Types Except Ancillary Service Providers)***	field shall equal 0. If at least one network provider responded to an urgent care appointment request, this field is equal to the "Number of Providers within County/Network" field. (Ancillary Service Providers are not surveyed for urgent care appointments. This field is not applicable for Ancillary Service Providers.)
Number of Providers Weight Used for Calculating Aggregate Percentage of Providers with Timely Appointments for Non-Urgent Appointments in Auto-Calculation Tabs	Verify the auto-calculated fields are accurately reflected in the Results Report Form based on the numbers in the following fields for the Provider Survey Type in the County/Network. This field is used for the total number of network providers in the County/Network for the Provider Survey Type when calculating aggregate weighted “Percentage of Providers with Timely Appointments for Non-Urgent Appointments (Weighted)” field in the Network by Provider Survey Type Tab. If no network providers in the County/Network responded to a non-urgent appointment request, this field shall equal 0. If at least one network provider responded to the non-urgent appointment request, this field is equal to the "Number of Providers within County/Network" field.
Network Tally	This field is used to calculate how many unique networks were reported in the data.

Results Report Form: Summary of Rates of Compliance Tab

The fields in the Summary of Rates of Compliance Tab are auto-calculated based on the information set forth in the following tabs:

- Primary Care Providers Results Tab;
- Non-Physician Mental Health Care Providers Results Tab;
- Specialist Physicians Results Tab;

- Psychiatrists Results Tab;
- Ancillary Service Providers Results Tab; and
- Network by Provider Survey Type Tab.

The health plan's final rates of compliance are reviewed and published by the Department in its Annual Timely Access Report. The final results published by the Department may be adjusted as a result of data errors, weighting corrections, omission of invalid data or other concerns identified by the Department.

Field Name	***Field Instructions - Results Report Form: Summary of Rates of Compliance Tab***
REQUIRED FIELD	***INSTRUCTIONS*** *Each field will auto-populate based on the information entered into the [Provider Survey Type] Results Tab and the instructions below.*
Network Name	This field auto-populates each network name reported by the health plan in the Results Tab.
Rate of Compliance Urgent Care Appointments (All Provider Survey Types)	This field auto-calculates the probability of obtaining an urgent care appointment using the weighted average of the urgent care appointment rate for each Provider Survey Type across all counties. In the Network by Provider Survey Type Tab, for each network, sum the product of the "Total Number of Providers in Network (Urgent Care Appointments)" and "Percentage of Providers with Timely Appointments for Urgent Care Appointment Types (Weighted)" fields across all Provider Survey Types except Ancillary Service Providers. Divide the result by the sum of the "Total Number of Providers in Network (Urgent Care Appointments)" for each Provider Survey Type for the network. $= \frac{\sum_{PT=1}^{n} \left(\begin{array}{c} "Total\ Number\ of\ Providers\ in\ Network\ (Urgent\ Care\ Appointments)" * \\ "Percentage\ of\ Providers\ with\ Timely\ Appointments\ for \\ Urgent\ Care\ Appointment\ Types\ (Weighted)" \end{array} \right)}{\sum_{PT=1}^{n} "Total\ Number\ of\ Providers\ in\ Network\ (Urgent\ Care\ Appointments)"}$

Field Name	***Field Instructions - Results Report Form: Summary of Rates of Compliance Tab***
REQUIRED FIELD	***INSTRUCTIONS*** *Each field will auto-populate based on the information entered into the [Provider Survey Type] Results Tab and the instructions below.*
	Where: PT = For each Provider Survey Type in the network.
Sampling Error Urgent Care Appointment Rates (±)	This field auto-calculates the sampling error for the urgent care appointment rate. In the Network by Provider Survey Type Tab, for each network, sum "Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care Appointment Across All Counties" to generate the total number of network providers surveyed across all Provider Survey Types. Then sum the "Total Number of Providers in Network (Urgent Care Appointments)" across all Provider Survey Types to generate the total number of network providers. The “Sampling Error Urgent Care Appointment Rates” is auto-calculated using the total number of network providers, the total number of network providers surveyed, and the "Rate of Compliance Urgent Care Appointments (All Provider Survey Types)," using the following formula: $$= 1.64 * \sqrt{\frac{\text{"Rate of Compliance Urgent Care"} * (1 - \text{"Rate of Compliance Urgent Care"})}{\sum_{PT=1}^{n} \text{"Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care Appointment Across All Counties"}}}$$ $$* \sqrt{\frac{\left(\left(\sum_{PT=1}^{n} \text{"Total Number of Providers in Network (Urgent Care Appointments)"}\right) - \left(\sum_{PT=1}^{n} \text{"Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care Appointment Across All Counties"}\right)\right)}{\left(\left(\sum_{PT=1}^{n} \text{"Number of Providers who Rsponded to the Question Regarding the Availability of an Urgent Care Appointment Across All Counties"}\right) - 1\right)}}$$

Field Name	***Field Instructions - Results Report Form: Summary of Rates of Compliance Tab***
REQUIRED FIELD	***INSTRUCTIONS*** *Each field will auto-populate based on the information entered into the [Provider Survey Type] Results Tab and the instructions below.*
	Where: PT = For each Provider Survey Type in the network.
Rate of Compliance Non-Urgent Appointments (All Provider Survey Types)	This field auto-calculates the probability of obtaining a non-urgent appointment using the weighted average of the non-urgent appointment rate for each Provider Survey Type across all counties. In the Network by Provider Survey Type Tab, for each network, multiply the "Total Number of Providers in Network (Non-Urgent Appointments)" field with the "Percentage of Providers with Timely Appointments for Non-Urgent Appointment Types (Weighted)" field for all Provider Survey Types. Sum the results from each Provider Survey Type. Divide the result by the sum of the "Total Number of Providers in Network (Non-Urgent Appointments)" for each Provider Survey Type for the Network. $$= \frac{\sum_{PT=1}^{n} \left(\begin{array}{c} \text{"Total Number of Providers in Network} \\ \text{(Non-Urgent Appointments)"} * \\ \text{"Percentage of Providers with Timely Appointments for} \\ \text{Non-Urgent Appointment Types (Weighted)"} \end{array} \right)}{\sum_{PT=1}^{n} \text{"Total Number of Providers in Network (Non-Urgent Appointments)"}}$$ Where: PT = For each Provider Survey Type in the Network

Field Name	***Field Instructions - Results Report Form: Summary of Rates of Compliance Tab***
REQUIRED FIELD	***INSTRUCTIONS*** *Each field will auto-populate based on the information entered into the [Provider Survey Type] Results Tab and the instructions below.*
Sampling Error Non-Urgent Appointment Rates (±)	This field auto-calculates the sampling error for the non-urgent appointment rate. In the Network by Provider Survey Type Tab, for each network, sum "Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent Appointment Across All Counties" to generate the total number of network providers surveyed across all Provider Survey Types for non-urgent appointments. Then sum the "Total Number of Providers in Network (Non-Urgent Appointments)" across all Provider Survey Types to generate the total number of providers for non-urgent appointments. The "Sampling Error Non-Urgent Appointment Rates" is auto-calculated with the total number of network providers, the total number of network providers surveyed, and "Rate of Compliance Non-Urgent Appointments (All Provider Survey Types)," using the following formula: $$= 1.64 * \sqrt{\frac{\text{"Rate of Compliance Non-Urgent "} * (1 - \text{"Rate of Compliance Non-Urgent "})}{\sum_{PT=1}^{n} \text{"Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent Appointment Across All Counties"}}} * \sqrt{\frac{\left(\left(\sum_{PT=1}^{n} \text{"Total Number of Providers in Network (Non-Urgent Appointments)"}\right) - \left(\sum_{PT=1}^{n} \text{"Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent Appointment Across All Counties"}\right)\right)}{\left(\left(\sum_{PT=1}^{n} \text{"Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent Appointment Across All Counties"}\right) - 1\right)}}$$

Field Name	***Field Instructions - Results Report Form: Summary of Rates of Compliance Tab***
REQUIRED FIELD	***INSTRUCTIONS*** *Each field will auto-populate based on the information entered into the [Provider Survey Type] Results Tab and the instructions below.*
	Where: PT = For each Provider Survey Type in the network.
Percentage of Primary Care Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types	This field is copied from "Percentage of Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types (Weighted)" field from the Network by Provider Survey Type Tab for Primary Care Providers. Please refer to the explanation of how this field is calculated in the Network by Provider Survey Type Tab.
Percentage of Non-Physician Mental Health Care Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types	This field is copied from "Percentage of Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types (Weighted)" field from the Network by Provider Survey Type Tab for Non-Physician Mental Health Care Providers. Please refer to the explanation of how this field is calculated in the Network by Provider Survey Type Tab.
Percentage of Specialist Physicians with Timely Appointments for Urgent Care and Non-Urgent Appointment Types	This field is copied from "Percentage of Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types (Weighted)" field from the Network by Provider Survey Type Tab for Specialist Physicians. Please refer to the explanation of how this field is calculated in the Network by Provider Survey Type Tab.

Field Name	***Field Instructions - Results Report Form: Summary of Rates of Compliance Tab***
REQUIRED FIELD	***INSTRUCTIONS*** *Each field will auto-populate based on the information entered into the [Provider Survey Type] Results Tab and the instructions below.*
Percentage of Psychiatrists with Timely Appointments for Urgent Care and Non-Urgent Appointment Types	This field is copied from "Percentage of Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types (Weighted)" field from the Network by Provider Survey Type Tab for Psychiatrists. Please refer to the explanation of how this field is calculated in the Network by Provider Survey Type Tab.
Percentage of Ancillary Service Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types	This field is copied from "Percentage of Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types (Weighted)" field from the Network by Provider Survey Type Tab for Ancillary Service Providers. Please refer to the explanation of how this field is calculated in the Network by Provider Survey Type Tab.

Results Report Form: Network by Provider Survey Type Tab

The fields in the Network by Provider Survey Type Tab are auto-calculated based on the information set forth in the following tabs:

- 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.

The information in the Network by Provider Survey Type Tab is used to calculate the information in the Summary of Rates of Compliance Tab. The health plan's final rates of compliance are reviewed and published by the Department in its Annual Timely Access Report. The final results published by the Department may be adjusted as a result of data errors, weighting corrections, omission of invalid data or other concerns identified by the Department.

Field Name	***Field Instructions - Results Report form: Network by Provider Survey Type Tab***
REQUIRED FIELD	***INSTRUCTIONS*** *Each field will auto-populate based on the information entered into the [Provider Survey Type] Results Tab and the instructions below.*
Provider Survey Type	This field auto-populates based on the corresponding Results Tab for the specific Provider Survey Type.
Network Name	For each Provider Survey Type, this field auto-populates each network name that reported data in the Results Tab associated with the Provider Survey Type.
Total Number of Providers in Network (Urgent Care Appointments)	For each Provider Survey Type in each network, this field auto-calculates the sum of the count of network providers in all counties. Network providers in counties where no network providers responded to the urgent care appointment request are not included in the sum. In the Results Tab for each Provider Survey Type, for each network, sum the "Number of Providers Weight Used for Calculating Aggregate Percentage of Providers with Timely Appointments for Urgent Care Appointments in Auto Calculation Tabs" field for all counties. $= \sum_{C=1}^{n} \text{"Number of Providers Weight Used for Calculating Aggregate Percentage of Providers with Timely Appointments for Urgent Care Appointments in Auto-Calculation Tabs"}$ Where: C= County where the network has the Provider Survey Type. This field contains N/A values for Ancillary Service Providers.

Field Name	***Field Instructions - Results Report form: Network by Provider Survey Type Tab***
REQUIRED FIELD	***INSTRUCTIONS*** *Each field will auto-populate based on the information entered into the [Provider Survey Type] Results Tab and the instructions below.*
Expected Number of Providers with an Available Urgent Care Appointment	For each Provider Survey Type in each network, this field auto-calculates the product of the percent of network providers that had an available urgent care appointment in a county and the number of network providers for each county, summed across all counties. In the Results Tab for each Provider Survey Type, for each county a network is in, multiply the "Number of Providers Weight Used for Calculating Aggregate Percentage of Providers with Timely Appointments for Urgent Care Appointments in Auto Calculation Tabs" field by "Percentage of Providers with an Urgent Care Appointment Available within [48 Hours or 96 Hours] (Unweighted)" field and sum the results for all counties included in the network. $= \sum_{C=1}^{n} \text{"Number of Providers Weight Used for Calculating Aggregate Percentage of Providers with Timely Appointments for Urgent Care Appointments in Auto-Calculation Tabs"} * \text{"Percentage of Providers with an Urgent Care Appointment Available within [48 Hours or 96 Hours] (Unweighted)"}$ Where: C= County where the network has the Provider Survey Type. This field contains N/A values for Ancillary Service Providers.

Field Name	***Field Instructions - Results Report form: Network by Provider Survey Type Tab***
REQUIRED FIELD	***INSTRUCTIONS*** *Each field will auto-populate based on the information entered into the [Provider Survey Type] Results Tab and the instructions below.*
Percentage of Providers with Timely Appointments for Urgent Care Appointments (Weighted)	For each Provider Survey Type in each network, this field auto-calculates the percentage of network providers with timely appointments for urgent care appointments for the entire network. Divide the "Expected Number of Providers with an Available Urgent Care Appointment" field by "Total Number of Providers in Network (Urgent Care Appointments)" field. $= \frac{\text{"Expected Number of Providers with an Available Urgent Care Appointments"}}{\text{"Total Number of Providers in Network (Urgent Care Appointments)"}}$ This field contains N/A values for Ancillary Service Providers.
Number of Providers Who Responded to the Question Regarding the Availability of an Urgent Care Appointment Across All Counties	For each Provider Survey Type in each network, this field auto-calculates the sum of network providers that responded to the availability of an urgent care appointment across all counties. In the Results Tab for each Provider Survey Type, for each county a network is in, sum "Number of Providers Who Responded to the Question Regarding the Availability of an Urgent Care Appointment" field for all counties included in the network. $= \sum_{C=1}^{n} \text{"Number of Providers that Responded to the Question Regarding the Availability of an Urgent Care Appointment"}$ Where: C= County where the network has the Provider Survey Type. This field contains N/A values for Ancillary Service Providers.

Field Name	***Field Instructions - Results Report form: Network by Provider Survey Type Tab***
REQUIRED FIELD	***INSTRUCTIONS*** *Each field will auto-populate based on the information entered into the [Provider Survey Type] Results Tab and the instructions below.*
Total Number of Providers in Network (Non-Urgent Appointments)	For each Provider Survey Type in each network, this field auto-calculates the sum of the count of network providers in all counties. Network providers in counties where no network providers responded to the non-urgent appointment request are not included in the sum. In the Results Tab for each Provider Survey Type, for each network, sum the "Number of Providers Weight Used for Calculating Aggregate Percentage of Providers with Timely Appointments for Non-Urgent Appointments in Auto Calculation Tabs" field for all counties. $= \sum_{C=1}^{n} \text{"Number of Providers Weight Used for Calculating Aggregate Percentage of Providers with Timely Appointments for Non-Urgent Appointments in Auto-Calculation Tabs"}$
Expected Number of Providers with an Available Non-Urgent Appointment	For each Provider Survey Type in each network, this field auto-calculates the product of the percent of network providers that had non-urgent appointments and the number of network providers for each county, summed across all counties. In the Results Tab for each Provider Survey Type, for each county a network is in, multiply the "Number of Providers Weight Used for Calculating Aggregate Percentage of Providers with Timely Appointments for Non-Urgent Appointments in Auto Calculation Tabs" field by "Percentage of Providers with a Non-Urgent Appointment Available within [10 Business Days or 15 Business Days] (Unweighted)" field and sum the results for all counties included in the network. $= \sum_{C=1}^{n} \text{"Number of Providers Weight Used for Calculating Aggregate Percentage of Providers with Timely Appointments for Non-Urgent Appointments in Auto-Calculation Tabs"} * \text{"Percentage of Providers with a Non-Urgent Appointment Available within Standard (Unweighted)"}$

Field Name	***Field Instructions - Results Report form: Network by Provider Survey Type Tab***
REQUIRED FIELD	***INSTRUCTIONS*** *Each field will auto-populate based on the information entered into the [Provider Survey Type] Results Tab and the instructions below.*
	Where: C= County where the network has the Provider Survey Type.
Percentage of Providers with Timely Appointments for Non-Urgent Appointments (Weighted)	For each Provider Survey Type in each network, this field auto-calculates the percentage of network providers with timely appointments for non-urgent care appointments for the entire network. Divide the "Expected Number of Providers with an Available Non-Urgent Appointment" field by "Total Number of Providers in Network (Non-Urgent Appointments)" field. $$= \frac{\text{"Expected Number of Providers with an Available Non-Urgent Appointment"}}{\text{"Total Number of Providers in Network (Non-Urgent Appointments)"}}$$
Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent Appointment Across All Counties	For each Provider Survey Type in each network, this field auto-calculates the count of network providers that responded to the availability of a non-urgent appointment across all counties. In the Results Tab for each Provider Survey Type, for each county a network is in, sum "Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent Appointment" field for all counties included in the network. $$= \sum_{C=1}^{n} \text{"Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent Appointment"}$$ Where: C= County where the network has the Provider Survey Type.

Field Name	***Field Instructions - Results Report form: Network by Provider Survey Type Tab***
REQUIRED FIELD	***INSTRUCTIONS*** *Each field will auto-populate based on the information entered into the [Provider Survey Type] Results Tab and the instructions below.*
Percentage of Providers with Timely Appointments for Urgent and Non-Urgent Appointment Types (Weighted)	For each Provider Survey Type in each network, this field auto-calculates the percentage of network providers with timely appointments for urgent care and non-urgent appointments by taking the weighted average of the percentage of network providers with timely appointments for urgent care and non-urgent appointments. Multiply the "Total Number of Providers in Network (Urgent Care Appointments)" field by "Percentage of Providers with Timely Appointments for Urgent Care Appointments (Weighted)" field and "Total Number of Providers in Network (Non-Urgent Appointments)" field by "Percentage of Providers with Timely Appointments for Non-Urgent Appointments (Weighted)" field and sum the results. Divide the result by the sum of "Total Number of Providers in Network (Urgent Care Appointments)" and "Total Number of Providers in Network (Non-Urgent Appointments)" fields. $$= \frac{\left(\begin{array}{c}\text{"Total Number of Providers in Network (Urgent Care Appointments)} * \\ \text{"Percentage of Providers with Timely Appointments for} \\ \text{Urgent Care Appointments (Weighted)"}\end{array}\right) + \left(\begin{array}{c}\text{"Total Number of Providers in Network (Non-Urgent Appointments)"} * \\ \text{"Percentage of Providers with Timely Appointments for} \\ \text{Non-Urgent Appointments (Weighted)"}\end{array}\right)}{\left(\begin{array}{c}\cancel{\text{"Total Number of Providers in Network (Urgent Care Appointments)"}} + \\ \text{"Total Number of Providers in Network (Non-Urgent Appointments)"}\end{array}\right)}$$
Network Tally	This field auto-calculates the number of unique networks reported in the Results Tab for each Provider Survey Type.

V. Annual Network Report Forms

All health plans that meet the description set forth in Rule 1300.67.2.2(h)(1) shall submit to the Department on an annual basis, an Annual Network Report, as set forth in subsection (h)(7) of Rule 1300.67.2.2. Health plans shall complete and submit all required Annual Network Report Forms according to the instructions within this Manual and within Rule 1300.67.2.2(h)(7). All reporting plans shall submit the Network Service Area and Enrollment Report Form and all other report forms applicable to the health plan network. Review the instructions set forth below, and the General Instructions Applicable to All Report Forms before populating each individual Annual Network Report Form. Health plans that do not complete and submit the Annual Network Report Forms according to the instructions may receive a finding of non-compliance pursuant to Rule 1300.67.2.2(i). Annual Network Report Forms are available within the Department's web portal.

A. Network Service Area and Enrollment Report Form (Form 40-265): Instructions

This report form consists of two tabs: the Network Service Area Report Tab and the Enrollment Report Tab. All health plans that are required to report annual network data shall complete a Network Service Area Report Tab and Enrollment Report Tab, in the manner described in the field instructions below. (Rule 1300.67.2.2(h)(7)(B)(vi).)

Within the Network Service Area Report Tab, for each reported network, report all ZIP Codes by county that comprise the health plan's network service area as of the network capture date. (Rule 1300.67.2.2(h)(7)(A)(ii).) The health plan shall report all ZIP Codes and counties within the network service area, regardless of whether enrollees reside or work within the ZIP Code, or whether the health plan currently offers products within the ZIP Code.

Within the Enrollment Tab, for each reported network, report the number of enrollees within each ZIP Code, county and product line as of the network capture date, in accordance with the instructions for each required field. (Rule 1300.67.2.2(h)(7)(A)(i).) When completing the Enrollment Tab, report enrollees in a County and ZIP Code based on the enrollee address that qualified the enrollee for enrollment in the network. Depending on how the enrollee became eligible for enrollment, this may be the enrollee's personal residence, workplace address or other location. (Rule 1300.51.)

When completing the Enrollment Tab of the Network Service and and Enrollment Report Form, if the health plan is reporting enrollment for the network as a primary plan that delegated enrollees to a subcontracted plan via a plan-to-plan contract, report the number of enrollees in the network by ZIP Code, county and product line, and separately report the number of enrollees within the network that the health plan delegated to the subcontracted plan, as follows:

1. Report the number of enrollees in the "Number of Enrollees" field for each corresponding product line, county and ZIP Code within the network. Include in this count the enrollees for which the primary plan directly arranges services, as well as the enrollees that the health plan delegated to a subcontracted plan. The health plan shall only report a number in this field once for each network, ZIP Code, county and product line, in accordance with the instructions in section II.B. of this Manual.

2. In a separate record, report in the "Subcontracted Plan License Number" field the subcontracted plan to which the health plan's enrollees were delegated for the applicable network, product line, county, and ZIP Code. Enter the enrollee count in the "Number of Subcontracted Plan Enrollees" field. If the reporting plan subcontracts with more than one plan, enter a separate record for each subcontracted plan and repeat all other relevant data fields (e.g. product line, county, ZIP Code, etc.). (Rule 1300.67.2.2(h)(3).)

The following field instructions describe the data that the reporting plan shall report within each field of the report form, consistent with Rule 1300.67.2.2(h)(7)(B). Refer to the Definitions section of this Instruction Manual for additional explanation of the terms used within the field instructions for this report form. Refer to the Reporting Multiple Entries for the Same Provider and Reporting With Standardized Terminology subsections in the General Instructions Applicable to All Required Report Forms section of this Instruction Manual for more information about how to complete these fields.

Network Service Area Report Tab

FIELD NAME - *NETWORK SERVICE AREA*	***FIELD INSTRUCTIONS -*** *NETWORK SERVICE AREA* *For each required field, enter the following data:*
Network Information	
Network Name	The network name as defined in Rule 1300.67.2.2(b)(8), for the reported network service area.
Network ID	The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Product Line	The product line(s) using the reported network in the reported ZIP Code and county, as set forth in Appendix A.
Network Service Area Information	
County	The county or partial county within the health plan's network service area for the reported network.
ZIP Code	The ZIP Codes associated with the reported county within the health plan's network service area for the reported network.

Enrollment Report Tab

FIELD NAME - *ENROLLMENT*	***FIELD INSTRUCTIONS -*** *ENROLLMENT* *For each required field, enter the following data:*
Network Information	
Network Name	The network name as defined in Rule 1300.67.2.2(b)(8), corresponding to the identified enrollment.
Network ID	The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Product Line	The product line(s) within the reported network, as set forth in Appendix A.
Subcontracted Plan Information	
Subcontracted Plan License Number	The subcontracted plan license number. Complete this field if the reporting plan has a has a plan-to-plan contract with a subcontracted plan for the delivery of services to enrollees within the network, as these terms are defined in Rule 1300.67.2.2(b)(12). Each health plan's license number is available on the Department's web portal.
Subcontracted Plan Network ID	The subcontracted plan network identifier. Complete this field if the reporting plan has a plan-to-plan contract with the subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(12).
Network Enrollment Information	
County	The county where identified enrollees reside or work. Report the county that qualifies an enrollee to be enrolled in the network and product line.
ZIP Code	The ZIP Code within the reported county where identified enrollees reside or work. Report the ZIP Code that qualifies an enrollee to be enrolled in the network and product line.
Number of Enrollees	The total number of Plan enrollees in the reported county and ZIP Code, for the identified network and product line. The total number of enrollees includes both the enrollees for whom the reporting plan arranges care and the enrollees that the reporting plan has delegated to one or more subcontracted plans, if applicable. The number reported in this field shall reflect the complete enrollment in the reported network for the identified county, ZIP Code, and product line.

Number of Subcontracted Plan Enrollees	The total number of enrollees in the reported county and ZIP Code, for the identified network and product line, that have been delegated to the subcontracted plan identified in the "Subcontracted Plan License Number" and "Subcontracted Plan Network ID" fields.
Inside / Outside Approved Network Service Area	The location of the enrollee relative to the approved network service area. Identify whether the reported enrollment by county and ZIP Code is within, or outside of the network service area for the identified network name.

B. PCP and PCP Non-Physician Medical Practitioner Report Form (Form No. 40-266): Instructions

This report form consists of two tabs: the Primary Care Physician (PCP) Report Tab and PCP Non-Physician Medical Practitioner (NPMP) Report Tab. All health plans that include PCPs or PCP NPMPs in the network shall complete the PCP Report Tab and PCP NPMP Report Tab, respectively, in the manner described in the field instructions below. (Rule 1300.67.2.2(h)(7)(B)(i).) Only report providers who meet the definition of "network provider" on this report form. (*See* Rule 1300.67.2.2(b)(9).)

Within the PCP Report Tab, for each reported network, report all primary care physicians as of the network capture date. (Rule 1300.67.2.2(h)(7)(A)(iii).) Only physicians may be included in this Report Tab.

Within the PCP NPMP Report Tab, for each reported network, report all non-physician medical practitioners as of the network capture date. Only report NPMPs who are supervised by a primary care physician that has been reported on the PCP Report Tab with a valid NPI.

The following field instructions describe the data that the reporting plan shall report within each field of the report form, consistent with Rule 1300.67.2.2(h)(7)(B). Refer to the Definitions section of this Instruction Manual for additional explanation of the terms used within the field instructions for this report form. Refer to the Reporting Multiple Entries for the Same Provider and Reporting With Standardized Terminology subsections in the General Instructions Applicable to All Required Report Forms section of this Instruction Manual for more information about how to complete these fields.

Primary Care Physician (PCP) Report Tab

FIELD NAME *- PCP*	***FIELD INSTRUCTIONS*** *- PCP* *For each required field, enter the following data:*
Network Information	
Network Name	The network name within which the reported provider serves as a network provider, as defined in Rule 1300.67.2.2(b)(8).

***FIELD NAME** - PCP*	***FIELD INSTRUCTIONS** - PCP* *For each required field, enter the following data:*
Network ID	The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Subcontracted Plan Information	
Subcontracted Plan License Number	The subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). Each health plan's license number is available on the Department's web portal.
Subcontracted Plan Network ID	The subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12).
Network Provider Information	
Last Name	Last name of the network provider.
First Name	First name of the network provider.
NPI	The unique National Provider Identifier (NPI) assigned to the network provider and active on the network capture date.
CA License	California license number of the network provider, active on the network capture date.
Non-CA License	License number issued outside of the state of California, active on the network capture date.
Non-CA License State	State in which the Non-California license was issued.
License Type	The network provider's type of license, as set forth in Appendix D.
Number of Enrollees Assigned to Provider	The total number of enrollees within the network assigned to the network provider, or, where enrollees are not assigned, for whom the network provider delivers primary care, as defined in section 1367.69(b).
Specialty	The network provider's specialty or subspecialty, as set forth in Appendix B.
Board Certified / Eligible	For each reported specialty or subspecialty, indicate whether the network provider is board-certified or board-eligible.
Provider Group	Name of the provider group affiliated with the network provider, if applicable.

***FIELD NAME** - PCP*	***FIELD INSTRUCTIONS** - PCP* *For each required field, enter the following data:*
Network Tier ID	The network tier, as the term isdefined in the Definitions section of this Manual, in which the network provider is available to enrollees, if the network is a tiered network.
Full-Time / Part-Time	The network provider's practice hours. Identify whether, as of the network capture date, the network provider is full-time or part-time as these terms are defined in the Definitions section of this Manual.
Facility	The name of each hospital or other facility where: • The network provider holds privileges; • The network provider uses a hospitalist or other physician arrangement to admit patients to the hospital; or • The network provider treats patients, if the provider delivers services within a facility.
Facility NPI	The NPI corresponding to the facility identified in the "Facility" field.
Provider Language 1	Language spoken by the network provider, other than English, as set forth in Appendix C, if applicable.
Provider Language 2	Language spoken by the network provider, other than English, as set forth in Appendix C, if applicable.
Provider Language 3	Language spoken by the network provider, other than English, as set forth in Appendix C, if applicable.
Network Provider Practice Location and Associated Information	
Practice Address	The street number and street name of the practice address. If the network provider also serves as a telehealth provider, report only the physical location at which the network provider delivers in-person health care services.
Practice Address 2	The number of the office, suite, building or other location identifier for the practice address, if applicable.
City	City in which the practice address is located.
County	County in which the practice address is located.
State	State in which the practice address is located.
ZIP Code	ZIP Code in which the practice address is located.
Phone Number	The phone number an enrollee may use to schedule an appointment at the reported practice address, if applicable.
Clinic Name	The name of the clinic at which the network provider delivers services either part-time or full-time, if applicable.

***FIELD NAME** - PCP*	***FIELD INSTRUCTIONS** - PCP* *For each required field, enter the following data:*
Accepting New Patients	The availability of the network provider to accept new patients, as the term is defined in the Definitions section of this Manual. Identify whether the network provider is accepting new patients at the reported practice address.
Displayed in Provider Directory	The network provider's inclusion in the health plan's provider directory for the network. Identify whether, on the network capture date, the network provider was displayed in the health plan's online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network, location, and service type identified in the corresponding fields of this tab.
In-Person Appointments	Identify whether the network provider is available to offer either in-person appointments or "walk-in" appointments at the reported practice address.
Unscheduled Urgent Services	The network provider's availability to deliver unscheduled urgent services as defined in the Definitions section of this Manual. Identify whether the network provider delivers unscheduled urgent services at the reported practice address.
E-mail Address	Network provider's office email address, if applicable, as set forth in section 1367.27(i)(6).

Non-Physician Medical Practitioner (NPMP) Report Tab

***FIELD NAME** - PCP NPMP*	***FIELD INSTRUCTIONS** - PCP NPMP* *For each required field, enter the following data:*
Network Information	
Network Name	The network name within which the reported provider serves as a network provider, as defined in Rule 1300.67.2.2(b)(8).
Network ID	The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Subcontracted Plan Information	
Subcontracted Plan License Number	The subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). Each health plan's license number is available on the Department's web portal.

FIELD NAME - *PCP NPMP*	***FIELD INSTRUCTIONS -*** *PCP NPMP* *For each required field, enter the following data:*
Subcontracted Plan Network ID	The subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12).
Network Provider Information	
Last Name	Last name of the network provider.
First Name	First name of the network provider.
NPI	The unique National Provider Identifier (NPI) assigned to the network provider and active on the network capture date.
CA License	California license number of the network provider, active on the network capture date.
License Type	The network provider's type of license, as set forth in Appendix D.
Number of Enrollees Assigned to Provider	If the NPMP serves as a PCP or otherwise independently provides direct care to enrollees, the total number of enrollees within the network assigned to the network provider, or, where enrollees are not assigned, the number of enrollees for whom the network provider delivers primary care, as defined in section 1367.69(b).
NPI of Supervising PCP	The unique National Provider Identifier (NPI) of the reported primary care physician (PCP) who supervises the non-physician medical practitioner.
Provider Group	Name of the provider group affiliated with the network provider, if applicable.
Network Tier ID	The network tier, as the term is defined in the Definitions section of this Manual, in which the network provider is available to enrollees, if the network is a tiered network.
Full-Time / Part-Time	The network provider's practice hours. Identify whether, as of the network capture date, the network provider is full-time or part-time as these terms are defined in the Instruction Manual.
Provider Language 1	Language spoken by the network provider, other than English, as set forth in Appendix C, if applicable.
Provider Language 2	Language spoken by the network provider, other than English, as set forth in Appendix C, if applicable.
Provider Language 3	Language spoken by the network provider, other than English, as set forth in Appendix C, if applicable.
Network Provider Practice Location and Associated Information	

***FIELD NAME** - PCP NPMP*	***FIELD INSTRUCTIONS** - PCP NPMP* *For each required field, enter the following data:*
Practice Address	The street number and street name of the practice address. If the network provider also serves as a telehealth provider, report only the physical locations at which the network provider delivers in-person health care services.
Practice Address 2	The number of the office, suite, building or other location identifier for the practice address, if applicable.
City	City in which the practice address is located.
County	County in which the practice address is located.
State	State in which the practice address is located.
ZIP Code	ZIP Code in which the practice address is located.
Phone Number	The phone number an enrollee may use to schedule an appointment at the reported practice location, if applicable.
Clinic Name	The name of the clinic at which the network provider delivers services either part-time or full-time, if applicable.
Accepting New Patients or Referrals	The availability of the network provider to accept new patients, as the term is defined in the Definitions section of this Manual. Identify whether the network provider is accepting new patients at the reported practice address.
Displayed in Provider Directory	The network provider's inclusion in the health plan's provider directory for the network. Identify whether, on the network capture date, the network provider was displayed in the health plan's online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network, location, and service type identified in the corresponding fields of this report form.
In-Person Appointments	Identify whether the network provider is available to offer either in-person appointments or "walk-in" appointments at the reported practice address.
Unscheduled Urgent Services	The network provider's availability to deliver unscheduled urgent services as defined in the Definitions section of this Manual. Identify whether the network provider delivers unscheduled urgent services at the reported practice address.
E-mail Address	Network provider's office email address, if applicable, as set forth in section 1367.27(i)(6).

C. Specialist and Specialist Non-Physician Medical Practitioner Report Form (Form No. 40-267): Instructions

This report form consists of two tabs: the Specialist Report Tab and the Specialist Non-Physician Medical Practitioner (NPMP) Report Tab. All health plans that include specialist physicians or specialist NPMPs in the network shall complete the Specialist Report Tab and Specialist NPMP Report Tab, respectively, in the manner described in the field instructions below. (Rule 1300.67.2.2(h)(7)(B)(ii).) Only report providers who meet the definition of "network provider" on this report form. (*See* Rule 1300.67.2.2(b)(9).)

Within the Specialist Report Tab, for each reported network, report all specialist physicians as of the network capture date. (Rule 1300.67.2.2(h)(7)(A)(iii).) Only physicians may be included in this report tab.

Within the Specialist NPMP Report Tab, for each reported network, report all non-physician medical practitioners as of the network capture date. Only report NPMPs who are supervised by a specialist physician that has been reported on the Specialist Report Tab with a valid NPI.

The following field instructions describe the data that the reporting plan shall report within each field of the report form, consistent with Rule 1300.67.2.2(h)(7)(B). Refer to the Definitions section of this Instruction Manual for additional explanation of the terms used within the field instructions for this report form. Refer to the Reporting Multiple Entries for the Same Provider and Reporting With Standardized Terminology subsections in the General Instructions Applicable to All Required Report Forms section of this Instruction Manual for more information about how to complete these fields.

Specialist Report Tab

FIELD NAME - SPECIALIST	***FIELD INSTRUCTIONS - SPECIALIST*** *For each required field, enter the following data:*
Network Information	
Network Name	The network name within which the reported provider serves as a network provider, as defined in Rule 1300.67.2.2(b)(8).
Network ID	The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Subcontracted Plan Information	

FIELD NAME - SPECIALIST	***FIELD INSTRUCTIONS - SPECIALIST*** *For each required field, enter the following data:*
Subcontracted Plan License Number	The subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). Each health plan's license number is available on the Department's web portal.
Subcontracted Plan Network ID	The subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12).
Network Provider Information	
Last Name	Last name of the network provider.
First Name	First name of the network provider.
NPI	The unique National Provider Identifier (NPI) assigned to the network provider and active on the network capture date.
CA License	California license number of the network provider, active on the network capture date.
Non-CA License	License number issued outside of the state of California, active on the network capture date.
Non-CA License State	State in which the non-California license was issued.
License Type	The network provider's type of license, as set forth in Appendix D.
Specialty	The network provider's specialty or subspecialty, as set forth in Appendix B.
Board Certified / Eligible	For each reported specialty or subspecialty, indicate whether the network provider is board-certified or board-eligible.
Provider Group	Name of the provider group affiliated with the network provider, if applicable.
Network Tier ID	The network tier, as the term is defined in the Definitions section of this Manual, in which the network provider is available to enrollees, if the network is a tiered network.
Full-Time / Part-Time	The network provider's practice hours. Identify whether, as of the network capture date, the network provider is full-time or part-time as these terms are defined in the Definitions section of this Manual.

FIELD NAME - SPECIALIST	***FIELD INSTRUCTIONS - SPECIALIST*** *For each required field, enter the following data:*
Facility	The name of each hospital or other facility where: • The network provider holds privileges; • The network provider uses a hospitalist or other physician arrangement to admit patients to the hospital; or • The network provider treats patients, if the provider delivers services within a facility.
Facility NPI	The NPI corresponding to the facility identified in the "Facility" field.
Hospitalist	The network provider's method of admitting patients. Identify whether the network provider admits patients to the hospital or other facility identified in the corresponding "Facility" field directly, or by using a hospitalist or some other physician arrangement.
Provider Language 1	Language spoken by the network provider, other than English, as set forth in Appendix C, if applicable.
Provider Language 2	Language spoken by the network provider, other than English, as set forth in Appendix C, if applicable.
Provider Language 3	Language spoken by the network provider, other than English, as set forth in Appendix C, if applicable.
Network Provider Practice Location and Associated Information	
Practice Address	The street number and street name of the practice address. If the network provider also serves as a telehealth provider, report only the physical location at which the network provider delivers in-person health care services.
Practice Address 2	The number of the office, suite, building or other location identifier for the practice address, if applicable.
City	City in which the practice address is located.
County	County in which the practice address is located.
State	State in which the practice address is located.
ZIP Code	ZIP Code in which the practice address is located.
Phone Number	The phone number an enrollee may use to schedule an appointment at the reported practice address, if applicable.
Clinic Name	The name of the clinic at which the network provider delivers services either part-time or full-time, if applicable.

FIELD NAME - *SPECIALIST*	***FIELD INSTRUCTIONS -*** *SPECIALIST* *For each required field, enter the following data:*
Accepting New Patients or Referrals	The availability of the network provider to accept new patients, as the term is defined in the Definitions section of this Manual. Identify whether the network provider is accepting new patients at the reported practice address.
Displayed in Provider Directory	The network provider's inclusion in the health plan's provider directory for the network. Identify whether, on the network capture date, the network provider was displayed in the health plan's online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network, location, and service type identified in the corresponding fields of this report form.
In-Person Appointments	Identify whether the network provider is available to offer either in-person appointments or "walk-in" appointments at the reported practice address.
E-mail Address	Network provider's office email address, if applicable, as set forth in section 1367.27(i)(6).

Specialist Non-Physician Medical Practitioner (NPMP) Report Tab

FIELD NAME - *SPECIALIST NPMP*	***FIELD INSTRUCTIONS -*** *SPECIALIST NPMP* *For each required field, enter the following data:*
Network Information	
Network Name	The network name within which the reported provider serves as a network provider, as defined in Rule 1300.67.2.2(b)(8).
Network ID	The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Subcontracted Plan Information	
Subcontracted Plan License Number	The subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). Each health plan's license number is available on the Department's web portal.
Subcontracted Plan Network ID	The subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12).

FIELD NAME - *SPECIALIST NPMP*	***FIELD INSTRUCTIONS -*** *SPECIALIST NPMP* *For each required field, enter the following data:*
Network Provider Information	
Last Name	Last name of the network provider.
First Name	First name of the network provider.
NPI	The unique National Provider Identifier (NPI) assigned to the network provider and active on the network capture date.
CA License	California license number of the network provider, active on the network capture date.
License Type	The network provider's type of license, as set forth in Appendix D.
Specialty	The type of certificate or acknowledgment of special qualifications, as recognized by the National Commission on Certification of Physician Assistants and the California Board of Registered Nursing, if the network provider has earned an additional specialty certificate from the appropriate state licensing board, as set forth in Appendix B.
NPI of Supervising Specialist	The unique National Provider Identifier (NPI) of the reported physician who supervises the non-physician medical practitioner.
Supervising Specialist Specialty	The supervising physician's specialty or subspecialty.
Provider Group	Name of the provider group affiliated with the network provider, if applicable.
Network Tier ID	The network tier, as the term is defined in the Definitions section of this Manual, in which the network provider is available to enrollees, if the network is a tiered network.
Full-Time / Part-Time	The network provider's practice hours. Identify whether, as of the network capture date, the network provider is full-time or part-time as these terms are defined in the Definitions section of this Manual.
Provider Language 1	Language spoken by the network provider, other than English, as set forth in Appendix C, if applicable.
Provider Language 2	Language spoken by the network provider, other than English, as set forth in Appendix C, if applicable.
Provider Language 3	Language spoken by the network provider, other than English, as set forth in Appendix C, if applicable.
Network Provider Practice Location and Associated Information	

FIELD NAME - *SPECIALIST NPMP*	***FIELD INSTRUCTIONS -*** *SPECIALIST NPMP* *For each required field, enter the following data:*
Practice Address	The street number and street name of the practice address. If the network provider also serves as a telehealth provider, report only the physical location at which the network provider delivers in-person health care services.
Practice Address 2	The number of the office, suite, building or other location identifier for the practice address, if applicable.
City	City in which the practice address is located.
County	County in which the practice address is located.
State	State in which the practice address is located.
ZIP Code	ZIP Code in which the practice address is located.
Phone Number	The phone number an enrollee may use to schedule an appointment at the reported practice address, if applicable.
Clinic Name	The name of the clinic at which the network provider delivers services either part-time or full-time, if applicable.
Accepting New Patients or Referrals	The availability of the network provider to accept new patients, as the term is defined in the Definitions section of this Manual. Identify whether the network provider is accepting new patients at the reported practice address.
Displayed in Provider Directory	The network provider's inclusion in the health plan's provider directory for the network. Identify whether, on the network capture date, the network provider was displayed in the health plan's online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network, location, and service type identified in the corresponding fields of this report form.
In-Person Appointments	Identify whether the network provider is available to offer either in-person appointments or "walk-in" appointments at the reported practice address.
E-mail Address	Network provider's office email address, if applicable, as set forth in section 1367.27(i)(6).

D. Mental Health Professional and Mental Health Facility Report Form (Form No. 40-268): Instructions

This report form consists of two tabs: the Mental Health Professional Report Tab and the Mental Health Facility Report Tab. All health plans that include mental health professionals or mental health facilities in the network shall complete a Mental Health Professional Report Tab and Mental Health Facility Report Tab, respectively, in the

manner described in the field instructions below. (Rule 1300.67.2.2(h)(7)(B)(v).) Only report providers who meet the definition of "network provider" on these tabs. (*See* Rule 1300.67.2.2(b)(9).)

Within the Mental Health Professional Report Tab, for each reported network, report all non-physician mental health professionals as of the network capture date. (Rule 1300.67.2.2(h)(7)(A)(iii).) "Non-physician mental health professionals" refers to network providers who are not licensed physicians, and who deliver mental health services, including counseling services, therapy, behavioral health treatment, and substance abuse services.

Within the Mental Health Facility Report Tab, for each reported network, report all mental health facilities as of the network capture date. "Mental health facilities" refers to providers that deliver facility-based mental health treatment, not including licensed hospitals.

The following field instructions describe the data that the reporting plan shall report within each field of the report form, consistent with Rule 1300.67.2.2(h)(7)(B). Refer to the Definitions section of this Instruction Manual for additional explanation of the terms used within the field instructions for this report form. Refer to the Reporting Multiple Entries for the Same Provider and Reporting With Standardized Terminology subsections in the General Instructions Applicable to All Required Report Forms section of this Instruction Manual for more information about how to complete these fields.

Mental Health Professional Report Tab

FIELD NAME - *MENTAL HEALTH PROFESSIONAL*	***FIELD INSTRUCTIONS -*** *MENTAL HEALTH PROFESSIONAL For each required field, enter the following data:*
Network Information	
Network Name	The network name within which the reported provider serves as a network provider, as defined in Rule 1300.67.2.2(b)(8).
Network ID	The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Subcontracted Plan Information	
Subcontracted Plan License Number	The subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). Each health plan's license number is available on the Department's web portal.

FIELD NAME - *MENTAL HEALTH PROFESSIONAL*	***FIELD INSTRUCTIONS -*** *MENTAL HEALTH PROFESSIONAL* *For each required field, enter the following data:*
Subcontracted Plan Network ID	The subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12).
Network Provider Information	
Last Name	Last name of the network provider.
First Name	First name of the network provider.
NPI	The unique National Provider Identifier (NPI) assigned to the network provider and active on the network capture date.
CA License / Certificate	California license or certificate identifier of the network provider, active on the network capture date.
Non-CA License / Certificate	License number or certificate identifier issued outside of the state of California, active on the network capture date.
Non-CA License / Certificate State	State in which the non-California license or certificate was issued.
Type of License / Certificate	The network provider's type of license or certificate, as set forth in Appendix D.
Specialty	The network provider's specialty, as set forth in Appendix B.
Provider Group	Name of the provider group affiliated with the network provider, if applicable.
Network Tier ID	The network tier, as the term is defined in the Definitions section of this Manual, in which the network provider is available to enrollees, if the network is a tiered network.
Full-Time / Part-Time	The network provider's practice hours. Identify whether, as of the network capture date, the network provider is full-time or part-time as these terms are defined in the Definitions section of this Manual.
Facility	The name of each hospital or other facility where the network provider treats patients, if the provider delivers services within a facility.
Facility NPI	The NPI corresponding to the facility identified in the "Facility" field.
Provider Language 1	Language spoken by the network provider, other than English, as set forth in Appendix C, if applicable.
Provider Language 2	Language spoken by the network provider, other than English, as set forth in Appendix C, if applicable.

FIELD NAME - *MENTAL HEALTH PROFESSIONAL*	***FIELD INSTRUCTIONS -*** *MENTAL HEALTH PROFESSIONAL* *For each required field, enter the following data:*
Provider Language 3	Language spoken by the network provider, other than English, as set forth in Appendix C, if applicable.
Network Provider Practice Location and Associated Information	
Practice Address	The street number and street name of the practice address. If the network provider also serves as a telehealth provider, report only the physical location at which the network provider delivers in-person health care services.
Practice Address 2	The number of the office, suite, building or other location identifier for the practice address, if applicable.
City	City in which the practice address is located.
County	County in which the practice address is located.
State	State in which the practice address is located.
ZIP Code	ZIP Code in which the practice address is located.
Phone Number	The phone number an enrollee may use to schedule an appointment at the reported practice address, if applicable.
Accepting New Patients or Referrals	The availability of the network provider to accept new patients, as the term is defined in the Definitions section of this Manual. Identify whether the facility is accepting new patients at the reported practice address.
Displayed in Provider Directory	The network provider's inclusion in the health plan's provider directory for the network. Identify whether, on the network capture date, the network provider was displayed in the health plan's online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network, location, and service type identified in the corresponding fields of this report form.
In-Person Appointments	Identify whether the network provider is available to offer either in-person appointments or "walk-in" appointments at the reported practice address.
E-mail Address	Network provider's office email address, if applicable, as set forth in section 1367.27(i)(6).

Mental Health Facility Report Tab

FIELD NAME - *MENTAL HEALTH FACILITY*	***FIELD INSTRUCTIONS -*** *MENTAL HEALTH FACILITY* *For each required field, enter the following data:*
Network Information	
Network Name	The network name within which the reported facility serves as a network provider, as defined in Rule 1300.67.2.2(b)(8).
Network ID	The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Subcontracted Plan Information	
Subcontracted Plan License Number	The subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). Each health plan's license number is available on the Department's web portal.
Subcontracted Plan Network ID	The subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12).
Network Provider Information	
Mental Health Facility Name	Legal name of the network provider.
DBA	"Doing-Business-As" name of network provider, if applicable.
NPI	The unique National Provider Identifier (NPI) assigned to the network provider and active on the network capture date.
CA License	California license number of the network provider, active on the network capture date.
Non-CA License	License number of the network provider, issued outside of the state of California, active on the network capture date.
Non-CA License State	State in which the non-California license was issued.
Mental Health Facility Type	The type of mental health facility, as set forth in Appendix B.
Network Tier ID	The network tier, as the term is defined in the Definitions section of this Manual, in which the network provider is available to enrollees, if the network is a tiered network.
Network Provider Practice Location and Associated Information	
Practice Address	The street number and street name of the facility practice address.

FIELD NAME - *MENTAL HEALTH FACILITY*	***FIELD INSTRUCTIONS -*** *MENTAL HEALTH FACILITY* *For each required field, enter the following data:*
Practice Address 2	The number of the office, suite, building or other location identifier for the practice address, if applicable.
City	City in which the practice address is located.
County	County in which the practice address is located.
State	State in which the practice address is located.
ZIP Code	ZIP Code in which the practice address is located.
Phone Number	The phone number an enrollee may use to schedule an appointment at the reported practice location, if applicable.
Accepting New Patients or Referrals	The availability of the network provider to accept new patients, as the term is defined in the Definitions section of this Manual. Identify whether the facility is accepting new patients at the reported practice address.
Displayed in Provider Directory	The network provider's inclusion in the health plan's provider directory for the network. Identify whether, on the network capture date, the network provider was displayed in the health plan's online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network, location, and service type identified in the corresponding fields of this report form.

E. Other Outpatient Provider Report Form (Form No. 40-269): Instructions

All health plans that include other outpatient providers not reported on any other report form shall submit an Other Outpatient Provider Report Form, in the manner described in the field instructions below. (Rule 1300.67.2.2(h)(7)(B)(iv).) Only report providers who meet the definition of "network provider" on this report form. (*See* Rule 1300.67.2.2(b)(9).)

Within the Other Outpatient Provider Report Form, for each reported network, report a complete list of the health plan's network providers that are "other outpatient providers," as of the network capture date. (Rule 1300.67.2.2(h)(7)(A)(iii).) "Other outpatient providers" refers to non-physician individual and entity network providers that provide outpatient health care services to enrollees, when the outpatient provider has not been reported within another report form. If the other outpatient provider is an individual provider that is also affiliated with an entity provider, follow the instructions within the fields below for reporting data associated with the individual provider and entity providers.

The following field instructions describe the data that the reporting plan shall report within each field of the report form, consistent with Rule 1300.67.2.2(h)(7)(B). Refer to the Definitions section of this Instruction Manual for additional explanation of the terms used within the field instructions for this report form. Refer to the Reporting Multiple Entries for the Same Provider and Reporting With Standardized Terminology subsections in the General Instructions Applicable to All Required Report Forms section of this Instruction Manual for more information about how to complete these fields.

Other Outpatient Provider Report Form

FIELD NAME - *OTHER OUTPATIENT PROVIDER*	***FIELD INSTRUCTIONS -*** *OTHER OUTPATIENT PROVIDER For each required field, enter the following data:*
Network Information	
Network Name	The network name within which the reported provider serves as a network provider, as defined in Rule 1300.67.2.2(b)(8).
Network ID	The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Subcontracted Plan License Number	The subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). Each health plan's license number is available on the Department's web portal. If no individual provider is reported in this record, complete this field if the reported entity is a network provider for the reported network as a result of a plan-to-plan contract with a subcontracted plan.
Subcontracted Plan Network ID	The subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this Network Name due to a plan-to-plan contract with a subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(12).
Network Provider Information	
Last Name	Last name of the network provider, if the network provider is an individual provider.
First Name	First name of the network provider, if the network provider is an individual provider.

FIELD NAME - OTHER OUTPATIENT PROVIDER	***FIELD INSTRUCTIONS - OTHER OUTPATIENT PROVIDER*** *For each required field, enter the following data:*
Individual NPI	The unique National Provider Identifier (NPI) assigned to the individual network provider, active on the network capture date.
CA License	California license number for the individual network provider reported, active on the network capture date. If no individual provider is reported in this record, report the entity network provider's California license number, if applicable.
Non-CA License	License number issued outside of the state of California for the individual network provider, active on the network capture date. If no individual provider is reported in this record, report the entity network provider's non-California license number, if applicable.
Non-CA License State	State in which the non-California license was issued.
Provider Group	Name of the provider group affiliated with the individual network provider, if applicable. If no individual provider is reported in this record, report the provider group affiliated with the entity network provider, if applicable.
Entity Name	Legal name of the entity, if the network provider is an entity. If the health plan reported an individual provider that delivers services through an entity, report the entity name in this field.
Entity DBA	"Doing-Business-As" name of the network provider entity, if applicable.
Entity NPI	The unique National Provider Identifier (NPI) assigned to the entity network provider. If an entity network provider is reported in this record, report the NPI of the entity, active on the network capture date.
Network Tier ID	The network tier, as the term is defined in the Definitions section of this Manual, in which the network provider is available to enrollees, if the network is a tiered network.
Facility	If the reported individual network provider delivers health care services in a facility setting, report the name of the facility. If no individual provider is reported in this record, report the name of the facility where the entity network provider delivers health care services, if the entity provider delivers health care services within a facility.
Facility NPI	The NPI corresponding to the facility identified in the “Facility” field.

FIELD NAME - OTHER OUTPATIENT PROVIDER	***FIELD INSTRUCTIONS - OTHER OUTPATIENT PROVIDER*** *For each required field, enter the following data:*
Provider Type	The provider type, as set forth in Appendix B, that describes the individual network provider's area of practice. If no individual provider is reported in this record, report the provider type that describes the entity network provider's area of practice.
Provider Language 1	Language spoken by the individual network provider, other than English, as set forth in Appendix C, if applicable.
Provider Language 2	Language spoken by the individual network provider, other than English, as set forth in Appendix C, if applicable.
Provider Language 3	Language spoken by the individual network provider, other than English, as set forth in Appendix C, if applicable.
Network Provider Practice Location and Associated Information	
Practice Address	The street number and street name of the practice address. If the network provider also serves as a telehealth provider, report only the physical location at which the network provider delivers in-person health care services.
Practice Address 2	The number of the office, suite, building or other location identifier for the practice address, if applicable.
City	City in which the practice address is located.
County	County in which the practice address is located.
State	State in which the practice address is located.
ZIP Code	ZIP Code in which the practice address is located.
Phone Number	The phone number an enrollee may use to schedule an appointment with the individual network provider at the reported practice address, if applicable. If no individual provider is reported in this record, report the phone number an enrollee may use to schedule an appointment with the entity network provider at the reported practice address, if applicable.
Accepting New Patients	The availability of the individual network provider to accept new patients or referrals, as the term is defined in the Definitions section of this Manual. Identify whether the network provider is accepting new patients at the reported practice address. If no individual provider is reported within this record, identify whether the entity network provider is accepting new patients at the reported practice address.

FIELD NAME - OTHER OUTPATIENT PROVIDER	***FIELD INSTRUCTIONS - OTHER OUTPATIENT PROVIDER*** *For each required field, enter the following data:*
Displayed in Provider Directory	The individual network provider's inclusion in the health plan's provider directory for the network. Identify whether, on the network capture date, the network provider was displayed in the health plan's online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network and practice location, and the specialty or subspecialty type identified in the corresponding fields of this report form. If no individual provider is reported in this record, identify this information for the reported entity network provider.
In-Person Appointments	Identify whether the network provider is available to offer either in-person appointments or "walk-in" appointments at the reported practice address. If no individual provider is reported in this record, identify the availability of the entity network provider to offer-in person appointments, including "walk-in" appointments, at the reported practice address.
Unscheduled Urgent Services	The individual network provider's availability to deliver unscheduled urgent services, as defined in the Instruction Manual. Identify whether the individual network provider delivers unscheduled urgent services at the reported practice address. If no individual provider is reported within this record, report the availability of the entity network provider to deliver unscheduled urgent services at the reported practice address.
E-mail Address	The individual network provider's office email address, if applicable, as set forth in section 1367.27(i)(6). If no individual provider is reported in this record, report the entity network provider's office email address, if applicable.

F. Hospital and Clinic Report Form (Form No. 40-270): Instructions

This report form consists of two tabs: the Hospital Report Tab and the Clinic Report Tab. All health plans that include hospital and clinic providers in the network shall complete a Hospital Report Tab and Clinic Report Tab, in the manner described in the field instructions below. (Rule 1300.67.2.2(h)(7)(B)(iii).) Only report providers who meet the definition of "network provider." (*See* Rule 1300.67.2.2(b)(9).)

Within the Hospital Report Tab, for each reported network, report all hospitals as of the network capture date. (Rule 1300.67.2.2(h)(7)(A)(iii).) "Hospital" refers to general acute

care hospitals, psychiatric hospitals, and other inpatient medical facilities. Do not include mental health facilities that are not hospitals on this t.

Within the Clinic Report Tab, for each reported network, report all clinics as of the network capture date. “Clinics” refers to those providers that meet the definition set forth in section 1200(a).

The following field instructions describe the data that the reporting plan shall report within each field of the report form, consistent with Rule 1300.67.2.2(h)(7)(B). Refer to the Definitions section of this Instruction Manual for additional explanation of the terms used within the field instructions for this report form. Refer to the Reporting Multiple Entries for the Same Provider and Reporting With Standardized Terminology subsections in the General Instructions Applicable to All Required Report Forms section of this Instruction Manual for more information about how to complete these fields.

Hospital Report Tab

FIELD NAME - *HOSPITAL*	***FIELD INSTRUCTIONS -*** *HOSPITAL* *For each required field, enter the following data:*
Network Information	
Network Name	The network name within which the reported hospital serves as a network provider, as defined in Rule 1300.67.2.2(b)(8).
Network ID	The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Subcontracted Plan Information	
Subcontracted Plan License Number	The subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). Each health plan's license number is available on the Department's web portal.
Subcontracted Plan Network ID	The subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan’s network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12).
Network Provider Information	
Hospital Name	Legal name of the network provider.

FIELD NAME - HOSPITAL	***FIELD INSTRUCTIONS - HOSPITAL*** *For each required field, enter the following data:*
DBA	"Doing-Business-As" name of hospital network provider, if applicable.
NPI	The unique National Provider Identifier (NPI) assigned to the network provider and active on the network capture date.
CA License	California license number of the network provider, active on the network capture date.
Non-CA License	License number of the network provider, issued outside of the state of California, active on the network capture date.
Non-CA License State	State in which the non-California license was issued.
Hospital Type	The type of hospital or inpatient facility, as set forth in Appendix B.
Network Tier ID	The network tier, as the term is defined in the Definitions section of this Manual, in which the network provider is available to enrollees, if the network is a tiered network.
Hospital System	Name of hospital system to which the network provider belongs, if applicable.
Network Provider Practice Location and Associated Information	
Practice Address	The street number and street name of the hospital practice address.
Practice Address 2	The number of the office, suite, building or other location identifier for the practice address, if applicable.
City	City in which the practice address is located.
County	County in which the practice address is located.
State	State in which the practice address is located.
ZIP Code	ZIP Code in which the practice address is located.
Type of Care	Identify whether the hospital is a network provider for basic hospital services, tertiary care services, or both at the identified practice address.
Displayed in Provider Directory	The network provider's inclusion in the health plan's provider directory for the network. Identify whether, on the network capture date, the network provider was displayed in the health plan's online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network, location, and service type identified in the corresponding fields of this report form.

Clinic Report Tab

FIELD NAME - *CLINIC*	***FIELD INSTRUCTIONS -*** *CLINIC* *For each required field, enter the following data:*
Network Information	
Network Name	The network name within which the reported clinic serves as a network provider, as defined in Rule 1300.67.2.2(b)(8).
Network ID	The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Subcontracted Plan Information	
Subcontracted Plan License Number	The subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). Each health plan's license number is available on the Department's web portal.
Subcontracted Plan Network ID	The subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12).
Network Provider Information	
Clinic Name	Legal name of the network provider.
DBA	"Doing-Business-As" name of network provider, if applicable.
NPI	The unique National Provider Identifier (NPI) assigned to the network provider and active on the network capture date.
CA License	California license number of the network provider, active on the network capture date.
Non-CA License	License number issued outside of the state of California, active on the network capture date.
Non-CA License State	State in which the non-California license was issued.
Clinic Type	The type of clinic, as set forth in Appendix B.
Number of Enrollees Assigned to Provider	The total number of enrollees within the network assigned to the network provider, or, where enrollees are not assigned, for whom the clinic network provider delivers primary care, as defined in section 1367.69(b).
Network Tier ID	The network tier, as the term is defined in the Definitions section of this Manual, in which the network provider is available to enrollees, if the network is a tiered network.

FIELD NAME - *CLINIC*	***FIELD INSTRUCTIONS -*** *CLINIC* *For each required field, enter the following data:*
Network Provider Practice Location and Associated Information	
Practice Address	The street number and street name of the clinic practice address.
Practice Address 2	The number of the office, suite, building or other location identifier for the practice address, if applicable.
City	City in which the practice address is located.
County	County in which the practice address is located.
State	State in which the practice address is located.
ZIP Code	ZIP Code in which the practice address is located.
Phone Number	The phone number an enrollee may use to schedule an appointment at the reported practice address, if applicable.
Accepting New Patients	The availability of the network provider to accept new patients, as the term is defined in the Definitions section of this Manual. Identify whether the clinic is accepting new patients at the reported practice address.
Displayed in Provider Directory	The network provider's inclusion in the health plan's provider directory for the network. Identify whether, on the network capture date, the network provider was displayed in the health plan's online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network, location, and service type identified in the corresponding fields of this report form.
Unscheduled Urgent Services	The network provider's availability to deliver unscheduled urgent services, as defined in the Definitions section of this Manual. Identify whether the clinic delivers unscheduled urgent services at the reported practice address.

G. Telehealth Report Form (Form No. 40-271): Instructions

All health plans that include telehealth providers in the network shall submit a Telehealth Report Form, in the manner described in the field instructions below. (Rule 1300.67.2.2(h)(7)(B)(vii).) Complete this report form only if the health plan's network includes network providers who deliver services via telehealth modalities. Only report providers who meet the definition of "network provider" on this report form. (*See* Rule 1300.67.2.2(b)(9).)

Within the Telehealth Report Form, for each reported network, report a complete list of the health plan's network providers who deliver primary care, specialty care, mental health and other outpatient provider services via telehealth modalities, as of the network

capture date. (Rule 1300.67.2.2(h)(7)(A)(iii).) The health plan shall report all network providers who deliver some or all services via a defined telehealth modality. Network providers who deliver services via a telehealth modality and in-person shall be reported in the Telehealth Report Form and in the Annual Network Report Form designated for their area of practice. Network providers who exclusively deliver telehealth services shall be reported only in the Telehealth Report Form.

The following field instructions describe the data that the reporting plan shall report within each field of the report form, consistent with Rule 1300.67.2.2(h)(7)(B). Refer to the Definitions section of this Instruction Manual for additional explanation of the terms used within the field instructions for this report form. Refer to the Reporting Multiple Entries for the Same Provider and Reporting With Standardized Terminology subsections in the General Instructions Applicable to All Required Report Forms section of this Instruction Manual for more information about how to complete these fields.

Telehealth Report Form

FIELD NAME - *TELEHEALTH*	***FIELD INSTRUCTIONS -*** *TELEHEALTH* *For each required field, enter the following data:*
Network Information	
Network Name	The network name within which the reported provider serves as a network provider, as defined in Rule 1300.67.2.2(b)(8).
Network ID	The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Subcontracted Plan Information	
Subcontracted Plan License Number	The subcontracted plan license number. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). Each health plan's license number is available on the Department's web portal.
Subcontracted Plan Network ID	The subcontracted plan network identifier. Complete this field if the reporting plan includes the network provider in this network due to a plan-to-plan contract with a subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12).
Network Provider Information	
Last Name	Last name of the network provider.
First Name	First name of the network provider.
Entity Name	If the network provider is an entity, report the entity name in this field.

Timely Access and Annual Network Submission Instruction Manual

FIELD NAME - TELEHEALTH	***FIELD INSTRUCTIONS - TELEHEALTH*** *For each required field, enter the following data:*
NPI	The unique National Provider Identifier (NPI) assigned to the network provider and active on the network capture date.
CA License / Certificate	California license or certificate identifier of the network provider, active on the network capture date.
Non-CA License / Certificate	License number or certificate identifier issued outside of the state of California, active on the network capture date.
Non-CA License / Certificate State	State in which the non-California license or certificate was issued.
Type of License / Certificate	The network provider's type of license or certificate, as set forth in Appendix D.
Specialty	The network provider's specialty, subspecialty, or area of expertise, as set forth in Appendix B.
Board Certified / Eligible	For each reported specialty or subspecialty, indicate whether the network provider is board-certified or board-eligible.
Provider Group	Name of the provider group affiliated with the network provider, if applicable.
Provider Language 1	Language spoken by the network provider, other than English, as set forth in Appendix C, if applicable.
Provider Language 2	Language spoken by the network provider, other than English, as set forth in Appendix C, if applicable.
Provider Language 3	Language spoken by the network provider, other than English, as set forth in Appendix C, if applicable.
Network Provider Distant Site Location and Associated Information	
County	County in which the network provider's distant site is located. The distant site is the location where the network provider is located when delivering telehealth services.
State	State in which the network provider's distant site is located, as defined in the Instruction Manual.
Number of Providers at Entity	If the health plan reported network provider information by "Entity Name," the number of network providers within the entity who provide telehealth services, for each specialty type reported.
Displayed in Provider Directory	The network provider's inclusion in the health plan's provider directory for the network. Identify whether, on the network capture date, the network provider was displayed in the health plan's online provider directory/directories maintained pursuant to section 1367.27. Only identify the network provider as listed in the provider directory if the network provider was displayed in the directory for the identified network and specialty identified in the corresponding fields of this report form.

Timely Access and Annual Network Submission Instruction Manual

FIELD NAME - TELEHEALTH	***FIELD INSTRUCTIONS - TELEHEALTH*** *For each required field, enter the following data:*
In-Person Appointments	Identify whether the network provider also treats patients in-person, or only treats patients via a telehealth modality.
Telehealth Delivery System	
Telehealth Delivery Modality	The telehealth modality used by the network provider to deliver telehealth services, as set forth in Appendix E.
Patient Location	The location where an enrollee may receive telehealth services, as set forth in Appendix E, if the network provider is available for synchronous interactions with the enrollee.

H. Timely Access and Network Adequacy Grievance Report Form (Form No. 40-272): Instructions

All health plans that are required to report annual network data shall submit a Timely Access and Network Adequacy Grievance Report Form, as applicable, in the manner described in the field instructions below. (Rule 1300.67.2.2(h)(7)(B)(viii).)

Within the Timely Access and Network Adequacy Grievance Report Form, for each reported network, report all timely access and network adequacy grievances received during the measurement year, as defined in Rule 1300.67.2.2(b)(3)(A). This includes all standard, exempt, and expedited grievances received directly by the primary plan, by the subcontracted plan, or through a contracted provider group or other entity. (Rule 1300.67.2.2(h)(7)(A)(iv) and (h)(7)(B)(viii).) If the reporting plan contracts with a subcontracted plan or a non-plan entity to handle any of its grievances (e.g. provider group, or other health services management company), the reporting plan shall report all grievances lodged by primary plan enrollees with the subcontracted plan or non-plan entity.

The instructions below describe the data that the reporting plan shall report within each field of the report form, consistent with Rule 1300.67.2.2(h)(7)(B). Refer to the Definitions section of this Instruction Manual for additional explanation of the terms used in the instructions below. Refer to the Reporting Multiple Entries for the Same Provider and Reporting With Standardized Terminology subsections in the General Instructions Applicable to All Required Report Forms section of this Instruction Manual for more information about how to complete these fields.

Timely Access and Network Adequacy Grievance Report Form

FIELD NAME - *GRIEVANCE*	***FIELD INSTRUCTIONS -*** *GRIEVANCE* *For each required field, enter the following data:*
Network Information	
Network Name	The network name within which the enrollee was enrolled on the date of the grievance, as defined in Rule 1300.67.2.2(b)(8).
Network ID	The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Product Line	The product line within which the enrollee was enrolled, as set forth in Appendix A, on the date of the grievance.
Subcontracted Plan Information	

FIELD NAME - *GRIEVANCE*	***FIELD INSTRUCTIONS -*** *GRIEVANCE* *For each required field, enter the following data:*
Subcontracted Plan License Number	The subcontracted plan license number. Complete this field if the reporting plan has a plan-to-plan contract with a subcontracted plan for the delivery of services to enrollees within the network, and the grievance concerns a network provider or providers available through the subcontracted plan's network, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12). Each health plan's license number is available in the Department's web portal.
Subcontracted Plan Network ID	The subcontracted plan network identifier. Complete this field if the reporting plan has a plan-to-plan contract with the subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12), and the grievance concerns a network provider or providers available through the subcontracted plan's network.
Grievance Information	
Date Received	The date the health plan received the grievance.
Date Resolved	The date the health plan resolved the grievance.
Grievance Type	The type of grievance based on the notice and resolution timeframes required under the Knox-Keene Act. Grievances shall be categorized as "Expedited," "Exempt" or "Standard," as set forth in Rule 1300.68(d) and Rule 1300.68.01.
Complaint ID	The reporting plan's unique identifier for the grievance, or if the complaint was lodged with a subcontracted plan, the unique identifier assigned by the subcontracted plan.
County	The county where the enrollee resides or works.
Provider Group	If the provider that is the subject of the complaint is affiliated with a provider group, and the enrollee was assigned to that provider group at the time of the complaint, the name of the provider group.
Complaint Category	The category of timely access or network adequacy grievance, as defined in the Definitions section of this Manual. See Appendix F for the list of complaint categories.
Provider Category	The category of network provider that is the subject of the complaint. See Appendix F for the list of provider categories.
Specialty	The specialty of the network provider who is the subject of the complaint. The entry shall reflect the provider's specialty as of the date of the grievance. See Appendix B for the list of provider types and specialties.
Nature of Resolution	The nature of the resolution for this grievance, as defined in the Definitions section of this Manual. See Appendix F for a list of resolutions.

FIELD NAME - *GRIEVANCE*	***FIELD INSTRUCTIONS -*** *GRIEVANCE* *For each required field, enter the following data:*
Resolution Determination	The resolution determination for this grievance, as defined in the Definitions section of this Manual. See Appendix F for the list of resolution determinations.

I. Out-of-Network Payment Report Form (Form No. 40-273): Instructions

This report form consists of two tabs: the Out-of-Network Payment Report Tab and the Proportion Report Tab. All health plans that are required to report annual network data shall complete an Out-of-Network Report Tab and Proportion Report Tab, if applicable, in the manner described in the field instructions below. (Rule 1300.67.2.2(h)(7)(C).)

Within the Out-of-Network Payment Report Tab, for each reported network, report all payments made to non-contracted providers who performed services for the health plan's enrollees at a contracting facility. (Section 1371.31(a)(4).) The Out-Of-Network Payment Report Tab shall contain all payments made to non-contracted providers during the measurement year that precedes the reporting year and shall include payments made by the reporting plan and any subcontracted plan that has been delegated health plan functions for the reporting plan's enrollees pursuant to a plan-to-plan contract.

Within the Proportion Report Tab, for each reported network, report the proportion of contracted to non-contracted providers at the health plan's contracting facilities. (Section 1371.31(a)(4).) The Proportion Report Tab shall include all contracting facilities in the health plan's network on the network capture date of the reporting year, regardless of whether a non-contracted provider delivered services at that facility. Report all contracting facilities that qualify as a network provider, including those that are contributed to the network by a subcontracted plan pursuant to a plan-to-plan contract.

The following field instructions describe the data that the reporting plan shall report within each field of the report form, consistent with Rule 1300.67.2.2(h)(7)(B). Refer to the Definitions section of this Instruction Manual for additional explanation of the terms used within the field instructions for this report form. Refer to the Reporting Multiple Entries for the Same Provider and Reporting With Standardized Terminology subsections in the General Instructions Applicable to All Required Report Forms section of this Instruction Manual for more information about how to complete these fields.

Out-of-Network Payment Report Tab

FIELD NAME – OUT-OF-NETWORK PAYMENT	***FIELD INSTRUCTIONS - OUT-OF-NETWORK PAYMENT*** *For each required field, enter the following data:*
Network Information	
Network Name	The network name within which the reported contracting facility participates, as defined in Rule 1300.67.2.2(b)(8).
Network ID	The network identifier for the reported network name. Network identifiers are assigned by the Department and made available in the Department's web portal.
Subcontracted Plan Information	
Subcontracted Plan License Number	The subcontracted plan license number. Complete this field if the reporting plan has a plan-to-plan contract with a subcontracted plan for the delivery of services to enrollees within the network, as described in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12),and the out-of-network payment was made by the subcontracted plan when arranging services for the reporting plan's enrollee. Each health plan's license number is available in the Department's web portal.
Subcontracted Plan Network ID	The subcontracted plan network identifier. Complete this field if the reporting plan has a plan-to-plan contract with the subcontracted plan's network, as the terms are defined in Rule 1300.67.2.2(b)(9)(B)(iv) and (b)(12), and the out-of-network payment was made by the subcontracted plan when arranging services for the reporting plan's enrollee.
Non-Contracted Provider Information	
Non-Contracted Provider Last Name	Last name of the non-contracted provider paid for delivering services to an enrollee at the contracting facility.
Non-Contracted Provider First Name	First name of the non-contracted provider paid for delivering services to an enrollee at the contracting facility.
Non-Contracted Provider NPI	The unique National Provider Identifier (NPI) assigned to the non-contracted provider paid for delivering services to an enrollee at the contracting facility.
Contracting Facility Information	
Contracting Facility Name	The name of the contracting facility where the non-contracted provider delivered services to an enrollee.

FIELD NAME – *OUT-OF-NETWORK PAYMENT*	***FIELD INSTRUCTIONS -*** *OUT-OF-NETWORK PAYMENT* *For each required field, enter the following data:*
Number of Payments Made at Contracting Facility	The number of payments made to the non-contracted provider for delivering services to an enrollee in the identified network at the contracting facility during the reporting period.

Proportion Report Tab

REQUIRED FIELD - *PROPORTION*	***FIELD INSTRUCTIONS*** *- PROPORTION* *For each required field, enter the following data:*
Contracting Facility Name	The name of the facility that is contracted with the health plan as of the network capture date.
Number of Non-Contracted Providers at Facility	The number of unique non-contracted providers paid by the reporting plan or a subcontracted plan for rendering services to the reporting plan's enrollees at the contracting facility during the reporting period.
Number of Contracted Providers at Facility	The number of unique contracted providers that were available to deliver services as in-network or "participating" providers at the contracting facility at any point during the measurement year, as defined in Rule 1300.67.2.2(b)(3)(A). If the reporting plan obtains network providers through a plan-to-plan contract, include all network providers made available to the reporting plan's enrollees via the subcontracted plan.
Proportion of Non-Contracted to Contracted Providers	The Number of Non-Contracted Providers at Facility to the Number of Contracted Providers at Facility, reported in the following format: Number of Non-Contracted Providers at Facility: Number of Contracted Providers at Facility

VI. Standardized Terminology Appendices

Appendix A: Product Line Categories

Standardized Terminology Product Line Categories
Covered CA EPO Individual Market
Covered CA EPO Individual Market
Covered CA EPO Individual Market
Covered CA EPO Small Group Market
Covered CA HMO Individual Market
Covered CA HMO Individual Market
Covered CA HMO Small Group Market
Covered CA HMO Small Group Market
Covered CA PPO Individual Market
Covered CA PPO Small Group Market
Covered CA Tiered EPO/PPO Individual Market
Covered CA Tiered EPO/PPO Small Group Market
Employer Group
EPO Individual Market
EPO Large Group Market
EPO Small Group Market
Healthy Kids
HMO Individual Market
HMO Individual Market
HMO Individual Market
HMO Large Group Market
HMO Small Group Market
IHSS
Medi-Cal
Medi-Cal Access (AIM)
MRMIP
PPO Individual Market
PPO Individual Market
PPO Large Group Market
PPO Small Group Market
Specialized Mental Health Commercial Market – Stand-Alone
Tiered EPO/PPO Individual Market
Tiered EPO/PPO Large Group Market
Tiered EPO/PPO Small Group Market
Other

Appendix B: Provider Types

Standardized Terminology Clinic Type
Alternative Birthing Center
Ambulatory Surgery Center/Surgical Clinic
Chronic Dialysis Clinic
Community Clinic
Federally Qualified Health Center (FQHC)
Free Standing - Primary Care
Free Standing - Specialty Care
Free Clinic
Psychology Clinic
Rehabilitation Clinic
Retail Health Clinic
Rural Health
Urgent Care Center
Other Outpatient Facility

Standardized Terminology Hospital and Other Inpatient Provider Type
Acute Psychiatric Hospital
Chemical Dependency Recovery Hospital
Congregate Living Health Facility
General Acute Care Hospital
Hospice Facility
Intermediate Care Facility for Individuals with Intellectual Disabilities
Inpatient Rehabilitation
Intermediate Care Facility
Psychiatric Health Facility
Skilled Nursing Facility
Other Inpatient Facility

Standardized Terminology Mental Health Facility Type
Alcohol and Other Drug (Outpatient)
Community Mental Health Center
Crisis Residential Facility
Crisis Stabilization Facility
Eating Disorder (Inpatient)
Eating Disorder (Outpatient)
Intensive Outpatient
Medication Assisted Treatment Programs

Standardized Terminology **Mental Health Facility Type**
Partial Hospitalization
Residential Treatment
Other

Standardized Terminology **Non-Physician Medical Practitioner Specialty**
Adult Nurse Practitioner
Cardiovascular & Thoracic Surgery Physician Assistant
Clinical Nurse Specialist
Emergency Medicine Physician Assistant
Family Nurse Practitioner
Hospital Medicine Physician Assistant
Nephrology Physician Assistant
Nurse Anesthetist
Nurse-Midwife
Obstetrical-Gynecological Nurse Practitioner
Orthopaedic Surgery Physician Assistant
Pediatric Nurse Practitioner
Pediatrics Physician Assistant
Psychiatric-Mental Health Nurse
Psychiatry Physician Assistant
Public Health Nurse
Other

Standardized Terminology **Non-Physician Mental Health Professional Specialty**
Adult
Adolescent
Alcohol and Other Drugs
Child
Geriatric
Qualified Autism Services Paraprofessional
Qualified Autism Services Professional
Qualified Autism Services Provider
Other

Standardized Terminology **Other Outpatient Provider Type**
Acupuncture
Audiology
Chiropractic
Dialysis/Dialysis Center/Facility
Dietician/Nutrition
Durable Medical Equipment/Supplies
Endodontics
Family Planning
General Dentist
Home Health
Hospice
Imaging/Radiology
Infusion/IV Therapy
Laboratory
Nurse (RN, LVN, etc.)
Nurse Practitioner
Occupational Therapy
Optometry/Vision
Orthodontics
Orthotics/Prosthetics
Pediatric Dentistry
Periodontics
Pharmacy
Physical Therapy
Physician Assistant
Prosthodontics
Sleep Disorder Diagnosis/Treatment
Speech Therapy
Surgery - Oral
Other

Standardized Terminology **Primary Care Physician Specialty**
Family Practice
General Practice
Internal Medicine
Obstetrics/Gynecology
Pediatrics
Other

Standardized Terminology **Specialist Physician Specialty**		
(Includes related ABMS designations, if different from the standardized terminology, and the ABMS Board(s) from which the specialty is issued.)		
Specialist Physician Specialty	***ABMS Designation (for reference)***	***ABMS Board (for reference)***
Addiction Medicine	-	Board of Preventive Medicine
Addiction Psychiatry	-	*Board of Psychiatry and Neurology*
Adult Congenital Heart Disease	-	*Board of Internal Medicine*
Advanced Heart Failure and Transplant Cardiology	-	*Board of Internal Medicine*
Allergy/Immunology	-	*Board of Allergy and Immunology*
Anesthesiology	-	*Board of Anesthesiology*
Brain Injury Medicine	-	*Board of Physical Medicine and Rehabilitation; Board of Psychiatry and Neurology*
Cardiovascular Disease	-	*Board of Internal Medicine*
Child and Adolescent Psychiatry	-	*Board of Psychiatry and Neurology*
Clinical Cardiac Electrophysiology	-	*Board of Internal Medicine*
Clinical Neurophysiology	-	*Board of Psychiatry and Neurology*
Consultation-Liaison Psychiatry	-	*Board of Psychiatry and Neurology*
Critical Care Medicine	*Critical Care Medicine; Anesthesiology Critical Care Medicine; Internal Medicine-Critical Care Medicine*	*Board of Anesthesiology; Board of Emergency Medicine; Board of Internal Medicine; Board of Obstetrics and Gynecology; Board of Pediatrics*
Dermatology	-	*Board of Dermatology*
Dermatopathology	-	*Board of Dermatology; Board of Pathology*
Diagnostic Radiology	*Diagnostic Radiology; Interventional Radiology and Diagnostic Radiology*	*Board of Radiology*
Emergency Medicine	*Emergency Medical Services*	*Board of Emergency Medicine*
Endocrinology	*Endocrinology, Diabetes and Metabolism*	*Board of Internal Medicine*

Standardized Terminology **Specialist Physician Specialty**		
(Includes related ABMS designations, if different from the standardized terminology, and the ABMS Board(s) from which the specialty is issued.)		
Specialist Physician Specialty	***ABMS Designation (for reference)***	***ABMS Board (for reference)***
Epilepsy		*Board of Psychiatry and Neurology*
Female Pelvic Medicine and Reconstructive Surgery		*Board of Obstetrics and Gynecology; Board of Urology*
Forensic Psychiatry		*Board of Psychiatry and Neurology*
Gastroenterology		*Board of Internal Medicine*
Genetics	*Clinical Biochemical Genetics; Clinical Genetics and Genomics (MD); Clinical Molecular Genetics and Genomics; Clinical Cytogenetics and Genomics*	*Board of Medical Genetics and Genomics*
Geriatric Medicine		*Board of Family Medicine; Board of Internal Medicine*
Geriatric Psychiatry		*Board of Psychiatry and Neurology*
Gynecologic Oncology		*Board of Obstetrics and Gynecology*
Hematology		*Board of Internal Medicine*
HIV/AIDS Specialist		*Rule 1300.74.16*
Hospice and Palliative Medicine		*Board of Anesthesiology; Board of Emergency Medicine; Board of Family Medicine, Board of Internal Medicine; Board of Obstetrics and Gynecology; Board of Pediatrics; Board of Physical Medicine and Rehabilitation; Board of Psychiatry and Neurology; Board of Radiology; Board of Surgery*
Infectious Disease		*Board of Internal Medicine*
Internal Medicine		*Board of Internal Medicine*
Interventional Cardiology		*Board of Internal Medicine*
Maternal and Fetal Medicine		*Board of Obstetrics and Gynecology*
Medical Toxicology		*Board of Emergency Medicine; Board of Pediatrics; Board of Preventive Medicine*

Standardized Terminology **Specialist Physician Specialty**		
(Includes related ABMS designations, if different from the standardized terminology, and the ABMS Board(s) from which the specialty is issued.)		
Specialist Physician Specialty	***ABMS Designation (for reference)***	***ABMS Board (for reference)***
Neonatology	*Neonatal-Perinatal Medicine*	*Board of Internal Medicine, Board of Pediatrics*
Nephrology	_	*Board of Internal Medicine*
Neurodevelopmental Disabilities	_	*Board of Psychiatry and Neurology*
Neurology	_	*Board of Psychiatry and Neurology*
Neuromuscular Medicine	_	*Board of Physical Medicine and Rehabilitation; Board of Psychiatry and Neurology*
Nuclear Medicine	_	*Board of Nuclear Medicine*
Obstetrics/Gynecology	_	*Board of Obstetrics and Gynecology*
Occupational Medicine	_	*Board of Preventive Medicine*
Oncology	*Medical Oncology*	*Board of Internal Medicine*
Ophthalmology	_	*Board of Ophthalmology*
Otolaryngology	_	*Board of Otolaryngology - Head and Neck Surgery*
Pain Medicine	_	*Board of Anesthesiology; Board of Emergency Medicine; Board of Family Medicine; Board of Physical Medicine and Rehabilitation; Board of Psychiatry and Neurology; Board of Radiology*
Pathology	*Pathology - Anatomic/Pathology - Clinical; Pathology - Anatomic; Pathology - Clinical*	*Board of Pathology*
Pediatric Anesthesiology	_	*Board of Anesthesiology*
Pediatric Cardiology	_	*Board of Pediatrics*
Pediatric Critical Care Medicine	_	*Board of Pediatrics*
Pediatric Dermatology	_	*Board of Dermatology*
Pediatric Developmental-Behavioral	_	*Board of Pediatrics*
Pediatric Endocrinology	_	*Board of Pediatrics*

Standardized Terminology **Specialist Physician Specialty**		
(Includes related ABMS designations, if different from the standardized terminology, and the ABMS Board(s) from which the specialty is issued.)		
Specialist Physician Specialty	***ABMS Designation (for reference)***	***ABMS Board (for reference)***
Pediatric Gastroenterology	-	*Board of Pediatrics*
Pediatric Hematology/Oncology	-	*Board of Pediatrics*
Pediatric Infectious Disease	-	*Board of Pediatrics*
Pediatric Nephrology	-	*Board of Pediatrics*
Pediatric Neurology	*Neurology with Special Qualification in Child Neurology*	*Board of Psychiatry and Neurology*
Pediatric Otolaryngology	*Complex Pediatric Otolaryngology*	*Board of Otolaryngology - Head and Neck Surgery*
Pediatric Pulmonology	-	*Board of Pediatrics*
Pediatric Radiology	-	*Board of Radiology*
Pediatric Rehabilitation Medicine	-	*Board of Physical Medicine and Rehabilitation*
Pediatric Rheumatology	-	*Board of Pediatrics*
Pediatric Surgery	-	*Board of Surgery*
Pediatric Transplant Hepatology	-	*Board of Pediatrics*
Pediatric Urology	-	*Board of Urology*
Physical Medicine and Rehabilitation	-	*Board of Physical Medicine and Rehabilitation*
Podiatry	-	*CA Board of Podiatric Medicine*
Psychiatry	-	*Board of Psychiatry and Neurology*
Pulmonology	*Pulmonary Disease*	*Board of Internal Medicine*
Radiation Oncology	-	*Board of Radiology*
Reproductive Endocrinology/Infertility	-	*Board of Obstetrics and Gynecology*
Rheumatology	-	*Board of Internal Medicine*
Sleep Medicine	-	*Board of Anesthesiology; Board of Family Medicine; Board of Internal Medicine; Board of Otolaryngology - Head and Neck Surgery; Board of Pediatrics; Board of Psychiatry and Neurology*

Standardized Terminology **Specialist Physician Specialty**		
(Includes related ABMS designations, if different from the standardized terminology, and the ABMS Board(s) from which the specialty is issued.)		
Specialist Physician Specialty	***ABMS Designation (for reference)***	***ABMS Board (for reference)***
Sports Medicine	*Sports Medicine; Orthopaedic Sports Medicine*	*Board of Orthopaedic Surgery; Board of Emergency Medicine; Board of Family Medicine; Board of Internal Medicine; Board of Pediatrics; Board of Physical Medicine and Rehabilitation*
Surgery - Cardiothoracic	*Thoracic and Cardiac Surgery*	*Board of Thoracic Surgery*
Surgery - Colon/Rectal	-	*Board of Colon and Rectal Surgery*
Surgery - Congenital Cardiac	-	*Board of Thoracic Surgery*
Surgery - Critical Care	*Surgical Critical Care*	*Board of Surgery*
Surgery - General	*Surgery*	*Board of Surgery*
Surgery - Hand	*Surgery of the Hand*	*Board of Orthopaedic Surgery; Board of Plastic Surgery; Board of Surgery*
Surgery - Neurological	-	*Board of Neurological Surgery*
Surgery - Oncology	*Complex General Surgical Oncology*	*Board of Surgery*
Surgery - Orthopaedic	*Orthopaedic Surgery*	*Board of Orthopaedic Surgery*
Surgery - Plastic	*Plastic Surgery; Plastic Surgery Within the Head and Neck*	*Board of Plastic Surgery; Board of Otolaryngology - Head and Neck Surgery*
Surgery - Thoracic	-	*Board of Thoracic Surgery*
Surgery - Vascular	-	*Board of Surgery*
Transplant Hepatology	-	*Board of Internal Medicine*
Urology	-	*Board of Urology*
Vascular Neurology	-	*Board of Psychiatry and Neurology*

Appendix C: Provider Languages

Standardized Terminology Provider Languages
Abnaki
Achinese
Achumawi
African
Afrikaans
Ahtena
Alabama
Albanian
Aleut
Algonquian
American Indian
American Sign Language
Amharic
Apache
Arabic
Arapaho
Arawakian
Arikara
Armenian
Assamese
Athapascan
Atsina
Atsugewi
Aymara
Azerabaijani
Aztecan
Balinese
Balochi
Bantu
Basque
Bengali
Berber
Bielorussian
Bihari

Standardized Terminology **Provider Languages**
Bikol
Bisayan
Blackfoot
Bulgarian
Burmese
Caddo
Cahuilla
Cajun
Cambodian
Cantonese
Carolinian
Catalonian
Cayuga
Chadic
Cham
Chamorro
Chasta Costa
Chemehuevi
Cherokee
Chetemacha
Cheyenne
Chibchan
Chinese
Chinook Jargon
Chiricahua
Chiwere
Choctaw
Chumash
Clallam
Cocomaricopa
Coeur D'alene
Columbia
Comanche
Cowlitz
Cree
Croatian
Crow

Standardized Terminology **Provider Languages**
Cupeno
Cushite
Czech
Dakota
Danish
Delaware
Delta River Yuman
Diegueno
Dravidian
Dutch
Efik
Eskimo
Estonian
Faroese
Farsi
Fijian
Finnish
Foothill North Yokuts
Formosan
Fox
French
French Creole
Frisian
Fuchow
Fulani
German
Gilbertese
Gondi
Greek
Gujarati
Gullah
Gur
Haida
Hakka
Havasupai
Hawaiian
Hawaiian Pidgin

Standardized Terminology **Provider Languages**
Hebrew
Hidatsa
Hindi
Hmong
Hopi
Hungarian
Hupa
Icelandic
Ilocano
Indonesian
Ingalit
Inupik
Irish Gaelic
Iroquois
Italian
Jamaican Creole
Japanese
Javanese
Jicarilla
Kachin
Kan, Hsiang
Kannada
Kansa
Karachay
Karen
Karok
Kashmiri
Kazakh
Keres
Khoisan
Kickapoo
Kiowa
Kirghiz
Klamath
Koasati
Korean
Koyukon

Standardized Terminology **Provider Languages**
Krio
Kru, Ibo, Yoruba
Kuchin
Kurdish
Kusaiean
Kutenai
Kwakiutl
Ladino
Laotian
Lettish
Lithuanian
Luiseno
Lusatian
Luxembourgian
Macedonian
Makah
Malagasy
Malay
Malayalam
Mandan
Mandarin
Mande
Maori
Mapuche
Marathi
Marquesan
Marshallese
Mayan languages
Mbum
Melanesian
Menomini
Miami
Miao-yao, Mien
Micmac
Micronesian
Mikasuki
Misumalpan

Standardized Terminology Provider Languages
Mohave
Mohawk
Mokilese
Mongolian
Mono
Mortlockese
Mountain Maidu
Munda
Muskogee
Navajo
Nepali
Nez Perce
Nilo-hamitic
Nilotic
Niuean
Nomlaki
Nootka
Northern Paiute
Northwest Maidu
Norwegian
Nubian
Nukuoro
Ojibwa
Okanogan
Omaha
Oneida
Onondaga
Oriya
Osage
Oto - Manguen
Ottawa
Pacific Gulf Yupik
Paiute
Palau
Paleo-siberian
Pampangan
Pangasinan

Standardized Terminology Provider Languages
Panjabi
Papia Mentae
Pashto
Passamaquoddy
Patois
Pawnee
Pennsylvania Dutch
Penobscot
Pidgin
Pima
Polish
Polynesian
Pomo
Ponapean
Ponca
Portuguese
Potawatomi
Puget Sound Salish
Quechua
Quinault
Rajasthani
Rarotongan
Rhaeto-romanic
Romanian
Romany
Russian
Sahaptian
Saharan
Salish
Samoan
Santiam
Saramacca
Scottic Gaelic
Sebuano
Seneca
Serbian
Serbocroatian

Standardized Terminology **Provider Languages**
Serrano
Shawnee
Shoshoni
Sierra Miwok
Sindhi
Sinhalese
Siuslaw
Slovak
Slovene
Sonoran
Spanish
Spokane
St Lawrence Island Yupik
Sudanic
Swahili
Swedish
Syriac
Tachi
Tadzhik
Tagalog
Taiwanese
Tamil
Tanaina
Tarascan
Telugu
Tewa
Thai
Tibetan
Tiwa
Tlingit
Tokelauan
Tongan
Tonkawa
Towa
Trukese
Tsimshian
Tungus

Standardized Terminology **Provider Languages**
Tupi-guarani
Turkish
Turkmen
Tuscarora
Uighur
Ukrainian
Ulithean
Upper Chinook
Urdu
Ute
Vietnamese
Walapai
Washo
Welsh
Wichita
Winnebago
Wintun
Woleai-ulithi
Wu
Yapese
Yaqui
Yavapai
Yiddish
Yuchi
Yuma
Yupik
Yurok
Zuni

Appendix D: Type of License and Certificate

Standardized Terminology Mental Health Professional License and Certificate Type
Alcohol and Other Drug Counselor
Board Certified Behavior Analyst
Board Certified Assistant Behavior Analyst
Licensed Clinical Social Worker
Licensed Marriage and Family Therapist
Licensed Professional Clinical Counselor
Psychiatric-Mental Health Nurse
Psychiatric Physician Assistant
Psychologist
Other License
Other Certificate

Standardized Terminology Non-Physician Medical Practitioner License Type
Certified Nurse Midwife
Licensed Midwife
Nurse Practitioner
Physician Assistant

Standardized Terminology Primary Care Physician License Type	
Primary Care Physician License Type	***Medical Degree (for reference)***
DO	Doctor of Osteopathic Medicine
MD	Doctor of Medicine

Standardized Terminology Specialist Physician License Type	
Specialist Physician License Type	***Medical Degree (for reference)***
DO	Doctor of Osteopathic Medicine
DPM	Doctor of Podiatric Medicine
MD	Doctor of Medicine

Appendix E: Telehealth Terminology

Standardized Terminology Patient Location Category
Medical Facility
Patient's Residence
Patient's Personal Mobile Device
Other

Standardized Terminology Telehealth Delivery Modality Category
Advice
e-Consult
Live visit
Remote Patient Monitoring
Store and forward
Triage
Other

Appendix F: Grievance Field Values

Standardized Terminology Complaint Category
Geographic Access
Language Assistance Plan
Language Assistance Provider
Office Wait Time
Provider Directory Error
Provider Not Taking New Patients
Telephone Access Plan
Telephone Access Provider
Timely Access
Timely Authorization

Standardized Terminology Provider Category
Ancillary Provider
Clinic
Hospital
Mental Health Facility
Mental Health Professional
PCP
PCP Non-Physician Medical Practitioner
Specialist
Specialist Non-Physician Medical Practitioner

Standardized Terminology Resolution Methods
Authorization Approved
Authorization Denied
Change Medical Group
Change PCP
Change Specialist
Enrollee Educated
No Confirmed Access Issue
Out-of-Network Referral
Provider Educated
Re-adjudicated claim
Secured Timely Appointment
Updated Provider Directory

Standardized Terminology **Resolution Determination**
Enrollee Favor
Partial Enrollee Favor
Health Plan Favor

Provider Appointment Availability Survey Manual

Eff. Date [OAL Insert Date Here]

DEPARTMENT OF MANAGED HEALTH CARE
PROVIDER APPOINTMENT AVAILABILITY SURVEY MANUAL

Table of Contents

Introduction to the Provider Appointment Availability Survey3

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 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)) 9

Step 4: Select Random Samples (Rule 1300.67.2.2(f)(1)(D))....10

Step 5: Engage in Provider Outreach 12

Step 6: Prepare Survey Questions (Rule 1300.67.2.2(f)(1)(E)) 12

Step 7: Administer Survey (Rule 1300.67.2.2(f)(1)(F)-(G)) 13

Step 8: Calculate Appointment Wait Times and the PAAS Results (Rule 1300.67.2.2(f)(1)(G)-(H))....21

Step 9: Create Quality Assurance Report (Rule 1300.67.2.2(f)(1)(J) and (f)(3)-(4)) 30

Step 10: Submit the Health Plan's Timely Access Compliance Report (Rule 1300.67.2.2(f)(1)(K) and (h))....33

Appendix 1: Sample Size Chart 34

Appendix 2: Survey Tool 37

1st Comment Period – Changes to the text noted by underline.

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).[1]

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 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[2] 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[3] 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. Health plans shall include in the submission whether any patterns of non-compliance were identified in the results of the PAAS, and if so, the health plan shall include in its submission the information set forth in Rule 1300.67.2.2(h)(6)(C).

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 1st 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);
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);

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[1] 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.

[2] 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)(16), unless otherwise indicated.

[3] All references to provider(s) in the PAAS Manual shall refer to network provider(s), as defined in Rule 1300.67.2.2(b)(9), unless otherwise indicated.

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[4];
    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 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. Health plans shall report a percentage of providers with an appointment available within each of the time-elapsed standards for each county in each network (County/Network) for each Provider Survey Type. Health plans shall report a percentage of providers with an appointment within each of the time-elapsed standards 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.

7. Health plans are not required to survey or report a rate of compliance for networks exclusively serving Medicare Advantage, CalMediConnect, 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. 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:

[4] 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.

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

a. The provider participates in the health plan's network as of the network capture date. The network capture date is January 15 of the measurement year, as defined in Rules 1300.67.2.2(b)(3) and (b)(6);[5]
b. The provider is located 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. 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;

[5] 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 January 15 of the measurement year. 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 Form 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 2022 PAAS Report Forms are submitted May 1, 2023).

c. The provider delivers health care services through enrollee appointments;
d. The provider delivers health care services within one or more of the five Provider Survey Types set forth below:

Provider Survey Types

i. Primary Care Providers:

1) Primary Care Physicians; or
2) Non-Physician Medical Practitioners providing primary care[6].

ii. Non-Physician Mental Health Care Providers (NPMH):

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[7]:

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;

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[6] 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 which are physician assistants and/or nurse practitioners performing primary care services under the supervision of a primary care physician 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 in collaboration with a physician pursuant to Chapter 6 (commencing with section 2700) of Division 2 of the Business and Professions Code.

[7] Unless otherwise specified, “specialty” or “subspecialty” means the primary specialty or subspecialty type(s) that the network provider currently practices in the identified network, and for which the provider has been credentialed by the health plan.

4) Consultation-Liaison Psychiatry;
5) Geriatric Psychiatry; or
6) Psychiatry-Pain Medicine.

v. Ancillary Service Providers, which are facilities or entities providing:[8]

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. For further detailed 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.[9] 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

[8] 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.
[9] 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 any individual provider performing services on behalf of the federally qualified health center or rural health clinic…"

FQHC/RHC, the health plan shall not include individual provider names, telephone 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. National Provider Identifier;
c. County; and
d. 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.

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 survey responses for each County/Network 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.

21. For each Provider Survey Type 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. Unless the health plan is prevented from meeting the required sample size based solely on ineligible providers, the health plan is required to obtain the number of valid survey responses sufficient to meet the required sample size, regardless of whether a random sample or census is surveyed.

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 utilizes 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 provider. As noted in paragraph 26 below, the size of the oversample used by the health

plan must be sufficient 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. All health plans are required to meet the required sample size, as identified in Appendix 1, to ensure that the 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 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 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
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 with the largest number of providers.

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 of 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:

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) of the Knox-Keene Act;

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 is utilized 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. The health plan does not delay administration of the survey by engaging in actions that prevent the single survey administrator from meeting all applicable timeframes for administering the survey, including allotting sufficient time to meet the required sample size for each County/Network, or other requirements set forth in the PAAS Manual.

Step 5: Engage in Provider Outreach

35. In order to accurately report network performance across the time-elapsed standards, the health plan shall obtain survey responses from a meaningful number 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-elapsed 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:

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;
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 data and responses for the Department's PAAS questions are transferred to the Department's PAAS Raw Data Report Form and Results Report Form;
f. The contact and/or notification comply with all other requirements of the Knox-Keene Act; and
g. Any revisions to the Department's standardized Survey Tool are identified by redline and filed as an Exhibit J-13 in eFile within 30 calendar days of the amendment, pursuant to section 1352(a) and Rule 1300.52(e).

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

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))

Timeframe and Waves

41. All surveys shall be completed between June 1 through December 31 of each measurement year. The surveys shall be conducted in waves spaced three weeks (21 calendar days) apart. For each County/Network, the health plan shall obtain approximately 50% (and no more than 60%) of the valid completed responses to the survey for each

Provider Survey Type in each wave. (Valid completed responses to the survey include only those identified as "Eligible – Survey Completed" on the Raw Data Report Form.) The survey waves may be of any duration necessary to complete the survey of all providers included in each wave, unless Electronic Extraction is used. (See Option 1 in Survey Administration Modality, below, for details related to the duration of the Electronic Extraction waves.) For each Provider Survey Type from a network, the second wave shall begin no sooner than three weeks (21 calendar days) following the last contact attempt date for that Provider Survey Type during the first wave. Waves may be staggered by Provider Survey Type to avoid periods in which surveys are not being administered.

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 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:

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 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: Manual or Electronic Extraction, or the provider can be deemed compliant via Option 3: Verified Advance Access Program;
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 1 or Wave 2. (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. 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. Day 16-17: Wait for the provider to respond to the survey via email, electronic communication, fax, or telephone. If no response is received by 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 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 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.[10] 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, electronic communication, or fax (except as described in paragraph 48). The health plan shall record this date as the "Date Survey Initiated" on the Raw Data Report Form. (If an email, electronic communication, or fax contact is not available, the health plan shall 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:

[10] See the Calculating Timeframes section below for further information related to calculating business days.

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.

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. If possible, 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[11]) 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, or 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 10 business days of sending the survey invitation via email, electronic communication, or fax,

[11] 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.

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:

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 utilizing 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 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[12];
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 he/she 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(e). 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

[12] 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.

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 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. Appointments occurring prior to the date and time of the call shall not be deemed compliant;
c. 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.);
d. 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.
e. 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
f. All survey calls shall be conducted from 8:00 am through 5:00 pm, Pacific Time.

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 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 of 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 Surveyed

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

Care Providers only) the "Number of Providers Responded as a Qualified Advanced Access Provider" to calculate the "Total Number of Providers Surveyed."

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, 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. For 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);
b. Urgent care appointments 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 first available appointment identified by the provider's office;

c. Where an urgent care appointment wait time standard expires on a weekend or holiday, the provider shall be recorded as compliant on the Raw Data Report Form if the provider has an appointment available during the next business day; and[13]

d. Non-urgent appointment standards are set forth in Rule 1300.67.2.2(c)(5)(D)-(F) in business days. For consistency, all health plans shall use the following rules in calculating appointment wait time standards:

   i. Count 14 calendar days to calculate the 10 business day standard for Primary Care Providers and non-physician mental health care provider appointments. Calendar days shall include Saturdays and Sundays;

   ii. Count 21 calendar days to calculate the 15 business day standard for Specialist Physicians, Psychiatrists, and ancillary service provider appointments. Calendar days shall include Saturdays and Sundays;

   iii. When calculating calendar 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.

69. Example: If a primary care provider responds with an appointment date and time on Tuesday the 15th, then the appointment identified shall be on or before Tuesday the 29th in order to meet the 10-business days standard (calculated by counting forward 14 calendar days) for non-urgent primary care appointments.[14]

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[13] 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 to record providers as compliant on the Raw Data Report Form when an urgent care appointment timeframe expires on a weekend or holiday and the provider has an appointment available on the next business day. 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 Rule 1300.67.2.2(c).

[14] In this example, 14 calendar days would be counted as follows: Tuesday the 15th is not counted (because, as the day of the request, it is excluded), Day 1: Wednesday the 16th, Day 2: Thursday the 17th, Day 3: Friday the 18th, Day 4: Saturday the 19th, Day 5: Sunday the 20th, Day 6: Monday the 21st, Day 7: Tuesday the 22nd, Day 8: Wednesday the 23rd, Day 9: Thursday the 24th, Day 10: Friday the 25th, Day 11: Saturday the 26th, Day 12: Sunday the

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 and non-urgent 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 compliant 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 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 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, Specialist Physicians, and Psychiatrists]" (as applicable), the provider 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[15] indicates that: "Yes, there is an available non-

27th, Day 13: Monday the 28th, Day 14: Tuesday the 29th.

[15] 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 appointment within [10 business days for Primary Care Providers and NPMH] or [15 business days for Specialist Physicians, Psychiatrists, and Ancillary Service Providers]" (as applicable), the provider is counted as compliant in the "Calculation 2" field on the Raw Data Report Form.

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] or [15 business days for Specialist Physicians, Psychiatrists, and Ancillary Service Providers]" (as applicable), the provider is counted as non-compliant in the "Calculation 2" field on the Raw Data Report Form.

Calculating the Percentage of Providers with an Urgent Care or Non-Urgent 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-elapsed 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. For each Provider Survey Type, in each Network/County, the formula divides:

Urgent Care Appointments

a. The total number of providers identified as compliant under the applicable urgent care time-elapsed 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]" field.

Non-Urgent Appointments

b. The total number of providers identified as compliant under the applicable non-urgent time-elapsed 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]" field.

(*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.) 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

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urgent appointments but replace "Question 2" with "Question 1" in these instructions.

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 compliant providers 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.
b. Denominator: Calculate the total number of providers that responded to the question regarding the availability of an urgent care appointment, which includes only compliant and non-compliant providers. 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.
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, which is then automatically recorded in the applicable field: "Percentage of Providers with an Urgent Care Appointments Available within 48 Hours (Unweighted)"; or "Percentage of Providers with an Urgent Care Appointments Available within 96 Hours (Unweighted)."

Non-Urgent Appointments

e. Numerator: Add the total number of compliant providers 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) 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.

f. Denominator: Calculate the total number of providers that responded to the question regarding the availability of a non-urgent appointment, which includes only compliant and non-compliant providers. 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) 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.
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 an urgent care appointment available, which is then automatically recorded in the applicable field: "Percentage of Providers with a Non-Urgent Appointments Available within 10 Business Days (Unweighted)"; or "Percentage of Providers with a Non-Urgent Appointments Available within 15 Business Days (Unweighted)."

Calculating the Weighted Percentage of Providers with an Appointment Available within Standard

73. The Results Report Form auto-calculates for each Provider Survey Type a weighted percentage of providers with timely appointments for urgent care and non-urgent appointments for each network in the "Percentage of [Provider Survey Type] with Timely Appointments for Urgent Care and Non-Urgent Appointment Types" fields on the Summary of Rates of Compliance Tab (for Ancillary Service Providers, this value represents the percentage of providers with timely appointments for non-urgent appointments). The values in these fields are copied from the "Percentage of Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types (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 [Provider Survey Type, except Ancillary Service Providers] with Timely Appointments for Urgent Care and Non-Urgent Appointment Types" 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 Ancillary Service Providers with Timely Appointments for Non-Urgent Appointments" 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 at which all providers in a network offer timely appointments for both urgent care and non-urgent appointments. The Report Form Instruction 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 of the health plan's networks for all urgent care and non-urgent appointments. In order for the formulas to accurately calculate a single urgent care appointment rate of compliance and a single non-urgent appointment rate of compliance for each network, 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.

76. The weighted "Rate of Compliance [Urgent Care and Non-Urgent Appointments] (All Provider Survey Types)" 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. The Rates of Compliance are calculated by dividing:

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) 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) 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.

The Report Form Instruction 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)(11). 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 Results Report Form.[16] 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:

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

[16] Ineligible and non-responders may be identified through the Three Step Protocol or through Extraction.

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;
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 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 must 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 utilize 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 1st 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;
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 a part of the health plan's network, the quality assurance review shall include a comparison of the health plan's Contact List Report Form, Raw Data Report Form, and Annual Network Report Forms for the same network capture date. The health plan shall provide an explanation of whether any non-network providers were identified and, if so, whether those providers (who are not part of the health plan's network) were included or excluded from the data submitted on the health plan's PAAS Report Forms. The health plan shall provide this information and an explanation, in narrative form, for any discrepancies identified between the data sources identified in paragraph 83f.

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

86. By May 1st 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.

Appendix 1: Sample Size Chart

To determine the required number of completed surveys, identify the required sample size[17] 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

[17] 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.

Sample Size Chart Continued

Number of Providers within County/Network	Required Sample Size	Number of Providers within County/Network	Required Sample Size
111 - 115	73	301 - 305	120
116 - 120	75	306 - 310	121
121 - 125	77	311 - 315	122
126 - 130	79	316 - 325	123
131 - 135	81	356 – 360	128
136 - 140	82	361 – 370	129
141 - 145	84	371 – 380	130
146 - 150	86	381 – 385	131
151 - 155	87	386 – 395	132
156 - 160	89	396 – 405	133
161 - 165	90	406 – 415	134
166 - 170	92	416 – 425	135
171 - 175	93	426 – 435	136
176 - 180	95	436 – 445	137
181 - 185	96	446 – 455	138
186 - 190	97	456 – 465	139
191 - 195	98	466 – 480	140
196 - 200	100	481 – 490	141
201 - 205	101	491 – 505	142
206 - 210	102	506 – 515	143
211 - 215	103	516 – 530	144
216 - 220	104	531 – 545	145
221 - 225	105	546 – 560	146
226 - 230	107	561 – 575	147
231 - 235	108	576 – 590	148
236 - 240	109	591 – 605	149
241 - 245	110	606 – 620	150
246 - 250	111	621 – 640	151
251 - 255	112	641 – 660	152
256 - 265	113	661 – 675	153
266 - 270	114	676 – 695	154
271 - 275	115	696 – 720	155
276 - 280	116	721 – 740	156
281 - 285	117	741 – 765	157
286 - 290	118	766 – 790	158

291 - 300	119	791 – 815	159

Sample Size Chart Continued

Number of Providers within County/Network	Required Sample Size	Number of Providers within County/Network	Required Sample Size
816 – 840	160	1941 – 2065	180
841 – 870	161	2206 – 2370	182
871 – 900	162	2371 – 2550	183
901 – 935	163	2551 – 2765	184
1086 – 1130	168	2766 – 3015	185
1131 – 1175	169	3016 – 3305	186
1176 – 1225	170	3306 – 3660	187
1226 – 1280	171	3661 – 4090	188
1281 – 1340	172	4091 – 4635	189
1341 – 1405	173	4636 – 5330	190
1406 – 1475	174	5331 – 6265	191
1476 – 1550	175	6266 – 7580	192
1551 – 1635	176	7581 – 9565	193
1636 – 1725	177	9566 – 12920	194
1726 – 1825	178	12921 – 41649	195
1826 – 1940	179	41650 and above	196

Appendix 2: Survey Tool

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

(1) The Email, Electronic Communication, or Fax Survey Script; and

(2) The Telephonic Survey Script.

Both survey scripts are designed to survey all Provider Survey Types.

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.

Instructions in both 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.

Email, Electronic Communication, or Fax Survey Script

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 [insert type of provider being surveyed] 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 one of the first five items, 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 he or she 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, use the earlier appointment date and time (shorter duration time).

Question 1: [18]

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

[18] 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.

Calculation 1: [19]

Calculate whether the appointment date and time in Question 1 is within 48 hours for Primary Care Providers or 96 hours for Non-Physician Mental Health Care Providers, Specialist Physicians, and Psychiatrists of this request for an appointment. Calculate the number of hours between the date and time of the request for the appointment and the date and time of the available appointment. Where an urgent care appointment wait time expires on a weekend or holiday, the provider shall be recorded as compliant on the Raw Data Report Form if the provider has an appointment available during the next business day. Record on the Raw Data Report Form in the "Calculation 1" field pertaining to the urgent care whether the provider's next available urgent care appointment is available 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 (Non-Physician Mental Health Care Providers 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 (Non-Physician Mental Health Care Providers, Specialist Physicians, and Psychiatrists). (Mark "N" if the provider is not scheduling appointments while he or she 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? *[Allow space for provider to insert date (mm/dd/yy) and time (hh:mm am/pm) PT or indicate that this appointment type is not applicable and provide a brief explanation. Record this information in "Question 2"* [20] *field of the applicable Raw Data Report Form.]*

[19] 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.

[20] Urgent care appointments questions are not included in the survey of Ancillary Service Providers. As a result, the plan shall record this information in the "Question 1" field on the Ancillary Service Provider Raw Data Report Form.

Calculation 2:

Calculate whether the appointment date and time in Question 2 is available within 10 business days (calculated as 14 calendar days for Primary Care Providers and Non-Physician Mental Health Care Providers) or within 15 business days (calculated as 21 calendar days) for Specialist Physicians, Psychiatrist and Ancillary Service Providers of this request for an appointment.[21] Indicate on the Raw Data Report Form in the "Calculation 2"[22] field pertaining to the non-urgent appointment whether the appointment is available within the appropriate wait time standard:

- *Mark "Y" to indicate yes, there is an available non-urgent appointment within 10 business days (Primary Care Providers and Non-Physician Mental Health 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 and Non-Physician Mental Health Care Providers) or 15 business days (Specialist Physicians, Psychiatrists, and Ancillary Service Providers). (Mark "N" if the provider is not scheduling appointments while he or she 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.

[21] When calculating calendar days exclude the first day (e.g., the day of request) and include the last day. Weekends, Saturday, and Sunday shall be included when calculating calendar 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.

[22] Urgent care appointments questions are not included in the survey of Ancillary Service Providers. As a result, the plan shall record this information in the "Calculation 1" field on the Ancillary Service Provider Raw Data Report Form.

Telephonic Survey Script (General)

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.[23] 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.

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.

[23] If additional Department-approved questions are included, revise the time it is anticipated to take the survey, as appropriate.

Question 1: [24]

"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?" *[Record this information in "Question 1" field of the applicable Raw Data Report Form.]*

Date: mm/dd/yy
Time: hh:mm am/pm PT
_____ Not applicable. This provider does not offer urgent care appointments.
_____ Not applicable. This provider is not scheduling appointments because he or she is out of the office on leave.

Calculation 1: [25]

Calculate whether the appointment date and time in Question 1 is within 48 hours for Primary Care Providers or 96 hours for Non-Physician Mental Health Care Providers, Specialist Physicians, and Psychiatrists of this request for an appointment. Calculate the number of hours between the date and time of the request for the appointment and the date and time of the available appointment. Where an urgent care appointment wait time expires on a weekend or holiday, the provider shall be recorded as compliant on the Raw Data Report Form if the provider has an appointment available during the next business day. Record on the Raw Data Report Form in the "Calculation 1" field pertaining to the urgent care whether the provider's next available appointment is available 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 (Non-Physician Mental Health Care Providers, 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 (Non-Physician Mental Health Care Providers, Specialist Physicians, and Psychiatrists). (Mark "N" if the provider is not scheduling appointments while he or she 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.)

[24] 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.
[25] 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.

Question 2:

"When is the next available appointment date and time with [Provider Name or FQHC/RHC Name] for non-urgent services?" *[Record this information in "Question 2"* [26] *field of the applicable Raw Data Report Form.]*

Date: mm/dd/yy
Time: hh:mm am/pm PT
_____ Not applicable. This provider does not offer non-urgent appointments.
_____ Not applicable. This provider is not scheduling appointments because he or she is out of the office on leave.

Calculation 2:

Calculate whether the appointment date and time in Question 2 is available within 15 business days (calculated as 21 calendar days) for Specialist Physicians, Psychiatrist and Ancillary Service Providers or within 10 business days (calculated as 14 calendar days) for Primary Care Providers and Non-Physician Mental Health Care Providers of this request for an appointment. [27] *Indicate on the Raw Data Report Form in the "Calculation 2"* [28] *field pertaining to the provider's next available non-urgent appointment whether the provider's next available appointment is available within the appropriate wait time standard:*

- *Mark "Y" to indicate yes, there is an available non-urgent appointment within 10 business days (Primary Care Providers and Non-Physician Mental Health 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 and Non-Physician Mental Health Care Providers) or 15 business days (Specialist Physicians, Psychiatrists, and Ancillary Service Providers). (Mark "N" if the provider is not scheduling appointments while he or she 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.)

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[26] Urgent care appointments questions are not included in the survey of Ancillary Service Providers. As a result, the plan shall record this information in the "Question 1" field on the Ancillary Service Provider Raw Data Report Form.
[27] When calculating calendar days exclude the first day (e.g., the day of request) and include the last day. Weekends, Saturday, and Sunday shall be included when calculating calendar 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.
[28] Urgent care appointments questions are not included in the survey of Ancillary Service Providers. As a result, the plan shall record this information in the "Calculation 1" field on the Ancillary Service Provider Raw Data Report Form.

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

ANCILLARY SERVICE PROVIDERS CONTACT LIST REPORT FORM
HEALTH PLAN INFORMATION

Complete the information requested below before submission to the Department of Managed Health Care.

Reporting Plan Name:	
Subcontracted Plan Name (If any)	
Measurement Year:	
Name of Survey Administrator:	
Name of Quality Assurance Vendor:	
Date Contact List Generated:	

Ancillary Service Providers Contact List Report Form						
Form No. 40-258						
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Entity or Facility Name	DBA
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Ancillary Service Providers Contact List Report Form						
Form No. 40-258						
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Entity or Facility Name	DBA
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Ancillary Service Providers Contact List Report Form						
Form No. 40-258						
Row #	FQHC/RHC Name	NPI	Provider Type	Provider Group	Practice Address	Practice Address 2
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Ancillary Service Providers Contact List Report Form						
Form No. 40-258						
Row #	FQHC/RHC Name	NPI	Provider Type	Provider Group	Practice Address	Practice Address 2
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Ancillary Service Providers Contact List Report Form							
Form No. 40-258							
Row #	City	County	State	Zip Code	Phone Number 1	Phone Number 2	Phone Number 3
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Ancillary Service Providers Contact List Report Form							
Form No. 40-258							
Row #	City	County	State	Zip Code	Phone Number 1	Phone Number 2	Phone Number 3
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Ancillary Service Providers Contact List Report Form						
Form No. 40-258						
Row #	Fax Number 1	Fax Number 2	Fax Number 3	Email Address 1	Email Address 2	Email Address 3
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Ancillary Service Providers Contact List Report Form						
Form No. 40-258						
Row #	Fax Number 1	Fax Number 2	Fax Number 3	Email Address 1	Email Address 2	Email Address 3
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Ancillary Service Providers Contact List Report Form					
Form No. 40-258					
Row #	Displayed in Provider Directory	Unique Provider	Provider Survey Type	Comments 1	Comments 2
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Ancillary Service Providers Contact List Report Form					
Form No. 40-258					
Row #	Displayed in Provider Directory	Unique Provider	Provider Survey Type	Comments 1	Comments 2
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ANCILLARY SERVICE PROVIDERS RAW DATA REPORT FORM
HEALTH PLAN INFORMATION

Complete the information requested below before submission to the Department of Managed Health Care.

Reporting Plan Name:	
Subcontracted Plan Name (If any)	
Measurement Year:	
Name of Survey Administrator:	
Name of Quality Assurance Vendor:	

Ancillary Service Providers Raw Data Report Form

Form No. 40-263

Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Entity or Facility Name	DBA
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Ancillary Service Providers Raw Data Report Form						
Form No. 40-263						
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Entity or Facility Name	DBA
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Ancillary Service Providers Raw Data Report Form						
Form No. 40-263						
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Entity or Facility Name	DBA
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Ancillary Service Providers Raw Data Report Form

Form No. 40-263

Row #	FQHC/RHC Name	NPI	Provider Type	Provider Group	Practice Address	Practice Address 2
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Ancillary Service Providers Raw Data Report Form						
Form No. 40-263						
Row #	FQHC/RHC Name	NPI	Provider Type	Provider Group	Practice Address	Practice Address 2
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Ancillary Service Providers Raw Data Report Form						
Form No. 40-263						
Row #	FQHC/RHC Name	NPI	Provider Type	Provider Group	Practice Address	Practice Address 2
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Ancillary Service Providers Raw Data Report Form

Form No. 40-263

Row #	City	County	State	Zip Code	Phone Number 1	Phone Number 2
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Ancillary Service Providers Raw Data Report Form						
Form No. 40-263						
Row #	City	County	State	Zip Code	Phone Number 1	Phone Number 2
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Ancillary Service Providers Raw Data Report Form						
Form No. 40-263						
Row #	City	County	State	Zip Code	Phone Number 1	Phone Number 2
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Ancillary Service Providers Raw Data Report Form

Form No. 40-263

Row #	Phone Number 3	Fax Number 1	Fax Number 2	Fax Number 3	Email Address 1	Email Address 2
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Ancillary Service Providers Raw Data Report Form

Form No. 40-263

Row #	Phone Number 3	Fax Number 1	Fax Number 2	Fax Number 3	Email Address 1	Email Address 2
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Ancillary Service Providers Raw Data Report Form						
Form No. 40-263						
Row #	Phone Number 3	Fax Number 1	Fax Number 2	Fax Number 3	Email Address 1	Email Address 2
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Ancillary Service Providers Raw Data Report Form						
Form No. 40-263						
Row #	Email Address 3	Provider Survey Type	Survey Modality	Sample Type	Outcome	Survey Completed via
1						
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Ancillary Service Providers Raw Data Report Form						
Form No. 40-263						
Row #	Email Address 3	Provider Survey Type	Survey Modality	Sample Type	Outcome	Survey Completed via
19						
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Ancillary Service Providers Raw Data Report Form						
Form No. 40-263						
Row #	Email Address 3	Provider Survey Type	Survey Modality	Sample Type	Outcome	Survey Completed via
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Ancillary Service Providers Raw Data Report Form

Form No. 40-263

Row #	Date Survey Initiated	Date Survey Completed	Time Survey Completed	Name of Individual Conducting the Survey	Person Spoken to
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Ancillary Service Providers Raw Data Report Form					
Form No. 40-263					
Row #	Date Survey Initiated	Date Survey Completed	Time Survey Completed	Name of Individual Conducting the Survey	Person Spoken to
19					
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Ancillary Service Providers Raw Data Report Form					
Form No. 40-263					
Row #	Date Survey Initiated	Date Survey Completed	Time Survey Completed	Name of Individual Conducting the Survey	Person Spoken to
37					
38					
39					
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Ancillary Service Providers Raw Data Report Form						
Form No. 40-263						
Row #	Question 1 - When is the next available appointment date with [Provider Name] for a non-urgent appointment?	Question 1 - When is the next available appointment time with [Provider Name] for a non-urgent appointment?	Calculation 1 - Yes, there is an available non-urgent appointment within 15 business days. No, there is no available non-urgent appointment within 15 business days.	Comments 1	Comments 2	Comments 3
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Ancillary Service Providers Raw Data Report Form						
Form No. 40-263						
Row #	Question 1 - When is the next available appointment date with [Provider Name] for a non-urgent appointment?	Question 1 - When is the next available appointment time with [Provider Name] for a non-urgent appointment?	Calculation 1 - Yes, there is an available non-urgent appointment within 15 business days. No, there is no available non-urgent appointment within 15 business days.	Comments 1	Comments 2	Comments 3
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Ancillary Service Providers Raw Data Report Form						
Form No. 40-263						
Row #	Question 1 - When is the next available appointment date with [Provider Name] for a non-urgent appointment?	Question 1 - When is the next available appointment time with [Provider Name] for a non-urgent appointment?	Calculation 1 - Yes, there is an available non-urgent appointment within 15 business days. No, there is no available non-urgent appointment within 15 business days.	Comments 1	Comments 2	Comments 3
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Hospital and Clinic Report Form					
Form No. 40-270					
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Hospital Name
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Hospital and Clinic Report Form					
Form No. 40-270					
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Hospital Name
31					
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Hospital and Clinic Report Form
Form No. 40-267

Row #	DBA	NPI	CA License	Non-CA License	Non-CA License State	Hospital Type
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Hospital and Clinic Report Form
Form No. 40-267

Row #	DBA	NPI	CA License	Non-CA License	Non-CA License State	Hospital Type
31						
32						
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Hospital and Clinic Report Form
Form No. 40-267

Row #	Network Tier ID	Hospital System	Practice Address	Practice Address 2	City
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Hospital and Clinic Report Form
Form No. 40-267

Row #	Network Tier ID	Hospital System	Practice Address	Practice Address 2	City
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32					
33					
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Hospital and Clinic Report Form
Form No. 40-267

Row #	County	State	ZIP Code	Type of Care	Displayed in Provider Directory
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Hospital and Clinic Report Form
Form No. 40-267

Row #	County	State	ZIP Code	Type of Care	Displayed in Provider Directory
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Hospital and Clinic Report Form					
Form No. 40-270					
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Clinic Name
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Hospital and Clinic Report Form					
Form No. 40-270					
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Clinic Name
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Hospital and Clinic Report Form						
Form No. 40-267						
Row #	DBA	NPI	CA License	Non-CA License	Non-CA License State	Clinic Type
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Hospital and Clinic Report Form						
Form No. 40-267						
Row #	DBA	NPI	CA License	Non-CA License	Non-CA License State	Clinic Type
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Hospital and Clinic Report Form						
Form No. 40-267						
Row #	Number of Enrollees Assigned to Provider	Network Tier ID	Practice Address	Practice Address 2	City	County
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Hospital and Clinic Report Form						
Form No. 40-267						
Row #	Number of Enrollees Assigned to Provider	Network Tier ID	Practice Address	Practice Address 2	City	County
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Hospital and Clinic Report Form						
Form No. 40-267						
Row #	State	ZIP Code	Phone Number	Accepting New Patients	Displayed in Provider Directory	Unscheduled Urgent Services
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Hospital and Clinic Report Form						
Form No. 40-267						
Row #	State	ZIP Code	Phone Number	Accepting New Patients	Displayed in Provider Directory	Unscheduled Urgent Services
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Mental Health Professional and Mental Health Facility Report Form					
Form No. 40-268					
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name
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Mental Health Professional and Mental Health Facility Report Form					
Form No. 40-268					
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name
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Mental Health Professional and Mental Health Facility Report Form
Form No. 40-269

Row #	First Name	NPI	CA License / Certificate	Non-CA License / Certificate	Non-CA License / Certificate State	Type of License / Certificate
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Mental Health Professional and Mental Health Facility Report Form
Form No. 40-269

Row #	First Name	NPI	CA License / Certificate	Non-CA License / Certificate	Non-CA License / Certificate State	Type of License / Certificate
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Mental Health Professional and Mental Health Facility Report Form
Form No. 40-269

Row #	Specialty	Provider Group	Network Tier ID	Full-Time / Part-Time	Facility	Facility NPI	Provider Language 1
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Mental Health Professional and Mental Health Facility Report Form
Form No. 40-269

Row #	Specialty	Provider Group	Network Tier ID	Full-Time / Part-Time	Facility	Facility NPI	Provider Language 1
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Mental Health Professional and Mental Health Facility Report Form
Form No. 40-269

Row #	Provider Language 2	Provider Language 3	Practice Address	Practice Address 2	City	County	State
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Mental Health Professional and Mental Health Facility Report Form
Form No. 40-269

Row #	Provider Language 2	Provider Language 3	Practice Address	Practice Address 2	City	County	State
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Mental Health Professional and Mental Health Facility Report Form
Form No. 40-269

Row #	ZIP Code	Phone Number	Accepting New Patients or Referrals	Displayed in Provider Directory	In-Person Appointments	E-mail Address
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Mental Health Professional and Mental Health Facility Report Form
Form No. 40-269

Row #	ZIP Code	Phone Number	Accepting New Patients or Referrals	Displayed in Provider Directory	In-Person Appointments	E-mail Address
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Mental Health Professional and Mental Health Facility Report Form					
Form No. 40-268					
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Mental Health Facility Name
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Mental Health Professional and Mental Health Facility Report Form					
Form No. 40-268					
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Mental Health Facility Name
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Mental Health Professional and Mental Health Facility Report Form						
Form No. 40-269						
Row #	DBA	NPI	CA License	Non-CA License	Non-CA License State	Mental Health Facility Type
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Mental Health Professional and Mental Health Facility Report Form						
Form No. 40-269						
Row #	DBA	NPI	CA License	Non-CA License	Non-CA License State	Mental Health Facility Type
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Mental Health Professional and Mental Health Facility Report Form							
Form No. 40-269							
Row #	Network Tier ID	Practice Address	Practice Address 2	City	County	State	ZIP Code
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Mental Health Professional and Mental Health Facility Report Form							
Form No. 40-269							
Row #	Network Tier ID	Practice Address	Practice Address 2	City	County	State	ZIP Code
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Mental Health Professional and Mental Health Facility Report Form					
Form No. 40-269					
Row #	Phone Number	Accepting New Patients or Referrals	Displayed in Provider Directory		
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Mental Health Professional and Mental Health Facility Report Form					
Form No. 40-269					
Row #	Phone Number	Accepting New Patients or Referrals	Displayed in Provider Directory		
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Network Service Area and Enrollment Report Form
Form No. 40-265

Row #	Network Name	Network ID	Product Line	County	ZIP Code
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Network Service Area and Enrollment Report Form
Form No. 40-265

Row #	Network Name	Network ID	Product Line	County	ZIP Code
32					
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Network Service Area and Enrollment Report Form					
Form No. 40-265					
Row #	Network Name	Network ID	Product Line	Subcontracted Plan License Number	Subcontracted Plan Network ID
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Network Service Area and Enrollment Report Form					
Form No. 40-265					
Row #	Network Name	Network ID	Product Line	Subcontracted Plan License Number	Subcontracted Plan Network ID
29					
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Network Service Area and Enrollment Report Form					
Form No. 270					
Row #	County	ZIP Code	Number of Enrollees	Number of Subcontracted Plan Enrollees	Inside / Outside Approved Service Area
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Network Service Area and Enrollment Report Form					
Form No. 270					
Row #	County	ZIP Code	Number of Enrollees	Number of Subcontracted Plan Enrollees	Inside / Outside Approved Service Area
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NON-PHYSICIAN MENTAL HEALTH CARE PROVIDERS RAW DATA REPORT FORM
HEALTH PLAN INFORMATION

Complete the information requested below before submission to the Department of Managed Health Care.

Reporting Plan Name:	
Subcontracted Plan Name (If any)	
Measurement Year:	
Name of Survey Administrator:	
Name of Quality Assurance Vendor:	

Non-Physician Mental Health Care Providers Raw Data Report Form						
Form No. 40-260						
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name	First Name
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Non-Physician Mental Health Care Providers Raw Data Report Form						
Form No. 40-260						
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name	First Name
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Non-Physician Mental Health Care Providers Raw Data Report Form						
Form No. 40-260						
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name	First Name
45						
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Non-Physician Mental Health Care Providers Raw Data Report Form						
Form No. 40-260						
Row #	FQHC/RHC Name	NPI	CA License / Certificate	Non-CA License / Certificate	Non-CA License / Certificate State	Type of License / Certificate
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Non-Physician Mental Health Care Providers Raw Data Report Form						
Form No. 40-260						
Row #	FQHC/RHC Name	NPI	CA License / Certificate	Non-CA License / Certificate	Non-CA License / Certificate State	Type of License / Certificate
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Non-Physician Mental Health Care Providers Raw Data Report Form						
Form No. 40-260						
Row #	FQHC/RHC Name	NPI	CA License / Certificate	Non-CA License / Certificate	Non-CA License / Certificate State	Type of License / Certificate
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Non-Physician Mental Health Care Providers Raw Data Report Form						
Form No. 40-260						
Row #	Specialty	Provider Group	Practice Address	Practice Address 2	City	County
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Non-Physician Mental Health Care Providers Raw Data Report Form						
Form No. 40-260						
Row #	Specialty	Provider Group	Practice Address	Practice Address 2	City	County
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Non-Physician Mental Health Care Providers Raw Data Report Form						
Form No. 40-260						
Row #	Specialty	Provider Group	Practice Address	Practice Address 2	City	County
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Non-Physician Mental Health Care Providers Raw Data Report Form						
Form No. 40-260						
Row #	State	Zip Code	Phone Number 1	Phone Number 2	Phone Number 3	Fax Number 1
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Non-Physician Mental Health Care Providers Raw Data Report Form						
Form No. 40-260						
Row #	State	Zip Code	Phone Number 1	Phone Number 2	Phone Number 3	Fax Number 1
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Non-Physician Mental Health Care Providers Raw Data Report Form						
Form No. 40-260						
Row #	State	Zip Code	Phone Number 1	Phone Number 2	Phone Number 3	Fax Number 1
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Non-Physician Mental Health Care Providers Raw Data Report Form						
Form No. 40-260						
Row #	Fax Number 2	Fax Number 3	Email Address 1	Email Address 2	Email Address 3	Provider Survey Type
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Non-Physician Mental Health Care Providers Raw Data Report Form						
Form No. 40-260						
Row #	Fax Number 2	Fax Number 3	Email Address 1	Email Address 2	Email Address 3	Provider Survey Type
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Non-Physician Mental Health Care Providers Raw Data Report Form						
Form No. 40-260						
Row #	Fax Number 2	Fax Number 3	Email Address 1	Email Address 2	Email Address 3	Provider Survey Type
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Non-Physician Mental Health Care Providers Raw Data Report Form						
Form No. 40-260						
Row #	Survey Modality	Sample Type	Outcome	Survey Completed via	Date Survey Initiated	Date Survey Completed
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Non-Physician Mental Health Care Providers Raw Data Report Form						
Form No. 40-260						
Row #	Survey Modality	Sample Type	Outcome	Survey Completed via	Date Survey Initiated	Date Survey Completed
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Non-Physician Mental Health Care Providers Raw Data Report Form						
Form No. 40-260						
Row #	Survey Modality	Sample Type	Outcome	Survey Completed via	Date Survey Initiated	Date Survey Completed
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Non-Physician Mental Health Care Providers Raw Data Report Form						
Form No. 40-260						
Row #	Time Survey Completed	Name of Individual Conducting the Survey	Person Spoken to	Question 1 - When is the next available appointment date with [Provider Name] for an urgent care appointment?	Question 1 - When is the next available appointment time with [Provider Name] for an urgent care appointment?	Calculation 1 - Yes, there is an available urgent care appointment within 96 hours. No, there is no available urgent care appointment within 96 hours.
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Non-Physician Mental Health Care Providers Raw Data Report Form						
Form No. 40-260						
Row #	Time Survey Completed	Name of Individual Conducting the Survey	Person Spoken to	Question 1 - When is the next available appointment date with [Provider Name] for an urgent care appointment?	Question 1 - When is the next available appointment time with [Provider Name] for an urgent care appointment?	Calculation 1 - Yes, there is an available urgent care appointment within 96 hours. No, there is no available urgent care appointment within 96 hours.
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Non-Physician Mental Health Care Providers Raw Data Report Form						
Form No. 40-260						
Row #	Time Survey Completed	Name of Individual Conducting the Survey	Person Spoken to	Question 1 - When is the next available appointment date with [Provider Name] for an urgent care appointment?	Question 1 - When is the next available appointment time with [Provider Name] for an urgent care appointment?	Calculation 1 - Yes, there is an available urgent care appointment within 96 hours. No, there is no available urgent care appointment within 96 hours.
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Non-Physician Mental Health Care Providers Raw Data Report Form						
Form No. 40-260						
Row #	Question 2 - When is the next available appointment date with [Provider Name] for a non-urgent appointment?	Question 2 - When is the next available appointment time with [Provider Name] for a non-urgent appointment?	Calculation 2 - Yes, there is an available non-urgent appointment within 10 business days. No, there is no available non-urgent appointment within 10 business days.	Comments 1	Comments 2	Comments 3
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Non-Physician Mental Health Care Providers Raw Data Report Form						
Form No. 40-260						
Row #	Question 2 - When is the next available appointment date with [Provider Name] for a non-urgent appointment?	Question 2 - When is the next available appointment time with [Provider Name] for a non-urgent appointment?	Calculation 2 - Yes, there is an available non-urgent appointment within 10 business days. No, there is no available non-urgent appointment within 10 business days.	Comments 1	Comments 2	Comments 3
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Non-Physician Mental Health Care Providers Raw Data Report Form						
Form No. 40-260						
Row #	Question 2 - When is the next available appointment date with [Provider Name] for a non-urgent appointment?	Question 2 - When is the next available appointment time with [Provider Name] for a non-urgent appointment?	Calculation 2 - Yes, there is an available non-urgent appointment within 10 business days. No, there is no available non-urgent appointment within 10 business days.	Comments 1	Comments 2	Comments 3
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Other Outpatient Provider Report Form					
Form No. 40-269					
Row #	Name of Network	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name
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Other Outpatient Provider Report Form					
Form No. 40-269					
Row #	Name of Network	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name
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Other Outpatient Provider Report Form
Form No. 40-268

Row #	First Name	Individual NPI	CA License	Non-CA License	Non-CA License State	Provider Group
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Other Outpatient Provider Report Form
Form No. 40-268

Row #	First Name	Individual NPI	CA License	Non-CA License	Non-CA License State	Provider Group
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Other Outpatient Provider Report Form
Form No. 40-268

Row #	Entity Name	Entity DBA	Entity NPI	Network Tier ID	Facility	Facility NPI
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Other Outpatient Provider Report Form
Form No. 40-268

Row #	Entity Name	Entity DBA	Entity NPI	Network Tier ID	Facility	Facility NPI
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Other Outpatient Provider Report Form
Form No. 40-268

Row #	Provider Type	Provider Language 1	Provider Language 2	Provider Language 3	Practice Address	Practice Address 2
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Other Outpatient Provider Report Form
Form No. 40-268

Row #	Provider Type	Provider Language 1	Provider Language 2	Provider Language 3	Practice Address	Practice Address 2
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Other Outpatient Provider Report Form						
Form No. 40-268						
Row #	City	County	State	ZIP Code	Phone Number	Accepting New Patients
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Other Outpatient Provider Report Form						
Form No. 40-268						
Row #	City	County	State	ZIP Code	Phone Number	Accepting New Patients
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Other Outpatient Provider Report Form				
Form No. 40-268				
Row #	Displayed in Provider Directory	In-Person Appointments	Unscheduled Urgent Services	E-mail Address
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Other Outpatient Provider Report Form				
Form No. 40-268				
Row #	Displayed in Provider Directory	In-Person Appointments	Unscheduled Urgent Services	E-mail Address
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Out-Of-Network Payment Report Form					
Form No. 40-273					
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Non-Contracted Provider Last Name
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Out-Of-Network Payment Report Form					
Form No. 40-273					
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Non-Contracted Provider Last Name
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Out-Of-Network Payment Report Form				
Form No. 40-273				
Row #	Non-Contracted Provider First Name	Non-Contracted Provider NPI	Contracting Facility Name	Number of Payments Made at Contracting Facility
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Out-Of-Network Payment Report Form				
Form No. 40-273				
Row #	Non-Contracted Provider First Name	Non-Contracted Provider NPI	Contracting Facility Name	Number of Payments Made at Contracting Facility
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Out-Of-Network Payment Report Form				
Form No. 40-273				
Row #	Contracting Facility Name	Number of Non-Contracted Providers at Facility	Number of Contracted Providers at Facility	Proportion of Non-Contracted to Contracted Providers
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Out-Of-Network Payment Report Form				
Form No. 40-273				
Row #	Contracting Facility Name	Number of Non-Contracted Providers at Facility	Number of Contracted Providers at Facility	Proportion of Non-Contracted to Contracted Providers
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PCP and PCP Non-Physician Medical Practitioner Report Form				
Form No. 40-266				
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID
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PCP and PCP Non-Physician Medical Practitioner Report Form				
Form No. 40-266				
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID
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PCP and PCP Non-Physician Medical Practitioner Report Form						
Form No. 40-265						
Row #	Last Name	First Name	NPI	CA License	Non-CA License	Non-CA License State
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PCP and PCP Non-Physician Medical Practitioner Report Form						
Form No. 40-265						
Row #	Last Name	First Name	NPI	CA License	Non-CA License	Non-CA License State
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PCP and PCP Non-Physician Medical Practitioner Report Form						
Form No. 40-265						
Row #	License Type	Number of Enrollees Assigned to Provider	Specialty	Board Certified / Eligible	Provider Group	Network Tier ID
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PCP and PCP Non-Physician Medical Practitioner Report Form						
Form No. 40-265						
Row #	License Type	Number of Enrollees Assigned to Provider	Specialty	Board Certified / Eligible	Provider Group	Network Tier ID
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PCP and PCP Non-Physician Medical Practitioner Report Form						
Form No. 40-265						
Row #	Full-Time / Part-Time	Facility	Facility NPI	Provider Language 1	Provider Language 2	Provider Language 3
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PCP and PCP Non-Physician Medical Practitioner Report Form						
Form No. 40-265						
Row #	Full-Time / Part-Time	Facility	Facility NPI	Provider Language 1	Provider Language 2	Provider Language 3
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PCP and PCP Non-Physician Medical Practitioner Report Form							
Form No. 40-265							
Row #	Practice Address	Practice Address 2	City	County	State	ZIP Code	Phone Number
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PCP and PCP Non-Physician Medical Practitioner Report Form							
Form No. 40-265							
Row #	Practice Address	Practice Address 2	City	County	State	ZIP Code	Phone Number
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PCP and PCP Non-Physician Medical Practitioner Report Form					
Form No. 40-265					
Row #	Clinic Name	Accepting New Patients	Displayed in Provider Directory	In-Person Appointments	Unscheduled Urgent Services
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PCP and PCP Non-Physician Medical Practitioner Report Form					
Form No. 40-265					
Row #	Clinic Name	Accepting New Patients	Displayed in Provider Directory	In-Person Appointments	Unscheduled Urgent Services
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PCP and PCP Non-Physician Medical Practitioner Report Form	
Form No. 40-265	
Row #	E-mail Address
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PCP and PCP Non-Physician Medical Practitioner Report Form	
Form No. 40-265	
Row #	E-mail Address
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PCP and PCP Non-Physician Medical Practitioner Report Form
Form No. 40-266

Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name
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PCP and PCP Non-Physician Medical Practitioner Report Form
Form No. 40-266

Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name
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PCP and PCP Non-Physician Medical Practitioner Report Form
Form No. 40-265

Row #	First Name	NPI	CA License	License Type	Enrollees Assigned to Provider	NPI of Supervising PCP
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PCP and PCP Non-Physician Medical Practitioner Report Form
Form No. 40-265

Row #	First Name	NPI	CA License	License Type	Enrollees Assigned to Provider	NPI of Supervising PCP
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PCP and PCP Non-Physician Medical Practitioner Report Form
Form No. 40-265

Row #	Provider Group	Network Tier ID	Full-Time / Part-Time	Provider Language 1	Provider Language 2
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PCP and PCP Non-Physician Medical Practitioner Report Form
Form No. 40-265

Row #	Provider Group	Network Tier ID	Full-Time / Part-Time	Provider Language 1	Provider Language 2
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PCP and PCP Non-Physician Medical Practitioner Report Form
Form No. 40-265

Row #	Provider Language 3	Practice Address	Practice Address 2	City	County	State
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PCP and PCP Non-Physician Medical Practitioner Report Form
Form No. 40-265

Row #	Provider Language 3	Practice Address	Practice Address 2	City	County	State
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PCP and PCP Non-Physician Medical Practitioner Report Form
Form No. 40-265

Row #	ZIP Code	Phone Number	Clinic Name	Accepting New Patients or Referrals	Displayed in Provider Directory	In-Person Appointments
1						
2						
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PCP and PCP Non-Physician Medical Practitioner Report Form
Form No. 40-265

Row #	ZIP Code	Phone Number	Clinic Name	Accepting New Patients or Referrals	Displayed in Provider Directory	In-Person Appointments
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PCP and PCP Non-Physician Medical Practitioner Report Form
Form No. 40-265

Row #	Unscheduled Urgent Services	E-mail Address
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PCP and PCP Non-Physician Medical Practitioner Report Form
Form No. 40-265

Row #	Unscheduled Urgent Services	E-mail Address
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PRIMARY CARE PHYSICIANS AND PROVIDERS CONTACT LIST REPORT FORM
HEALTH PLAN INFORMATION

Complete the information requested below before submission to the Department of Managed Health Care.

Reporting Plan Name:	
Subcontracted Plan Name (If any)	
Measurement Year:	
Name of Survey Administrator:	
Name of Quality Assurance Vendor:	
Date Contact List Generated:	

Primary Care Providers Contact List Report Form							
Form No. 40-254							
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name	First Name	FQHC/RHC Name
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Primary Care Providers Contact List Report Form							
Form No. 40-254							
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name	First Name	FQHC/RHC Name
27							
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Primary Care Providers Contact List Report Form							
Form No. 40-254							
Row #	NPI	CA License	Non-CA License	Non-CA License State	License Type	Specialty	NPI of Supervising PCP
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Primary Care Providers Contact List Report Form							
Form No. 40-254							
Row #	NPI	CA License	Non-CA License	Non-CA License State	License Type	Specialty	NPI of Supervising PCP
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Primary Care Providers Contact List Report Form							
Form No. 40-254							
Row #	Board Certified / Eligible	Provider Group	Practice Address	Practice Address 2	City	County	State
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Primary Care Providers Contact List Report Form							
Form No. 40-254							
Row #	Board Certified / Eligible	Provider Group	Practice Address	Practice Address 2	City	County	State
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Primary Care Providers Contact List Report Form							
Form No. 40-254							
Row #	Zip Code	Phone Number 1	Phone Number 2	Phone Number 3	Fax Number 1	Fax Number 2	Fax Number 3
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Primary Care Providers Contact List Report Form							
Form No. 40-254							
Row #	Zip Code	Phone Number 1	Phone Number 2	Phone Number 3	Fax Number 1	Fax Number 2	Fax Number 3
27							
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Primary Care Providers Contact List Report Form							
Form No. 40-254							
Row #	Email Address 1	Email Address 2	Email Address 3	Displayed in Provider Directory	Unique Provider	Advanced Access Provider	Qualified Advanced Access Provider
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Primary Care Providers Contact List Report Form							
Form No. 40-254							
Row #	Email Address 1	Email Address 2	Email Address 3	Displayed in Provider Directory	Unique Provider	Advanced Access Provider	Qualified Advanced Access Provider
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Primary Care Providers Contact List Report Form			
Form No. 40-254			
Row #	Provider Survey Type	Comments 1	Comments 2
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Primary Care Providers Contact List Report Form			
Form No. 40-254			
Row #	Provider Survey Type	Comments 1	Comments 2
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PRIMARY CARE PHYSICIANS AND PROVIDERS RAW DATA REPORT FORM
HEALTH PLAN INFORMATION

Complete the information requested below before submission to the Department of Managed Health Care.

Reporting Plan Name:	
Subcontracted Plan Name (If any)	
Measurement Year:	
Name of Survey Administrator:	
Name of Quality Assurance Vendor:	

Primary Care Providers Raw Data Report Form

Form No. 40-259

Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name	First Name
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Primary Care Providers Raw Data Report Form
Form No. 40-259

Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name	First Name
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Primary Care Providers Raw Data Report Form
Form No. 40-259

Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name	First Name
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Primary Care Providers Raw Data Report Form

Form No. 40-259

Row #	FQHC/RHC Name	NPI	CA License	Non-CA License	Non-CA License State	License Type
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Primary Care Providers Raw Data Report Form
Form No. 40-259

Row #	FQHC/RHC Name	NPI	CA License	Non-CA License	Non-CA License State	License Type
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Primary Care Providers Raw Data Report Form
Form No. 40-259

Row #	FQHC/RHC Name	NPI	CA License	Non-CA License	Non-CA License State	License Type
45						
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Primary Care Providers Raw Data Report Form

Form No. 40-259

Row #	Specialty	NPI of Supervising PCP	Board Certified / Eligible	Provider Group	Practice Address	Practice Address 2
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Primary Care Providers Raw Data Report Form
Form No. 40-259

Row #	Specialty	NPI of Supervising PCP	Board Certified / Eligible	Provider Group	Practice Address	Practice Address 2
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Primary Care Providers Raw Data Report Form

Form No. 40-259

Row #	Specialty	NPI of Supervising PCP	Board Certified / Eligible	Provider Group	Practice Address	Practice Address 2
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Primary Care Providers Raw Data Report Form

Form No. 40-259

Row #	County	State	Zip Code	Phone Number 1	Phone Number 2	Phone Number 3
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Primary Care Providers Raw Data Report Form
Form No. 40-259

Row #	County	State	Zip Code	Phone Number 1	Phone Number 2	Phone Number 3
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Primary Care Providers Raw Data Report Form
Form No. 40-259

Row #	County	State	Zip Code	Phone Number 1	Phone Number 2	Phone Number 3
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Primary Care Providers Raw Data Report Form
Form No. 40-259

Row #	Fax Number 1	Fax Number 2	Fax Number 3	Email Address 1	Email Address 2	Email Address 3
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Primary Care Providers Raw Data Report Form
Form No. 40-259

Row #	Fax Number 1	Fax Number 2	Fax Number 3	Email Address 1	Email Address 2	Email Address 3
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Primary Care Providers Raw Data Report Form
Form No. 40-259

Row #	Fax Number 1	Fax Number 2	Fax Number 3	Email Address 1	Email Address 2	Email Address 3
45						
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Primary Care Providers Raw Data Report Form

Form No. 40-259

Row #	Qualified Advanced Access Provider	Provider Survey Type	Survey Modality	Sample Type	Outcome	Survey Completed via
1						
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Primary Care Providers Raw Data Report Form
Form No. 40-259

Row #	Qualified Advanced Access Provider	Provider Survey Type	Survey Modality	Sample Type	Outcome	Survey Completed via
23						
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Primary Care Providers Raw Data Report Form

Form No. 40-259

Row #	Qualified Advanced Access Provider	Provider Survey Type	Survey Modality	Sample Type	Outcome	Survey Completed via
45						
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Primary Care Providers Raw Data Report Form

Form No. 40-259

Row #	Date Survey Initiated	Date Survey Completed	Time Survey Completed	Name of Individual Conducting the Survey	Person Spoken to	Question 1 - When is the next available appointment date with [Provider Name] for an urgent care appointment?
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Primary Care Providers Raw Data Report Form
Form No. 40-259

Row #	Date Survey Initiated	Date Survey Completed	Time Survey Completed	Name of Individual Conducting the Survey	Person Spoken to	Question 1 - When is the next available appointment date with [Provider Name] for an urgent care appointment?
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Primary Care Providers Raw Data Report Form

Form No. 40-259

Row #	Date Survey Initiated	Date Survey Completed	Time Survey Completed	Name of Individual Conducting the Survey	Person Spoken to	Question 1 - When is the next available appointment date with [Provider Name] for an urgent care appointment?
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Primary Care Providers Raw Data Report Form

Form No. 40-259

Row #	Question 1 - When is the next available appointment time with [Provider Name] for an urgent care appointment?	Calculation 1 - Yes, there is an available urgent care appointment within 48 hours. No, there is no available urgent care appointment within 48 hours.	Question 2 - When is the next available appointment date with [Provider Name] for a non-urgent appointment?	Question 2 - When is the next available appointment time with [Provider Name] for a non-urgent appointment?	Calculation 2 - Yes, there is an available non-urgent appointment within 10 business days. No, there is no available non-urgent appointment within 10 business days.	Comments 1
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Primary Care Providers Raw Data Report Form

Form No. 40-259

Row #	Question 1 - When is the next available appointment time with [Provider Name] for an urgent care appointment?	Calculation 1 - Yes, there is an available urgent care appointment within 48 hours. No, there is no available urgent care appointment within 48 hours.	Question 2 - When is the next available appointment date with [Provider Name] for a non-urgent appointment?	Question 2 - When is the next available appointment time with [Provider Name] for a non-urgent appointment?	Calculation 2 - Yes, there is an available non-urgent appointment within 10 business days. No, there is no available non-urgent appointment within 10 business days.	Comments 1
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Primary Care Providers Raw Data Report Form

Form No. 40-259

Row #	Question 1 - When is the next available appointment time with [Provider Name] for an urgent care appointment?	Calculation 1 - Yes, there is an available urgent care appointment within 48 hours. No, there is no available urgent care appointment within 48 hours.	Question 2 - When is the next available appointment date with [Provider Name] for a non-urgent appointment?	Question 2 - When is the next available appointment time with [Provider Name] for a non-urgent appointment?	Calculation 2 - Yes, there is an available non-urgent appointment within 10 business days. No, there is no available non-urgent appointment within 10 business days.	Comments 1
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Primary Care Providers Raw Data Report Form
Form No. 40-259

Row #	Comments 2	Comments 3
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Primary Care Providers Raw Data Report Form
Form No. 40-259

Row #	Comments 2	Comments 3
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Primary Care Providers Raw Data Report Form
Form No. 40-259

Row #	Comments 2	Comments 3
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PSYCHIATRISTS RAW DATA REPORT FORM
HEALTH PLAN INFORMATION

Reporting Plan Name:	
Subcontracted Plan Name (If any)	
Measurement Year:	
Name of Survey Administrator:	
Name of Quality Assurance Vendor:	

Psychiatrists Raw Data Report Form

Form No. 40-262

Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name	First Name
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Psychiatrists Raw Data Report Form						
Form No. 40-262						
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name	First Name
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Psychiatrists Raw Data Report Form						
Form No. 40-262						
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name	First Name
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Psychiatrists Raw Data Report Form

Form No. 40-262

Row #	FQHC/RHC Name	NPI	CA License	Non-CA License	Non-CA License State	License Type
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Psychiatrists Raw Data Report Form						
Form No. 40-262						
Row #	FQHC/RHC Name	NPI	CA License	Non-CA License	Non-CA License State	License Type
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Psychiatrists Raw Data Report Form						
Form No. 40-262						
Row #	FQHC/RHC Name	NPI	CA License	Non-CA License	Non-CA License State	License Type
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Psychiatrists Raw Data Report Form						
Form No. 40-262						
Row #	Specialty	Board Certified / Eligible	Provider Group	Practice Address	Practice Address 2	City
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Psychiatrists Raw Data Report Form						
Form No. 40-262						
Row #	Specialty	Board Certified / Eligible	Provider Group	Practice Address	Practice Address 2	City
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Psychiatrists Raw Data Report Form						
Form No. 40-262						
Row #	Specialty	Board Certified / Eligible	Provider Group	Practice Address	Practice Address 2	City
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Psychiatrists Raw Data Report Form						
Form No. 40-262						
Row #	County	State	Zip Code	Phone Number 1	Phone Number 2	Phone Number 3
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Psychiatrists Raw Data Report Form						
Form No. 40-262						
Row #	County	State	Zip Code	Phone Number 1	Phone Number 2	Phone Number 3
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Psychiatrists Raw Data Report Form						
Form No. 40-262						
Row #	County	State	Zip Code	Phone Number 1	Phone Number 2	Phone Number 3
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Psychiatrists Raw Data Report Form						
Form No. 40-262						
Row #	Fax Number 1	Fax Number 2	Fax Number 3	Email Address 1	Email Address 2	Email Address 3
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Psychiatrists Raw Data Report Form						
Form No. 40-262						
Row #	Fax Number 1	Fax Number 2	Fax Number 3	Email Address 1	Email Address 2	Email Address 3
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Psychiatrists Raw Data Report Form						
Form No. 40-262						
Row #	Fax Number 1	Fax Number 2	Fax Number 3	Email Address 1	Email Address 2	Email Address 3
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Psychiatrists Raw Data Report Form

Form No. 40-262

Row #	Provider Survey Type	Survey Modality	Sample Type	Outcome	Survey Completed via	Date Survey Initiated
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Psychiatrists Raw Data Report Form						
Form No. 40-262						
Row #	Provider Survey Type	Survey Modality	Sample Type	Outcome	Survey Completed via	Date Survey Initiated
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Psychiatrists Raw Data Report Form						
Form No. 40-262						
Row #	Provider Survey Type	Survey Modality	Sample Type	Outcome	Survey Completed via	Date Survey Initiated
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Psychiatrists Raw Data Report Form						
Form No. 40-262						
Row #	Date Survey Completed	Time Survey Completed	Name of Individual Conducting the Survey	Person Spoken to	Question 1 - When is the next available appointment date with [Provider Name] for an urgent care appointment?	Question 1 - When is the next available appointment time with [Provider Name] for an urgent care appointment?
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Psychiatrists Raw Data Report Form						
Form No. 40-262						
Row #	Date Survey Completed	Time Survey Completed	Name of Individual Conducting the Survey	Person Spoken to	Question 1 - When is the next available appointment date with [Provider Name] for an urgent care appointment?	Question 1 - When is the next available appointment time with [Provider Name] for an urgent care appointment?
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Psychiatrists Raw Data Report Form						
Form No. 40-262						
Row #	Date Survey Completed	Time Survey Completed	Name of Individual Conducting the Survey	Person Spoken to	Question 1 - When is the next available appointment date with [Provider Name] for an urgent care appointment?	Question 1 - When is the next available appointment time with [Provider Name] for an urgent care appointment?
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Psychiatrists Raw Data Report Form							
Form No. 40-262							
Row #	Calculation 1 - Yes, there is an available urgent care appointment within 96 hours. No, there is no available urgent care appointment within 96 hours.	Question 2 - When is the next available appointment date with [Provider Name] for a non-urgent appointment?	Question 2 - When is the next available appointment time with [Provider Name] for a non-urgent appointment?	Calculation 2 - Yes, there is an available non-urgent appointment within 15 business days. No, there is no available non-urgent appointment within 15 business days.	Comments 1	Comments 2	Comments 3
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Psychiatrists Raw Data Report Form							
Form No. 40-262							
Row #	Calculation 1 - Yes, there is an available urgent care appointment within 96 hours. No, there is no available urgent care appointment within 96 hours.	Question 2 - When is the next available appointment date with [Provider Name] for a non-urgent appointment?	Question 2 - When is the next available appointment time with [Provider Name] for a non-urgent appointment?	Calculation 2 - Yes, there is an available non-urgent appointment within 15 business days. No, there is no available non-urgent appointment within 15 business days.	Comments 1	Comments 2	Comments 3
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Psychiatrists Raw Data Report Form							
Form No. 40-262							
Row #	Calculation 1 - Yes, there is an available urgent care appointment within 96 hours. No, there is no available urgent care appointment within 96 hours.	Question 2 - When is the next available appointment date with [Provider Name] for a non-urgent appointment?	Question 2 - When is the next available appointment time with [Provider Name] for a non-urgent appointment?	Calculation 2 - Yes, there is an available non-urgent appointment within 15 business days. No, there is no available non-urgent appointment within 15 business days.	Comments 1	Comments 2	Comments 3
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RESULTS REPORT FORM
PLAN INFORMATION

Complete the information requested below related to the Provider Appointment Availability Survey results reported in each of the Provider Survey Type tabs before submission to the Department of Managed Health Care.

Reporting Plan Name:	
Subcontracted Plan Name (If any)	
Measurement Year:	
Name of Survey Administrator:	
Name of Quality Assurance Vendor:	

Primary Care Providers Results Tab						
Form No. 40-264						
Row #	Provider Survey Type	Survey Modality	Sample Type	Network Name	Network ID	Subcontracted Plan License Number
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Primary Care Providers Results Tab								
Form No. 40-264								
Row #	Subcontracted Plan Network ID	County	State	Number of Providers within County/Network	Number of Providers Attempted to be Surveyed	Number of Providers Responded via Three Step Protocol	Number of Providers Responded via Extraction	Number of Providers Responded as a Qualified Advanced Access Provider
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Primary Care Providers Results Tab								
Form No. 40-264								
Row #	Required Sample Size	Required Sample Size Achieved	Number of Non-Responding Providers	Number of Ineligible Providers	Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care Appointment within 48 Hours	Number of Providers with an Urgent Care Appointment Available within 48 Hours	Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent Appointment within 10 Business Days	Number of Providers with a Non-Urgent Appointment Available within 10 Business Days
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Primary Care Providers Results Tab								
Form No. 40-264								
Row #	Total Number of Providers Responded to Survey	Percentage of Non-Responding Providers	Percentage of Ineligible Providers	Percentage of Providers with an Urgent Care Appointment Available within 48 Hours (Unweighted)	Percentage of Providers with a Non-Urgent Appointment Available within 10 Business Days (Unweighted)	Number of Providers Weight Used for Calculating Aggregate Percentage of Providers with Timely Appointments for Urgent Care Appointments in Auto-Calculation Tabs	Number of Providers Weight Used for Calculating Aggregate Percentage of Providers with Timely Appointments for Non-Urgent Appointments in Auto-Calculation Tabs	Network Tally
1	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
2	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
3	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
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Primary Care Providers Results Tab						
Form No. 40-264						
Row #	Provider Survey Type	Survey Modality	Sample Type	Network Name	Network ID	Subcontracted Plan License Number
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Primary Care Providers Results Tab								
Form No. 40-264								
Row #	Subcontracted Plan Network ID	County	State	Number of Providers within County/Network	Number of Providers Attempted to be Surveyed	Number of Providers Responded via Three Step Protocol	Number of Providers Responded via Extraction	Number of Providers Responded as a Qualified Advanced Access Provider
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Primary Care Providers Results Tab								
Form No. 40-264								
Row #	Required Sample Size	Required Sample Size Achieved	Number of Non-Responding Providers	Number of Ineligible Providers	Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care Appointment within 48 Hours	Number of Providers with an Urgent Care Appointment Available within 48 Hours	Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent Appointment within 10 Business Days	Number of Providers with a Non-Urgent Appointment Available within 10 Business Days
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Primary Care Providers Results Tab								
Form No. 40-264								
Row #	Total Number of Providers Responded to Survey	Percentage of Non-Responding Providers	Percentage of Ineligible Providers	Percentage of Providers with an Urgent Care Appointment Available within 48 Hours (Unweighted)	Percentage of Providers with a Non-Urgent Appointment Available within 10 Business Days (Unweighted)	Number of Providers Weight Used for Calculating Aggregate Percentage of Providers with Timely Appointments for Urgent Care Appointments in Auto-Calculation Tabs	Number of Providers Weight Used for Calculating Aggregate Percentage of Providers with Timely Appointments for Non-Urgent Appointments in Auto-Calculation Tabs	Network Tally
1	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
2	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
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Primary Care Providers Results Tab						
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Row #	Provider Survey Type	Survey Modality	Sample Type	Network Name	Network ID	Subcontracted Plan License Number
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Primary Care Providers Results Tab								
Form No. 40-264								
Row #	Subcontracted Plan Network ID	County	State	Number of Providers within County/Network	Number of Providers Attempted to be Surveyed	Number of Providers Responded via Three Step Protocol	Number of Providers Responded via Extraction	Number of Providers Responded as a Qualified Advanced Access Provider
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Primary Care Providers Results Tab								
Form No. 40-264								
Row #	Required Sample Size	Required Sample Size Achieved	Number of Non-Responding Providers	Number of Ineligible Providers	Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care Appointment within 48 Hours	Number of Providers with an Urgent Care Appointment Available within 48 Hours	Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent Appointment within 10 Business Days	Number of Providers with a Non-Urgent Appointment Available within 10 Business Days
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Primary Care Providers Results Tab								
Form No. 40-264								
Row #	Total Number of Providers Responded to Survey	Percentage of Non-Responding Providers	Percentage of Ineligible Providers	Percentage of Providers with an Urgent Care Appointment Available within 48 Hours (Unweighted)	Percentage of Providers with a Non-Urgent Appointment Available within 10 Business Days (Unweighted)	Number of Providers Weight Used for Calculating Aggregate Percentage of Providers with Timely Appointments for Urgent Care Appointments in Auto-Calculation Tabs	Number of Providers Weight Used for Calculating Aggregate Percentage of Providers with Timely Appointments for Non-Urgent Appointments in Auto-Calculation Tabs	Network Tally
1	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
2	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
3	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
4	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
5	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
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22	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
23	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
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30	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
31	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
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48	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
49	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
50	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field

Psychiatrists Results Tab						
Form No. 40-264						
Row #	Provider Survey Type	Survey Modality	Sample Type	Network Name	Network ID	Subcontracted Plan License Number
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Psychiatrists Results Tab								
Form No. 40-264								
Row #	Subcontracted Plan Network ID	County	State	Number of Providers within County/Network	Number of Providers Attempted to be Surveyed	Number of Providers Responded via Three Step Protocol	Number of Providers Responded via Extraction	Required Sample Size
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Psychiatrists Results Tab								
Form No. 40-264								
Row #	Required Sample Size Achieved	Number of Non-Responding Providers	Number of Ineligible Providers	Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care Appointment within 96 Hours	Number of Providers with an Urgent Care Appointment Available within 96 Hours	Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent Appointment within 15 Business Days	Number of Providers with a Non-Urgent Appointment Available within 15 Business Days	Total Number of Providers Responded to Survey
1								Calculated Field
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Psychiatrists Results Tab							
Form No. 40-264							
Row #	Percentage of Non-Responding Providers	Percentage of Ineligible Providers	Percentage of Providers with an Urgent Care Appointment Available within 96 Hours (Unweighted)	Percentage of Providers with a Non-Urgent Appointment Available within 15 Business Days (Unweighted)	Number of Providers Weight Used for Calculating Aggregate Percentage of Providers with Timely Appointments for Urgent Care Appointments in Auto-Calculation Tabs	Number of Providers Weight Used for Calculating Aggregate Percentage of Providers with Timely Appointments for Non-Urgent Appointments in Auto-Calculation Tabs	Network Tally
1	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
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3	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
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48	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
49	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
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Psychiatrists Results Tab						
Form No. 40-264						
Row #	Provider Survey Type	Survey Modality	Sample Type	Network Name	Network ID	Subcontracted Plan License Number
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Psychiatrists Results Tab								
Form No. 40-264								
Row #	Subcontracted Plan Network ID	County	State	Number of Providers within County/Network	Number of Providers Attempted to be Surveyed	Number of Providers Responded via Three Step Protocol	Number of Providers Responded via Extraction	Required Sample Size
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Psychiatrists Results Tab								
Form No. 40-264								
Row #	Required Sample Size Achieved	Number of Non-Responding Providers	Number of Ineligible Providers	Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care Appointment within 96 Hours	Number of Providers with an Urgent Care Appointment Available within 96 Hours	Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent Appointment within 15 Business Days	Number of Providers with a Non-Urgent Appointment Available within 15 Business Days	Total Number of Providers Responded to Survey
1								Calculated Field
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4								Calculated Field
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Psychiatrists Results Tab							
Form No. 40-264							
Row #	Percentage of Non-Responding Providers	Percentage of Ineligible Providers	Percentage of Providers with an Urgent Care Appointment Available within 96 Hours (Unweighted)	Percentage of Providers with a Non-Urgent Appointment Available within 15 Business Days (Unweighted)	Number of Providers Weight Used for Calculating Aggregate Percentage of Providers with Timely Appointments for Urgent Care Appointments in Auto-Calculation Tabs	Number of Providers Weight Used for Calculating Aggregate Percentage of Providers with Timely Appointments for Non-Urgent Appointments in Auto-Calculation Tabs	Network Tally
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Psychiatrists Results Tab						
Form No. 40-264						
Row #	Provider Survey Type	Survey Modality	Sample Type	Network Name	Network ID	Subcontracted Plan License Number
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50						

Psychiatrists Results Tab								
Form No. 40-264								
Row #	Subcontracted Plan Network ID	County	State	Number of Providers within County/Network	Number of Providers Attempted to be Surveyed	Number of Providers Responded via Three Step Protocol	Number of Providers Responded via Extraction	Required Sample Size
1								
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Psychiatrists Results Tab								
Form No. 40-264								
Row #	Required Sample Size Achieved	Number of Non-Responding Providers	Number of Ineligible Providers	Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care Appointment within 96 Hours	Number of Providers with an Urgent Care Appointment Available within 96 Hours	Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent Appointment within 15 Business Days	Number of Providers with a Non-Urgent Appointment Available within 15 Business Days	Total Number of Providers Responded to Survey
1								Calculated Field
2								Calculated Field
3								Calculated Field
4								Calculated Field
5								Calculated Field
6								Calculated Field
7								Calculated Field
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46								Calculated Field
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48								Calculated Field
49								Calculated Field
50								Calculated Field

Psychiatrists Results Tab							
Form No. 40-264							
Row #	Percentage of Non-Responding Providers	Percentage of Ineligible Providers	Percentage of Providers with an Urgent Care Appointment Available within 96 Hours (Unweighted)	Percentage of Providers with a Non-Urgent Appointment Available within 15 Business Days (Unweighted)	Number of Providers Weight Used for Calculating Aggregate Percentage of Providers with Timely Appointments for Urgent Care Appointments in Auto-Calculation Tabs	Number of Providers Weight Used for Calculating Aggregate Percentage of Providers with Timely Appointments for Non-Urgent Appointments in Auto-Calculation Tabs	Network Tally
1	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
2	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
3	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
4	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
5	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
6	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
7	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
8	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
9	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
10	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
11	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
12	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
13	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
14	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
15	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
16	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
17	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
18	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
19	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
20	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
21	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
22	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
23	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
24	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
25	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
26	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
27	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
28	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
29	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
30	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
31	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
32	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
33	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
34	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
35	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
36	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
37	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
38	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
39	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
40	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
41	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
42	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
43	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
44	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
45	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
46	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
47	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
48	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
49	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field
50	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field	Calculated Field

Network by Provider Survey Type Tab				
Form No. 40-264				
Row #	Provider Survey Type	Network Name	Total Number of Providers in Network (Urgent Care Appointments)	Expected Number of Providers with an Available Urgent Care Appointment
1	Primary Care Providers			
2	Primary Care Providers			
3	Primary Care Providers			
4	Primary Care Providers			
5	Primary Care Providers			
6	Primary Care Providers			
7	Primary Care Providers			
8	Primary Care Providers			
9	Primary Care Providers			
10	Primary Care Providers			
11	Primary Care Providers			
12	Primary Care Providers			
13	Primary Care Providers			
14	Primary Care Providers			
15	Primary Care Providers			
16	Primary Care Providers			
17	Primary Care Providers			
18	Primary Care Providers			
19	Primary Care Providers			
20	Primary Care Providers			
21	Primary Care Providers			
22	Primary Care Providers			
23	Primary Care Providers			
24	Primary Care Providers			
25	Primary Care Providers			
26	Primary Care Providers			

Network by Provider Survey Type Tab				
Form No. 40-264				
Row #	Provider Survey Type	Network Name	Total Number of Providers in Network (Urgent Care Appointments)	Expected Number of Providers with an Available Urgent Care Appointment
27	Primary Care Providers			
28	Primary Care Providers			
29	Primary Care Providers			
30	Primary Care Providers			
31	Primary Care Providers			
32	Primary Care Providers			
33	Primary Care Providers			
34	Primary Care Providers			
35	Primary Care Providers			
36	Primary Care Providers			
37	Primary Care Providers			
38	Primary Care Providers			
39	Primary Care Providers			
40	Primary Care Providers			
41	Primary Care Providers			
42	Primary Care Providers			
43	Primary Care Providers			
44	Primary Care Providers			
45	Primary Care Providers			
46	Primary Care Providers			
47	Primary Care Providers			
48	Primary Care Providers			
49	Primary Care Providers			
50	Primary Care Providers			
51	Non-Physician Mental Health Care Providers			
52	Non-Physician Mental Health Care Providers			

Network by Provider Survey Type Tab				
Form No. 40-264				
Row #	Provider Survey Type	Network Name	Total Number of Providers in Network (Urgent Care Appointments)	Expected Number of Providers with an Available Urgent Care Appointment
53	Non-Physician Mental Health Care Providers			
54	Non-Physician Mental Health Care Providers			
55	Non-Physician Mental Health Care Providers			
56	Non-Physician Mental Health Care Providers			
57	Non-Physician Mental Health Care Providers			
58	Non-Physician Mental Health Care Providers			
59	Non-Physician Mental Health Care Providers			
60	Non-Physician Mental Health Care Providers			
61	Non-Physician Mental Health Care Providers			
62	Non-Physician Mental Health Care Providers			
63	Non-Physician Mental Health Care Providers			
64	Non-Physician Mental Health Care Providers			
65	Non-Physician Mental Health Care Providers			
66	Non-Physician Mental Health Care Providers			
67	Non-Physician Mental Health Care Providers			
68	Non-Physician Mental Health Care Providers			
69	Non-Physician Mental Health Care Providers			
70	Non-Physician Mental Health Care Providers			
71	Non-Physician Mental Health Care Providers			
72	Non-Physician Mental Health Care Providers			
73	Non-Physician Mental Health Care Providers			
74	Non-Physician Mental Health Care Providers			
75	Non-Physician Mental Health Care Providers			
76	Non-Physician Mental Health Care Providers			
77	Non-Physician Mental Health Care Providers			
78	Non-Physician Mental Health Care Providers			

Network by Provider Survey Type Tab				
Form No. 40-264				
Row #	Provider Survey Type	Network Name	Total Number of Providers in Network (Urgent Care Appointments)	Expected Number of Providers with an Available Urgent Care Appointment
79	Non-Physician Mental Health Care Providers			
80	Non-Physician Mental Health Care Providers			
81	Non-Physician Mental Health Care Providers			
82	Non-Physician Mental Health Care Providers			
83	Non-Physician Mental Health Care Providers			
84	Non-Physician Mental Health Care Providers			
85	Non-Physician Mental Health Care Providers			
86	Non-Physician Mental Health Care Providers			
87	Non-Physician Mental Health Care Providers			
88	Non-Physician Mental Health Care Providers			
89	Non-Physician Mental Health Care Providers			
90	Non-Physician Mental Health Care Providers			
91	Non-Physician Mental Health Care Providers			
92	Non-Physician Mental Health Care Providers			
93	Non-Physician Mental Health Care Providers			
94	Non-Physician Mental Health Care Providers			
95	Non-Physician Mental Health Care Providers			
96	Non-Physician Mental Health Care Providers			
97	Non-Physician Mental Health Care Providers			
98	Non-Physician Mental Health Care Providers			
99	Non-Physician Mental Health Care Providers			
100	Non-Physician Mental Health Care Providers			
101	Specialist Physicians			
102	Specialist Physicians			
103	Specialist Physicians			
104	Specialist Physicians			

Network by Provider Survey Type Tab				
Form No. 40-264				
Row #	Provider Survey Type	Network Name	Total Number of Providers in Network (Urgent Care Appointments)	Expected Number of Providers with an Available Urgent Care Appointment
105	Specialist Physicians			
106	Specialist Physicians			
107	Specialist Physicians			
108	Specialist Physicians			
109	Specialist Physicians			
110	Specialist Physicians			
111	Specialist Physicians			
112	Specialist Physicians			
113	Specialist Physicians			
114	Specialist Physicians			
115	Specialist Physicians			
116	Specialist Physicians			
117	Specialist Physicians			
118	Specialist Physicians			
119	Specialist Physicians			
120	Specialist Physicians			
121	Specialist Physicians			
122	Specialist Physicians			
123	Specialist Physicians			
124	Specialist Physicians			
125	Specialist Physicians			
126	Specialist Physicians			
127	Specialist Physicians			
128	Specialist Physicians			
129	Specialist Physicians			

Network by Provider Survey Type Tab				
Form No. 40-264				
Row #	Provider Survey Type	Network Name	Total Number of Providers in Network (Urgent Care Appointments)	Expected Number of Providers with an Available Urgent Care Appointment
130	Specialist Physicians			
131	Specialist Physicians			
132	Specialist Physicians			
133	Specialist Physicians			
134	Specialist Physicians			
135	Specialist Physicians			
136	Specialist Physicians			
137	Specialist Physicians			
138	Specialist Physicians			
139	Specialist Physicians			
140	Specialist Physicians			
141	Specialist Physicians			
142	Specialist Physicians			
143	Specialist Physicians			
144	Specialist Physicians			
145	Specialist Physicians			
146	Specialist Physicians			
147	Specialist Physicians			
148	Specialist Physicians			
149	Specialist Physicians			
150	Specialist Physicians			
151	Psychiatrists			
152	Psychiatrists			
153	Psychiatrists			
154	Psychiatrists			

Network by Provider Survey Type Tab				
Form No. 40-264				
Row #	Provider Survey Type	Network Name	Total Number of Providers in Network (Urgent Care Appointments)	Expected Number of Providers with an Available Urgent Care Appointment
155	Psychiatrists			
156	Psychiatrists			
157	Psychiatrists			
158	Psychiatrists			
159	Psychiatrists			
160	Psychiatrists			
161	Psychiatrists			
162	Psychiatrists			
163	Psychiatrists			
164	Psychiatrists			
165	Psychiatrists			
166	Psychiatrists			
167	Psychiatrists			
168	Psychiatrists			
169	Psychiatrists			
170	Psychiatrists			
171	Psychiatrists			
172	Psychiatrists			
173	Psychiatrists			
174	Psychiatrists			
175	Psychiatrists			
176	Psychiatrists			
177	Psychiatrists			
178	Psychiatrists			
179	Psychiatrists			

Network by Provider Survey Type Tab				
Form No. 40-264				
Row #	Provider Survey Type	Network Name	Total Number of Providers in Network (Urgent Care Appointments)	Expected Number of Providers with an Available Urgent Care Appointment
180	Psychiatrists			
181	Psychiatrists			
182	Psychiatrists			
183	Psychiatrists			
184	Psychiatrists			
185	Psychiatrists			
186	Psychiatrists			
187	Psychiatrists			
188	Psychiatrists			
189	Psychiatrists			
190	Psychiatrists			
191	Psychiatrists			
192	Psychiatrists			
193	Psychiatrists			
194	Psychiatrists			
195	Psychiatrists			
196	Psychiatrists			
197	Psychiatrists			
198	Psychiatrists			
199	Psychiatrists			
200	Psychiatrists			
201	Ancillary Service Providers		N/A	N/A
202	Ancillary Service Providers		N/A	N/A
203	Ancillary Service Providers		N/A	N/A
204	Ancillary Service Providers		N/A	N/A

Network by Provider Survey Type Tab				
Form No. 40-264				
Row #	Provider Survey Type	Network Name	Total Number of Providers in Network (Urgent Care Appointments)	Expected Number of Providers with an Available Urgent Care Appointment
205	Ancillary Service Providers		N/A	N/A
206	Ancillary Service Providers		N/A	N/A
207	Ancillary Service Providers		N/A	N/A
208	Ancillary Service Providers		N/A	N/A
209	Ancillary Service Providers		N/A	N/A
210	Ancillary Service Providers		N/A	N/A
211	Ancillary Service Providers		N/A	N/A
212	Ancillary Service Providers		N/A	N/A
213	Ancillary Service Providers		N/A	N/A
214	Ancillary Service Providers		N/A	N/A
215	Ancillary Service Providers		N/A	N/A
216	Ancillary Service Providers		N/A	N/A
217	Ancillary Service Providers		N/A	N/A
218	Ancillary Service Providers		N/A	N/A
219	Ancillary Service Providers		N/A	N/A
220	Ancillary Service Providers		N/A	N/A
221	Ancillary Service Providers		N/A	N/A
222	Ancillary Service Providers		N/A	N/A
223	Ancillary Service Providers		N/A	N/A
224	Ancillary Service Providers		N/A	N/A
225	Ancillary Service Providers		N/A	N/A
226	Ancillary Service Providers		N/A	N/A
227	Ancillary Service Providers		N/A	N/A
228	Ancillary Service Providers		N/A	N/A
229	Ancillary Service Providers		N/A	N/A
230	Ancillary Service Providers		N/A	N/A

Network by Provider Survey Type Tab				
Form No. 40-264				
Row #	Provider Survey Type	Network Name	Total Number of Providers in Network (Urgent Care Appointments)	Expected Number of Providers with an Available Urgent Care Appointment
231	Ancillary Service Providers		N/A	N/A
232	Ancillary Service Providers		N/A	N/A
233	Ancillary Service Providers		N/A	N/A
234	Ancillary Service Providers		N/A	N/A
235	Ancillary Service Providers		N/A	N/A
236	Ancillary Service Providers		N/A	N/A
237	Ancillary Service Providers		N/A	N/A
238	Ancillary Service Providers		N/A	N/A
239	Ancillary Service Providers		N/A	N/A
240	Ancillary Service Providers		N/A	N/A
241	Ancillary Service Providers		N/A	N/A
242	Ancillary Service Providers		N/A	N/A
243	Ancillary Service Providers		N/A	N/A
244	Ancillary Service Providers		N/A	N/A
245	Ancillary Service Providers		N/A	N/A
246	Ancillary Service Providers		N/A	N/A
247	Ancillary Service Providers		N/A	N/A
248	Ancillary Service Providers		N/A	N/A
249	Ancillary Service Providers		N/A	N/A
250	Ancillary Service Providers		N/A	N/A

Percentage of Providers with Timely Appointments for Urgent Care Appointments (Weighted)	**Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care**	**Total Number of Providers in Network (Non-Urgent Appointments)**	**Expected Number of Providers with an Available Non-Urgent Appointment**	**Percentage of Providers with Timely Appointments for Non-Urgent Appointments (Weighted)**	**Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent**	**Percentage of Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types**	**Network Tally**
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Percentage of Providers with Timely Appointments for Urgent Care Appointments (Weighted)	**Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care**	**Total Number of Providers in Network (Non-Urgent Appointments)**	**Expected Number of Providers with an Available Non-Urgent Appointment**	**Percentage of Providers with Timely Appointments for Non-Urgent Appointments (Weighted)**	**Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent**	**Percentage of Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types**	**Network Tally**
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Percentage of Providers with Timely Appointments for Urgent Care Appointments (Weighted)	**Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care**	**Total Number of Providers in Network (Non-Urgent Appointments)**	**Expected Number of Providers with an Available Non-Urgent Appointment**	**Percentage of Providers with Timely Appointments for Non-Urgent Appointments (Weighted)**	**Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent**	**Percentage of Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types**	**Network Tally**
							1
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Percentage of Providers with Timely Appointments for Urgent Care Appointments (Weighted)	**Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care**	**Total Number of Providers in Network (Non-Urgent Appointments)**	**Expected Number of Providers with an Available Non-Urgent Appointment**	**Percentage of Providers with Timely Appointments for Non-Urgent Appointments (Weighted)**	**Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent**	**Percentage of Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types**	**Network Tally**
							1
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Percentage of Providers with Timely Appointments for Urgent Care Appointments (Weighted)	**Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care**	**Total Number of Providers in Network (Non-Urgent Appointments)**	**Expected Number of Providers with an Available Non-Urgent Appointment**	**Percentage of Providers with Timely Appointments for Non-Urgent Appointments (Weighted)**	**Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent**	**Percentage of Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types**	**Network Tally**
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Percentage of Providers with Timely Appointments for Urgent Care Appointments (Weighted)	**Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care**	**Total Number of Providers in Network (Non-Urgent Appointments)**	**Expected Number of Providers with an Available Non-Urgent Appointment**	**Percentage of Providers with Timely Appointments for Non-Urgent Appointments (Weighted)**	**Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent**	**Percentage of Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types**	**Network Tally**
							1
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Percentage of Providers with Timely Appointments for Urgent Care Appointments (Weighted)	**Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care**	**Total Number of Providers in Network (Non-Urgent Appointments)**	**Expected Number of Providers with an Available Non-Urgent Appointment**	**Percentage of Providers with Timely Appointments for Non-Urgent Appointments (Weighted)**	**Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent**	**Percentage of Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types**	**Network Tally**
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Percentage of Providers with Timely Appointments for Urgent Care Appointments (Weighted)	**Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care**	**Total Number of Providers in Network (Non-Urgent Appointments)**	**Expected Number of Providers with an Available Non-Urgent Appointment**	**Percentage of Providers with Timely Appointments for Non-Urgent Appointments (Weighted)**	**Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent**	**Percentage of Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types**	**Network Tally**
							1
							1
							1
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							1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1

Percentage of Providers with Timely Appointments for Urgent Care Appointments (Weighted)	**Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care**	**Total Number of Providers in Network (Non-Urgent Appointments)**	**Expected Number of Providers with an Available Non-Urgent Appointment**	**Percentage of Providers with Timely Appointments for Non-Urgent Appointments (Weighted)**	**Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent**	**Percentage of Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types**	**Network Tally**
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
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N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1

Percentage of Providers with Timely Appointments for Urgent Care Appointments (Weighted)	**Number of Providers who Responded to the Question Regarding the Availability of an Urgent Care**	**Total Number of Providers in Network (Non-Urgent Appointments)**	**Expected Number of Providers with an Available Non-Urgent Appointment**	**Percentage of Providers with Timely Appointments for Non-Urgent Appointments (Weighted)**	**Number of Providers who Responded to the Question Regarding the Availability of a Non-Urgent**	**Percentage of Providers with Timely Appointments for Urgent Care and Non-Urgent Appointment Types**	**Network Tally**
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1
N/A	N/A						1

Specialist and Specialist Non-Physician Medical Practitioner Report Form					
Form No. 40-267					
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name
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Specialist and Specialist Non-Physician Medical Practitioner Report Form					
Form No. 40-267					
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name
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Specialist and Specialist Non-Physician Medical Practitioner Report Form
Form No. 40-266

Row #	First Name	NPI	CA License	Non-CA License	Non-CA License State	License Type
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Specialist and Specialist Non-Physician Medical Practitioner Report Form
Form No. 40-266

Row #	First Name	NPI	CA License	Non-CA License	Non-CA License State	License Type
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Specialist and Specialist Non-Physician Medical Practitioner Report Form
Form No. 40-266

Row #	Specialty	Board Certified / Eligible	Provider Group	Network Tier ID	Full-Time / Part-Time	Facility
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Specialist and Specialist Non-Physician Medical Practitioner Report Form
Form No. 40-266

Row #	Specialty	Board Certified / Eligible	Provider Group	Network Tier ID	Full-Time / Part-Time	Facility
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Specialist and Specialist Non-Physician Medical Practitioner Report Form
Form No. 40-266

Row #	Facility NPI	Hospitalist	Provider Language 1	Provider Language 2	Provider Language 3
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Specialist and Specialist Non-Physician Medical Practitioner Report Form
Form No. 40-266

Row #	Facility NPI	Hospitalist	Provider Language 1	Provider Language 2	Provider Language 3
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Specialist and Specialist Non-Physician Medical Practitioner Report Form
Form No. 40-266

Row #	Practice Address	Practice Address 2	City	County	State	ZIP Code
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Specialist and Specialist Non-Physician Medical Practitioner Report Form
Form No. 40-266

Row #	Practice Address	Practice Address 2	City	County	State	ZIP Code
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Specialist and Specialist Non-Physician Medical Practitioner Report Form
Form No. 40-266

Row #	Phone Number	Clinic Name	Accepting New Patients or Referrals	Displayed in Provider Directory	In-Person Appointments	E-mail Address
1						
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Specialist and Specialist Non-Physician Medical Practitioner Report Form
Form No. 40-266

Row #	Phone Number	Clinic Name	Accepting New Patients or Referrals	Displayed in Provider Directory	In-Person Appointments	E-mail Address
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Specialist and Specialist Non-Physician Medical Practitioner Report Form					
Form No. 40-267					
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name
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Specialist and Specialist Non-Physician Medical Practitioner Report Form					
Form No. 40-267					
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name
31					
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Specialist and Specialist Non-Physician Medical Practitioner Report Form						
Form No. 40-266						
Row #	First Name	NPI	CA License	License Type	Specialty	NPI of Supervising Specialist
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Specialist and Specialist Non-Physician Medical Practitioner Report Form						
Form No. 40-266						
Row #	First Name	NPI	CA License	License Type	Specialty	NPI of Supervising Specialist
31						
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Specialist and Specialist Non-Physician Medical Practitioner Report Form						
Form No. 40-266						
Row #	Supervising Specialist Specialty	Provider Group	Network Tier ID	Full-Time / Part-Time	Provider Language 1	Provider Language 2
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Specialist and Specialist Non-Physician Medical Practitioner Report Form						
Form No. 40-266						
Row #	Supervising Specialist Specialty	Provider Group	Network Tier ID	Full-Time / Part-Time	Provider Language 1	Provider Language 2
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Specialist and Specialist Non-Physician Medical Practitioner Report Form						
Form No. 40-266						
Row #	Provider Language 3	Practice Address	Practice Address 2	City	County	State
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Specialist and Specialist Non-Physician Medical Practitioner Report Form						
Form No. 40-266						
Row #	Provider Language 3	Practice Address	Practice Address 2	City	County	State
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Specialist and Specialist Non-Physician Medical Practitioner Report Form					
Form No. 40-266					
Row #	ZIP Code	Phone Number	Clinic Name	Accepting New Patients or Referrals	Displayed in Provider Directory
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Specialist and Specialist Non-Physician Medical Practitioner Report Form					
Form No. 40-266					
Row #	ZIP Code	Phone Number	Clinic Name	Accepting New Patients or Referrals	Displayed in Provider Directory
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Specialist and Specialist Non-Physician Medical Practitioner Report Form		
Form No. 40-266		
Row #	In-Person Appointments	E-mail Address
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Specialist and Specialist Non-Physician Medical Practitioner Report Form		
Form No. 40-266		
Row #	In-Person Appointments	E-mail Address
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SPECIALIST PHYSICIANS CONTACT LIST REPORT FORM
HEALTH PLAN INFORMATION

Complete the information requested below before submission to the Department of Managed Health Care.

Reporting Plan Name:	
Subcontracted Plan Name (If any)	
Measurement Year:	
Name of Survey Administrator:	
Name of Quality Assurance Vendor:	
Date Contact List Generated:	

Specialist Physicians Contact List Report Form							
Form No. 40-256							
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name	First Name	FQHC/RHC Name
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Specialist Physicians Contact List Report Form							
Form No. 40-256							
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name	First Name	FQHC/RHC Name
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Specialist Physicians Contact List Report Form							
Form No. 40-256							
Row #	NPI	CA License	Non-CA License	Non-CA License State	License Type	Specialty	Board Certified / Eligible
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Specialist Physicians Contact List Report Form							
Form No. 40-256							
Row #	NPI	CA License	Non-CA License	Non-CA License State	License Type	Specialty	Board Certified / Eligible
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Specialist Physicians Contact List Report Form							
Form No. 40-256							
Row #	Provider Group	Practice Address	Practice Address 2	City	County	State	Zip Code
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Specialist Physicians Contact List Report Form							
Form No. 40-256							
Row #	Provider Group	Practice Address	Practice Address 2	City	County	State	Zip Code
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Specialist Physicians Contact List Report Form							
Form No. 40-256							
Row #	Phone Number 1	Phone Number 2	Phone Number 3	Fax Number 1	Fax Number 2	Fax Number 3	Email Address 1
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Specialist Physicians Contact List Report Form							
Form No. 40-256							
Row #	Phone Number 1	Phone Number 2	Phone Number 3	Fax Number 1	Fax Number 2	Fax Number 3	Email Address 1
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Specialist Physicians Contact List Report Form							
Form No. 40-256							
Row #	Email Address 2	Email Address 3	Displayed in Provider Directory	Unique Provider	Provider Survey Type	Comments 1	Comments 2
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Specialist Physicians Contact List Report Form							
Form No. 40-256							
Row #	Email Address 2	Email Address 3	Displayed in Provider Directory	Unique Provider	Provider Survey Type	Comments 1	Comments 2
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SPECIALIST PHYSICIANS RAW DATA REPORT FORM
HEALTH PLAN INFORMATION

Complete the information requested below before submission to the Department of Managed Health Care.

Reporting Plan Name:	
Subcontracted Plan Name (If any)	
Measurement Year:	
Name of Survey Administrator:	
Name of Quality Assurance Vendor:	

Specialist Physicians Raw Data Report Form						
Form No. 40-261						
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name	First Name
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Specialist Physicians Raw Data Report Form						
Form No. 40-261						
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name	First Name
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Specialist Physicians Raw Data Report Form						
Form No. 40-261						
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name	First Name
43						
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Specialist Physicians Raw Data Report Form						
Form No. 40-261						
Row #	FQHC/RHC Name	NPI	CA License	Non-CA License	Non-CA License State	License Type
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Specialist Physicians Raw Data Report Form						
Form No. 40-261						
Row #	FQHC/RHC Name	NPI	CA License	Non-CA License	Non-CA License State	License Type
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Specialist Physicians Raw Data Report Form						
Form No. 40-261						
Row #	FQHC/RHC Name	NPI	CA License	Non-CA License	Non-CA License State	License Type
43						
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Specialist Physicians Raw Data Report Form

Form No. 40-261

Row #	Specialty	Board Certified / Eligible	Provider Group	Practice Address	Practice Address 2	City
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Specialist Physicians Raw Data Report Form						
Form No. 40-261						
Row #	Specialty	Board Certified / Eligible	Provider Group	Practice Address	Practice Address 2	City
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Specialist Physicians Raw Data Report Form						
Form No. 40-261						
Row #	Specialty	Board Certified / Eligible	Provider Group	Practice Address	Practice Address 2	City
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Specialist Physicians Raw Data Report Form						
Form No. 40-261						
Row #	County	State	Zip Code	Phone Number 1	Phone Number 2	Phone Number 3
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Specialist Physicians Raw Data Report Form						
Form No. 40-261						
Row #	County	State	Zip Code	Phone Number 1	Phone Number 2	Phone Number 3
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Specialist Physicians Raw Data Report Form						
Form No. 40-261						
Row #	County	State	Zip Code	Phone Number 1	Phone Number 2	Phone Number 3
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Specialist Physicians Raw Data Report Form						
Form No. 40-261						
Row #	Fax Number 1	Fax Number 2	Fax Number 3	Email Address 1	Email Address 2	Email Address 3
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Specialist Physicians Raw Data Report Form						
Form No. 40-261						
Row #	Fax Number 1	Fax Number 2	Fax Number 3	Email Address 1	Email Address 2	Email Address 3
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Specialist Physicians Raw Data Report Form						
Form No. 40-261						
Row #	Fax Number 1	Fax Number 2	Fax Number 3	Email Address 1	Email Address 2	Email Address 3
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Specialist Physicians Raw Data Report Form						
Form No. 40-261						
Row #	Provider Survey Type	Survey Modality	Sample Type	Outcome	Survey Completed via	Date Survey Initiated
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Specialist Physicians Raw Data Report Form						
Form No. 40-261						
Row #	Provider Survey Type	Survey Modality	Sample Type	Outcome	Survey Completed via	Date Survey Initiated
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Specialist Physicians Raw Data Report Form						
Form No. 40-261						
Row #	Provider Survey Type	Survey Modality	Sample Type	Outcome	Survey Completed via	Date Survey Initiated
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Specialist Physicians Raw Data Report Form						
Form No. 40-261						
Row #	Date Survey Completed	Time Survey Completed	Name of Individual Conducting the Survey	Person Spoken to	Question 1 - When is the next available appointment date with [Provider Name] for an urgent care appointment?	Question 1 - When is the next available appointment time with [Provider Name] for an urgent care appointment?
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Specialist Physicians Raw Data Report Form						
Form No. 40-261						
Row #	Date Survey Completed	Time Survey Completed	Name of Individual Conducting the Survey	Person Spoken to	Question 1 - When is the next available appointment date with [Provider Name] for an urgent care appointment?	Question 1 - When is the next available appointment time with [Provider Name] for an urgent care appointment?
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Specialist Physicians Raw Data Report Form						
Form No. 40-261						
Row #	Date Survey Completed	Time Survey Completed	Name of Individual Conducting the Survey	Person Spoken to	Question 1 - When is the next available appointment date with [Provider Name] for an urgent care appointment?	Question 1 - When is the next available appointment time with [Provider Name] for an urgent care appointment?
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Specialist Physicians Raw Data Report Form							
Form No. 40-261							
Row #	Calculation 1 - Yes, there is an available urgent care appointment within 96 hours. No, there is no available urgent care appointment within 96 hours.	Question 2 - When is the next available appointment date with [Provider Name] for a non-urgent appointment?	Question 2 - When is the next available appointment time with [Provider Name] for a non-urgent appointment?	Calculation 2 - Yes, there is an available non-urgent appointment within 15 business days. No, there is no available non-urgent appointment within 15 business days.	Comments 1	Comments 2	Comments 3
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Specialist Physicians Raw Data Report Form							
Form No. 40-261							
Row #	Calculation 1 - Yes, there is an available urgent care appointment within 96 hours. No, there is no available urgent care appointment within 96 hours.	Question 2 - When is the next available appointment date with [Provider Name] for a non-urgent appointment?	Question 2 - When is the next available appointment time with [Provider Name] for a non-urgent appointment?	Calculation 2 - Yes, there is an available non-urgent appointment within 15 business days. No, there is no available non-urgent appointment within 15 business days.	Comments 1	Comments 2	Comments 3
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Specialist Physicians Raw Data Report Form							
Form No. 40-261							
Row #	Calculation 1 - Yes, there is an available urgent care appointment within 96 hours. No, there is no available urgent care appointment within 96 hours.	Question 2 - When is the next available appointment date with [Provider Name] for a non-urgent appointment?	Question 2 - When is the next available appointment time with [Provider Name] for a non-urgent appointment?	Calculation 2 - Yes, there is an available non-urgent appointment within 15 business days. No, there is no available non-urgent appointment within 15 business days.	Comments 1	Comments 2	Comments 3
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Telehealth Report Form					
Form No. 40-271					
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name
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Telehealth Report Form					
Form No. 40-271					
Row #	Network Name	Network ID	Subcontracted Plan License Number	Subcontracted Plan Network ID	Last Name
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Telehealth Report Form						
Form No. 40-271						
Row #	First Name	Entity Name	NPI	CA License / Certificate	Non-CA License / Certificate	Non-CA License / Certificate State
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Telehealth Report Form						
Form No. 40-271						
Row #	First Name	Entity Name	NPI	CA License / Certificate	Non-CA License / Certificate	Non-CA License / Certificate State
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Telehealth Report Form							
Form No. 40-271							
Row #	Type of License / Certificate	Specialty	Board Certified / Eligible	Provider Group	Provider Language 1	Provider Language 2	Provider Language 3
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Telehealth Report Form							
Form No. 40-271							
Row #	Type of License / Certificate	Specialty	Board Certified / Eligible	Provider Group	Provider Language 1	Provider Language 2	Provider Language 3
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Telehealth Report Form							
Form No. 40-271							
Row #	County	State	Number of Providers at Entity	Displayed in Provider Directory	In-Person Appointments	Telehealth Delivery Modality	Patient Location
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Telehealth Report Form							
Form No. 40-271							
Row #	County	State	Number of Providers at Entity	Displayed in Provider Directory	In-Person Appointments	Telehealth Delivery Modality	Patient Location
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Timely Access and Network Adequacy Grievance Report Form					
Form No. 40-272					
Row #	Network Name	Network ID	Product Line	Subcontracted Plan License Number	Subcontracted Plan Network ID
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Timely Access and Network Adequacy Grievance Report Form					
Form No. 40-272					
Row #	Network Name	Network ID	Product Line	Subcontracted Plan License Number	Subcontracted Plan Network ID
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Timely Access and Network Adequacy Grievance Report Form						
Form No. 40-272						
Row #	Date Resolved	Grievance Type	Complaint ID	County	Provider Group	Complaint Category
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Timely Access and Network Adequacy Grievance Report Form						
Form No. 40-272						
Row #	Date Resolved	Grievance Type	Complaint ID	County	Provider Group	Complaint Category
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Timely Access and Network Adequacy Grievance Report Form					
Form No. 40-272					
Row #	Provider Category	Specialty	Nature of Resolution	Resolution Determination	
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Timely Access and Network Adequacy Grievance Report Form					
Form No. 40-272					
Row #	Provider Category	Specialty	Nature of Resolution	Resolution Determination	
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