MEASUREMENT YEAR 2019
PROVIDER APPOINTMENT AVAILABILITY SURVEY (PAAS)

METHODOLOGY

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MEASUREMENT YEAR 2019
DEPARTMENT OF MANAGED HEALTH CARE
PROVIDER APPOINTMENT AVAILABILITY SURVEY METHODOLOGY

The Provider Appointment Availability Survey (PAAS) Methodology was developed by the Department of Managed Health Care (Department), pursuant to the Knox-Keene Health Care Service Plan Act of 1975.[1] The PAAS Methodology, published under the authority granted in Section 1367.03, subd. (f)(3), is a regulation in accordance with Government Code section 11342.600. For measurement year 2019 (MY 2019), all reporting health plans shall adhere to the PAAS Methodology when administering the PAAS and reporting rates of compliance for timely access appointment standards, pursuant to Rule 1300.67.2.2, subd. (g).

All health plans that are required to submit an annual Timely Access Compliance Report shall maintain the administrative capacity necessary to gather compliance data in accordance with this mandatory methodology, validate compliance data, and identify and rectify compliance data errors, so that all documents submitted to the Department in connection with Timely Access Compliance Reports are accurate and present appointment availability data regarding the health plan's in-network providers.

All PAAS data included in the Timely Access Compliance Report shall be submitted using the Department's PAAS Templates, which include:

- *Contact List Template*
- *Raw Data Template*
- *Results Template*

The health plan's MY 2019 *Timely Access Compliance Report,* including the completed *PAAS Templates*, shall be submitted through the Timely Access Reporting Web Portal no later than April 1, 2020[2], pursuant to Rule 1300.67.2.2, subd. (g)(2).

[1] California Health and Safety Code sections 1340 et seq. (the "Act"). References herein to "Section" are to Sections of the Act. References to "Rule" refer to the regulations promulgated by the Department at California Code of Regulations, title 28.

[2] March 31 is a holiday. As a result, the Timely Access Compliance Report is required to be submitted the following business day. (Cal. Gov. Code section 6707.)

Step 1: Determine Which Networks to Survey

Health plans shall report separate rates of compliance with the time elapsed standards for each county in each network (County/Network) for each Provider Survey Type.[3] Health plans shall report rates of compliance for all counties in which contracted providers are located.

Health plans are not currently required to report a rate of compliance for networks serving exclusively Medicare Advantage, CalMediConnect or Employee Assistance Program enrollees, unless that network also serves other lines-of-business that are subject to timely access reporting requirements.

Plan-to-Plan Arrangements

Health plans shall report a rate of compliance that is representative of all providers who are a part of the health plan's network, whether the providers are contracted with the health plan directly, via a plan-to-plan agreement or through another arrangement. How the health plan reports this information depends on whether or not the secondary plan in the plan-to-plan arrangement is required to submit a Timely Access Compliance Report.

The Secondary Health Plan Also Submits a *Timely Access Compliance Report*

Where the health plan contracts with another health plan that also submits a *Timely Access Compliance Report*, each health plan is required to indicate the relationship in its health plan profile located in the Timely Access Reporting Web Portal. Where the secondary health plan's approved network is used to provide health care services to the primary health plan's enrollees, these providers will be incorporated into the primary health plan's *Timely Access Compliance Report* through identification of this arrangement in both health plans' profiles in the Timely Access Reporting Web Portal.

The secondary health plan shall survey and submit separate *PAAS Templates* to be incorporated into the primary health plan's *Timely Access Compliance Report*. The *PAAS Templates* submitted by the secondary health plan in the Other Plan Network tab of the Timely Access Reporting Web Portal shall only include the relevant providers and data, based on the plan-to-plan arrangement. The primary health plan is responsible for reviewing the relevant plan-to-plan data that will be incorporated into its *Timely Access Compliance Report* prior to submission by the secondary health plan so that the primary health plan can complete the required affirmation regarding accuracy and completeness.[4]

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[3] This methodology requires timely access rates of compliance be reported by county and network, rather than provider group. As a result, this methodology supersedes the provider group reporting requirement set forth in Rule 1300.67.2.2, subd. (g)(2)(B). (Section 1367.03, subd. (f)(3).) Accordingly, this subdivision is amended to require health plans to report "The rate of compliance, during the reporting period, with the time elapsed standards set forth in subsection (c)(5), separately reported for each county in which contracted providers are located."

[4] Under Section 1395, health plans are required to affirm, at the time of submission to the Department, that its *Timely Access Compliance Report* is true, complete, and accurate. This includes portions of the health plan's *Timely Access Compliance Report* that have been incorporated from any other health plan submissions.

The profile includes plan-to-plan relationships for the health plan's Annual Provider Network Report. If a plan-to-plan relationship is created or is terminated and as a result the plan-to-plan relationship(s) reflected in the Timely Access Compliance Report data is not the same as the relationship(s) reflected in the health plan's profile, the health plan shall submit a narrative in its Timely Access Compliance Report that identifies (1) the name of the health plan it has a plan-to-plan relationship with, (2) the type and scope of services delivered (e.g., full service or mental health services, including both psychiatric and non-physician mental health care provider services), (3) the counties in which the health care services are delivered, (4) the names of the health plan networks that are served through the plan-to-plan arrangement, (5) whether the health plan delivers services to its enrollees through this relationship or whether the health plan maintains a network for use with another health plan and (6) the date the relationship began and/or terminated. This narrative is not required where the relationship(s) reflected in the profile are accurately reflected for both the health plan's Annual Provider Network Report and its Timely Access Compliance Report.

The Secondary Health Plan Does Not Submit a *Timely Access Compliance Report*

Where the health plan contracts with another health plan that does not submit a *Timely Access Compliance Report*, the primary health plan shall include the data for relevant providers contracted through the plan-to-plan arrangement in the primary health plan's *PAAS Templates*.

Step 2: Complete the Contact List

The *Contact List* is used as the source to calculate the required target sample size and select a random sample of the health plan's network providers to survey for each County/Network. The *Contact List* shall include providers meeting all of the following requirements:

- The provider is contracted with the health plan as of December 31 of the prior year, including contracted providers located outside of the health plan's service area. [5]
- The provider furnishes health care services through enrollee appointments.
- The provider furnishes relevant health care services set forth under at least one of the five Provider Survey Types:

Provider Survey Types

(1) Primary Care Providers: Primary Care Physicians and Non-Physician Medical Practitioners providing primary care[6]

[5] The PAAS Methodology requires that timely access rates of compliance be reported for all contracted providers, regardless of whether the provider is located outside the health plan's service area. As a result, this methodology supersedes the reference to service area reporting requirement set forth in Rule 1300.67.2.2, subd. (g)(2)(B). (Section 1367.03, subd. (f)(3).) Accordingly, this subdivision is amended as set forth in footnote 3 above.

[6] Primary Care Physicians may include Family Practice, General Practice, Pediatrics, OB/GYN, or Internal Medicine Physicians. For other specialty types, health plans 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

(2) Specialist Physicians: Cardiovascular Disease, Endocrinology and Gastroenterology
(3) Psychiatrists
(4) Non-Physician Mental Health Care Providers (NPMH): Licensed Professional Clinical Counselor (LPCC), Psychologist (PhD-Level), Marriage and Family Therapist/Licensed Marriage and Family Therapist and Master of Social Work/Licensed Clinical Social Worker
(5) Ancillary Service Providers[7]: Facilities or entities providing mammogram or physical therapy appointments

If the providers meet all of the applicable requirements to be included in the Contact List the Contact List shall also include:

- Federally Qualified Health Clinics and Rural Health Clinics.
- Providers offering in-person and/or telehealth appointments to enrollees.[8]
- Primary Care Providers participating in the health plan's advanced access program.

The Department developed separate *Contact Lists* for each of the five Provider Survey Types set forth above. Use the *Contact List* Instructions to complete a separate a *Contact List* for each of the relevant Provider Survey Types. When completing the *Contact List* for Specialists, the health plan shall combine all specialists into one single *Contact List*. Psychiatrists shall be set forth on a separate *Contact List*. Similarly, the *Ancillary Contact List* shall include all entities or facilities providing the ancillary services set forth above and shall be combined on one single *Contact List*.

For further detailed information in the creation of the five required *Contact List Template*s, please reference the Instructions tab, located within each of the *Contact List Template*s. Specialties, counties, and other look-up codes are available on the Department's Timely Access Reporting Web Portal. A copy of each *Contact List* shall be retained to be submitted to the Department in the health plan's *Timely Access Compliance Report*.

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 services in collaboration with a physician pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code.

[7] Ancillary providers in the Contact List shall only include facilities or entities; do not include individual persons providing ancillary services in the Contact List.

[8] As with all other providers in the MY 2019 DMHC Provider Appointment Survey Methodology, only those telehealth providers offering appointments shall be included in the *Contact List.* The *Contact List* and *Raw Data Templates* require health plans to create a row for each telehealth provider with "NA" in the Address, City, State, and Zip Code fields. The health plan shall enter "Telehealth" into the County field of this row. Health plans shall treat "Telehealth" as a single virtual county for the purpose of this Methodology and survey providers within each network in the telehealth virtual county in the same manner as all other County/Networks. Providers that offer both in-person appointments and telehealth appointments shall be included in both the physical county they offer in-person appointments and in the telehealth virtual county. Providers that offer only telehealth appointments shall be included only in the telehealth virtual county.

Federally Qualified Health Centers and Rural Health Clinics

Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC) shall be included in the *Contact List* 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.

The telephone, fax and email address included in the *Contact List* and used to administer the survey shall be associated with only the FQHC/RHC. In order to avoid surveying individual provider's to assess availability at each FQHC/RHC, health plans shall not include individual provider telephone numbers, fax numbers and email addresses associated with FQHCs/RHCs in the *Contact List*.

De-duplicating the *Contact List*

The goal of identifying duplicate entries in the *Contact List* is to identify unique providers for the random sample selection process. This ensures that each provider in each county has an equal chance of being selected to be surveyed during the random sample selection process.

Review each *Contact List* to identify duplicate entries. Duplicate and unique entries must be identified in the "Unique Provider" field of the Contact list and *Raw Data Template*s. Enter "Y" to identify whether the entry represent a unique provider and "N" to identify duplicate entries. Duplicate entries must be excluded from consideration when selecting a random sample of providers to survey.

Duplicate entries are rows where the same provider appears more than once in a single county for a single network. Any manual corrections that affect the identification of duplicate entries, such as slight name corrections, shall be incorporated into the data set forth on the *PAAS Templates* submitted to the Department. Unique providers are those providers remaining after all duplicate entries have been identified.

Identify duplicates for each of the five Provider Survey Types using all of the following fields:

- Last Name and First Name (for Ancillary Providers use Other Contracted Provider Facility Name)
- FQHC/RHC Name
- National Provider Identification (NPI)[10]
- County
- Name of Network

[9] Welfare and Institutions Code section 14087.325, subd. (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…"

[10] For Ancillary and FQHCs/RHCs, health plans shall use an organizational NPI. For individual providers, health plans shall use the unique NPI number assigned to the provider.

Step 3: Determine Sample and Oversample Size

Determine the Sample Size

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 Section 1367.03, subd. (f)(2) and Rule 1300.67.2.2, subd. (g)(2)(B). The number of providers that must be surveyed for each County/Network is determined separately for each of the five Provider Survey Types.[11] (Section 1367.03, subd. (f)(3) and Rule 1300.67.2.2, subd. (g)(2)(B).)

For each Provider Survey Type in each Network/County, the health plan shall either survey:

- A sample of providers until the target sample size has been met; or
- All providers in the County/Network (census).

Determine the number of unique providers for each of the Provider Survey Types in each County/Network in the de-duplicated *Contact List*. 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.

A health plan may survey a sample larger than what is set forth in the Sample Size Chart (e.g., for internal quality assurance purposes), but it shall only include results in its *Raw Data and Results Templates* for either all providers in the County/Network (census) or the number of providers identified in the Required Target Sample Size column in the Sample Size Chart. Where census is used, all providers in the Network/County will be surveyed, and no oversample selection is necessary.

Determine the Oversample Size for Replacements

The health plan must obtain valid survey responses to reach the target sample size in each County/Network for each of the five Provider Survey Types.[12] Ineligible or non-responding providers shall be replaced with another provider, if available in the County/Network, in order to meet the required target sample size and ensure that the health plan's reported rates of compliance are statistically reliable and comparable. (*See* Replacements of Non-Responding and Ineligible Providers, below, to ascertain whether a provider may be replaced.)

[11] Combine Specialists to determine the sample size for the Specialist Physicians sample for each County/Network. Combine the entities or facilities providing Ancillary services to determine the sample size for the Ancillary Provider sample for each County/Network.

[12] Unless the health plan is unable to meet the target sample size due solely to ineligible providers, it must obtain enough valid survey responses to meet the target sample size regardless of whether a sample or census is surveyed.

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-responders and ineligible providers necessary to meet the target sample size. If the initial 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 should continue to add providers to the oversample using the random sample selection process until either the target sample size is reached or all providers have been contacted.

Step 4: Select Random Samples

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 Template* from the health plan's working copy of the *Contact List*.

- Assign a random number to each unique provider in the health plan's de-duplicated *Contact List.*
- Sort each *Contact List* by the random number within each County/Network by each Provider Survey Type.
- Starting with the first unique provider in the randomly sorted de-duplicated *Contact List,* 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 instructions.)
- If there is only one health plan network in the county, move to Step 5.

Health plans may use excel, SAS, or other software to assign a random number and to complete the random sample selection process.

Counties with Multiple Networks

The process used to sample multiple networks is designed to sample the smallest number of providers needed to produce results for all networks. For health plans with multiple networks in a single county, use the process described above to select a random sample from the network in the county with the largest number of providers.

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 the other networks in that county. (For Ancillary Providers, use the Other Contracted Provider Facility 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 response will be applied to the provider for all relevant networks.

Review each network by size to determine whether additional providers need to be sampled to meet the required target sample size. If so, select additional unique providers from that network in the randomly sorted *Contact List* 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. (The oversample for replacement is selected following this same process.)

Step 5: Engage in Provider Outreach

In order to accurately report network performance across the time elapsed standards, health plans must obtain survey responses from a meaningful number of providers. Simple, strategic communications with health plan-contracted providers can yield a significant increase in response rates, putting the health plan (and its contracted providers) in the best position to demonstrate compliance with Timely Access appointment availability standards. Special focus for provider groups and Provider Survey Types that had high non-response rates in prior measurement years may be necessary to ensure adequate responses.

Health plans may send outreach communications that inform the provider:

- Who is administering the survey;
- Provide information about the importance of participating in the survey;
- What the survey is, why it is being done, how it is administered and the types of questions that will be asked;
- Identify the date range during which the survey is likely to occur;
- Inform providers that rates of compliance and response rates will be part of publicly available information;
- Offer information on how to participate through the Extraction method to avoid providing this information through another survey mode; and
- Remind providers of any contractual obligations indicating that they shall furnish appointment availability information to the health plan. (See Section 1367.03, subd. (f)(1).)

Outreach communications shall be clear to ensure that providers do not respond directly to the Department. Health plans are required to obtain adequate provider responses to meet the appropriate sample sizes in each County/Network, and where appropriate, to send outreach communications that encourage provider response.

Step 6: Prepare Survey Questions

The Department developed a *Survey Tool*, to be used with this methodology. Health plans are permitted to make minor adjustments to the *Survey Tool* introductory language and add language that allows confirmations of the provider's identifying information. In addition, the *Survey Tool* may be amended to indicate that the provider is contractually required to furnish this information, if applicable. Any redlined revisions to the *Survey Tool* are required to be filed as an Exhibit J-13 in eFile within 30 days of the amendment, pursuant to Section 1352, subd. (a) and Rule 1300.52, subd. (e).

In addition, health plans may incorporate additional survey questions, provider identification verification items and required provider contacts and/or notifications, including those set forth under Section 1367.27, into the Department's *Survey Tool*, if all of the following conditions are met:

- All of the Department's PAAS Methodology is followed.
- The Department's questions, set forth in the *Survey Tool*, are included as a block at beginning of the survey. No modifications can be made to *Survey Tool*'s individual items or the item order.
- In prior years, the DMHC's *Survey Tool* included a follow-up question: "Is there another practitioner in the same physical office who could see the patient sooner? (If yes) On what date and time is the earliest appointment?" **This question is no longer allowed to be used in connection with the PAAS**. If a health plan asks a similar question in relation to assessing compliance and monitoring of other timely access standards, the answers from the question may not be considered in determining the health plan's rate of compliance submitted to the Department.
- The resulting survey is not too exhaustive (which may decrease willingness to respond or may frustrate providers responding to the survey).
- The data and responses for the Department's PAAS questions are transferred to the Department's PAAS *Raw Data Template* and *Results Template*.
- The contact and/or notification comply with all other requirements of the Act.
- The redlined revisions are filed as an Exhibit J-13 in eFile within 30 days of the amendment, pursuant to Section 1352, subd. (a) and Rule 1300.52, subd. (e).

Health plans may use software or a computer program for capturing survey data, if the following requirements are met:

- The survey questions are identical to the survey questions in the *Survey Tool*.
- The health plan captures the same data fields included in the *Survey Tool*.
- The health plan populates the *Contact List, Raw Data* and *Results Templates* in accordance with the PAAS Methodology and template instructions and submits these documents in its *Timely Access Compliance Report* submission.

Step 7: Administer Survey

Timeframe and Waves

All surveys shall be completed between April 1, 2019 and December 31, 2019. The surveys shall be conducted in two waves. For each county, approximately 50% (and no more than 60%) of the providers will be surveyed in each wave. The two survey waves may be of any duration necessary to complete the survey of all providers included in the 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.) Waves shall be spaced at least three weeks apart, and the second wave shall begin no sooner than three weeks after the final survey of the first wave has been completed. Health plans may sequence the survey administration so that the waves are staggered by Provider Survey Type to avoid periods in which surveys are not being administered.

Survey Administration Modality

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 a Verified Advanced Access Program (Option 3).

Option 1: Manual or Electronic Extraction

Health plans may extract the next available urgent and non-urgent appointments for providers that were selected to be surveyed from the provider's practice management software. Health plans may manually extract appointment data (e.g., individual urgent and non-urgent appointment queries are ran manually for each provider) or electronically extract appointment data (e.g., the next available urgent and non-urgent appointments are downloaded), if all of the following requirements are met:

- Prior to administering the survey, a reliable method is in place to identify the providers that are able and willing to allow the health plan to access the next available urgent and non-urgent appointment via an Extraction method.
- The method for extracting appointment data from a provider or provider group/IPA's practice management software is reliable and results in accurate data.
- The method for extracting appointment data from a provider or provider group/IPA's practice management software allows the health plan to distinguish ineligible and non-responding providers.
- The date and time the extraction of the appointment data occurred (e.g., the date the practice management software is queried or downloaded) is captured and used to populate the "Date Survey Completed" and the "Time Survey Completed" field on the *Raw Data Template*.
- The Extraction method used by the health plan captures the date and time of the next available urgent and non-urgent appointment for the individual provider sampled. The health plan shall populate this information in the appropriate survey question field on the *Raw Data Template*.
- The date and time of the extraction and the first available urgent and non-urgent appointment shall accurately represent what would be available to an enrollee if an appointment was requested by an enrollee on the date of the data extraction.

- The Department's Methodology and administration procedures are followed, including selection of the random sample or census of providers. The sample must be randomly selected from all providers in the Contact List, and may not be selected based on whether providers' scheduling data can be accessed via Extraction and Advance Access Program.
- 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* and *Results Template*, even if Electronic Extraction is available for all providers in a provider group/IPA.
- The health plan completes the *Contact List, Raw Data and Results Templates* in accordance with the instructions set forth in each template and submits these documents as part of its *Timely Access Compliance Report* submission.

For Electronic Extraction, the health plan shall randomly assign extraction dates to provider groups/IPAs and/or providers with accessible practice management software over a three-week period during each of the survey waves. If the total number of providers in any provider group/IPA 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/IPA that will furnish appointment data by extraction in Wave 1 or Wave 2. (This may allow the health plan to access the provider group/IPA's practice management software only once.) If a single provider group/IPA constitutes more than 50% of the sample, the health plan shall extract data from the provider group/IPA across both waves.

Option 2: The Three Step Protocol

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

1. Initiate the Survey via Email, Electronic Communication or Fax[13]: The health plan shall initiate the survey set forth in the Email, Electronic Communication or Fax *Survey Tool* by sending a survey invitation either by email, electronic communication or fax. (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:

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

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

2. Send a Survey Reminder: If the provider has not responded within two business days of sending the initial survey invitation, a reminder notice may be sent. 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.

3. Conduct a Telephone Survey: If the provider does not respond to the email or fax survey invitation within five business days, the health plan shall initiate the survey via telephone, using the appropriate *Telephone Survey Tool*. The telephone survey shall be initiated within 6-15 business days of sending the initial survey attempt conducted via email, electronic communication or fax.

    - If a provider responds to the survey 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 Template and no phone call shall be made to the provider.
    - Health plans may conduct the survey of several providers during a single telephone call, but survey responses must be individualized to each selected provider.
    - If a provider's office does not answer the initial call, the surveyor shall call the provider back on or before the next business day to initiate the telephone survey. If possible, the surveyor may also leave a message requesting that the provider complete the survey (via a call-back number and/or email, electronic communication or fax[14]) within two business days of the message.
    - If a provider declines to respond to the survey, the surveyor shall offer the provider's office the option to respond at a later time. If the provider is willing to participate later, the health plan shall offer the provider the option to receive a follow-up call within the next two business days.

    If the provider does not complete the telephone survey within two business days of the initial telephone call, the provider shall be recorded on the *Raw Data Template* as a non-responder and replaced with a provider from the oversample. If the health plan was unable to initiate a telephonic survey of the provider within ten business days of sending the initial survey attempt conducted via email, electronic communication or fax, the provider shall be recorded on the *Raw Data Template* as a non-responder and replaced with a provider from the oversample.

[14] 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 Template.

Option 3: Verified Advanced Access Program

Primary Care Providers that are designated by the health plan as providing advanced access in the health plan's *Raw Data* do not need to furnish further appointment availability responses through the PAAS. Primary Care Providers that are both part of the random sample (or census) and identified in the *Raw Data* as participating in the health plan's advanced access program shall be counted as compliant for all applicable standards in the *Raw Data* and included in the health plan's calculations set forth on the *Results Template*.

If the health plan's Access and Availability Quality Assurance System verifies the advanced access programs by confirming that appointments are scheduled consistent with the definition of advanced access in subsection (b)(1), in accordance with Rule 1300.67.2.2, subd. (d)(2)(E), the health plan shall designate the Primary Care Providers participating in the advanced access program in the *Contact List* and *Raw Data Templates*. A health plan may not deem a Primary Care Provider compliant or identify its providers as participating in its advanced access program in the *Contact List* or *Raw Data Templates*, if it uses the PAAS to conduct the verification of its advanced access program.

Replacements of Non-Responding and Ineligible Providers

Whether using Extraction or the Three Step Protocol, an ineligible or non-responding provider (defined below) shall be replaced if another provider from the oversample of the same Provider Survey Type and within the same County/Network is available. If a replacement of a provider is necessary, the surveyor will use the next available provider in the oversample 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 all of the providers of that same Provider Survey Type in the County/Network have been exhausted. (This may require the health plan to select additional oversample providers, as set forth in Step 4 above.)

Non-Responding Providers

A non-responding provider is a provider that does not respond to one or more applicable items within the required time-frame or that 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 in the *Raw Data Template*.

Ineligible Providers

A provider is ineligible if he/she meets the definition of one or more of the following outcomes:

- "Provider not in 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 December 31 of the prior year[15];

[15] 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 not in County" – The provider does not practice in the relevant county at the time the survey is administered or on December 31 of the prior year;
- "Provider retired or ceasing to practice" – The provider retired or for other reasons is no longer practicing;
- "Provider Listed under Incorrect Specialty" – Was included in the *Contact List* under an incorrect Provider Survey Type;
- "Contact Information Issue (Incorrect Phone or Fax Number/Email)" – Was unable to be surveyed because he/she was listed in the database with incorrect contact information that could not be corrected; or
- "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).

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, subd. (e). In addition, health plans shall record the reason the provider is ineligible in its *Raw Data Template*, and use the information obtained in administering the survey to update health plan records to improve the *Contact List* for the following measurement year (e.g., update contact information and exclude all ineligible providers that are retired from future *Contact Lists*).

Survey Administration Notes

- 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).
- 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. Appointments occurring prior to the date and time of the call shall not be deemed compliant.
- 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.)
- If a provider's office indicates that urgent appointments are not offered, record "NA" on the *Raw Data Template* in the applicable urgent appointment time, date and compliance calculation fields.

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.

- 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.), in the *Raw Data Template* record "NA" in the appointment date and time fields and "N" in the calculation fields to indicate that the provider does not have an urgent and non-urgent appointment available within the applicable standard.
- All survey calls shall be conducted during normal business hours.

Record the Response and/or Outcome in the Raw Data Template

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/or outcome to that provider for all applicable networks within the county in the *Raw Data Template*. The health plan shall record all of the information designated with an asterisk in the *Raw Data Template* for each provider it surveys or attempts to survey using one of the three survey modalities set forth above.

Step 8: Calculate the Results

Health plans shall calculate the rates of compliance, the number of providers surveyed, whether it surveyed a sufficient number of providers to meet the target 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 responses to the survey questions for each Provider Survey Type. Use the *Results Template* Instructions, the health plan's *Raw Data Template*, and the calculation instructions set forth below to complete these calculations and enter the required information on the *Results Template*.

Calculate the Total Number of Providers Surveyed

The health plan shall ascertain the number of providers that responded to the survey via Three Step Protocol, Extraction and the Advanced Access Program on the *Raw Data Template and* record these numbers on the *Results Template* for each Provider Survey Type in each County/Network. The *Results Template* will calculate the total number of providers that responded to the survey.

- Count the number of providers that responded via the Three Step Protocol. Record this number on the *Results Template* in the "Number of Providers Responded via Three Step Protocol."
- Count the number of providers that responded via the Extraction. Record this number in the "Number of Providers Responded via Extraction."
- For Primary Care Providers only, count the number of providers that responded via the Advanced Access Program. Record this number on the *Results Template* in the "Number of Providers Responded via Advanced Access Program."
- The *Results Template* 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 via Advanced Access Program" to calculate the "Total Number of Providers Surveyed."

Identify Whether the Target Sample Size Was Achieved

Health plans must obtain a sufficient number of valid survey responses in each County/Network for each of the five Provider Survey Types in order to meet the required target sample size and ensure that its reported rates of compliance are statistically reliable and comparable across the industry. The health plan shall ascertain and record on the *Results Template* 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:

- Identify the number of unique providers in the *Contact List*. Record this number in the “Number of Providers within County/Network” field.
- Use the “Number of Providers within County/Network” and Appendix 1: County/Network Sample Size Chart to identify the target sample size. Record the target sample size in the “Target Sample Size” field.
- If the health plan was able to successfully survey a sufficient number of providers to reach the target sample size based on the numbers in the "Target Sample Size" and the "Total Number of Providers Responded to Survey” fields, enter "Y" in the “Target Sample Size Achieved” field. Enter “N” if the health plan was unable to meet the target sample size.

If the health plan did not survey a sufficient number of providers in the County/Network to meet the target sample size, the health plan must include an explanation and corrective actions, where necessary, for the failure to meet the target sample size in the health plan’s Quality Assurance Report. Each health plan must report all required information in the *Results Template*, even if it was unable to meet the target sample size in a County/Network.

Calculating Timeframes

For consistency, timeframes shall be calculated in accordance with the following instructions:

- When calculating timeframes to make a compliance determination use the date and time the provider responded to the survey or extracted the appointment data 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).
- Urgent appointments are measured in <u>hours</u> and include weekends and holidays. As a result, health plans shall capture the <u>date and time</u> the provider responded to the questions and the <u>date and time</u> of the first available appointment identified by the provider’s office.
- Non-urgent appointment standards are set forth in the Timely Access regulation in business days. For consistency, all health plans shall use the following rules in calculating timeframes:
    - Count 14 calendar days (including weekends) to calculate the 10 business day standard.

- Count 21 calendar days (including weekends) to calculate the 15 business day standard.
- When calculating calendar days, exclude the first day (e.g., the day of the request) and include the last day.
- The holidays set forth in Government Code section 6700 are excluded when calculating non-urgent appointment timeframes and the Three Step Protocol timeframes.

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 day standard (calculated by counting forward 14 calendar days) for non-urgent primary care appointments.[16]

Compliance Determinations

For each response to the question related to the next available appointment (whether obtained through the Three Step Protocol, Extraction or Advanced Access Program), a calculation must be made to determine compliance. All compliance determinations shall be recorded on the *Raw Data Template* in accordance with the following instructions:

Advanced Access Providers

- If the provider is included in the health plan's advanced access program and is identified as providing advanced access in the *Raw Data Template*, the provider is counted as compliant for the relevant appointment type(s).

Non-Advanced Access Providers

- Record the date and time of the next available urgent care appointment provided in response to Question 1 and the next available non-urgent care appointment provided in response to Question 2. Calculate whether each appointment was available within the applicable timeframe in accordance with the instructions set forth in the Calculating Timeframes section above.

Urgent Appointments

- If the response to Question 1 indicates that: "Yes, there is an available appointment within [48 hours for Primary Care Providers] or [96 hours for Specialist and NPMH]" (as applicable), the provider is counted as compliant for urgent care appointments in Calculation 1.
- If the provider's response to Question 1 indicates: "No, there is no available appointment within [48 hours for Primary Care Providers] or [96 hours for Specialist and NPMH]" (as applicable), the provider is counted as non-compliant in Calculation 1.

[16] In this example, 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 27th, Day 13: Monday the 28th, Day 14: Tuesday the 29th.

Non-Urgent Appointments

- If the response to Question 2[17] indicates that: "Yes, there is an available appointment within [10 business days for Primary Care Providers and NPMH] or [15 business days for Specialist and Ancillary providers]" (as applicable), the provider is counted as compliant in Calculation 2.
- If the provider's response to Question 2 indicates: "No, there is no available appointment within [10 business days for Primary Care Providers and NPMH] or [15 business days for Specialist and Ancillary providers]" (as applicable), the provider is counted as non-compliant in Calculation 2.

Calculating the Rate of Compliance

The *Results Template* includes a formula that automatically divides the total number of compliant providers (the numerator) by the total number of providers that responded (the denominator) and records the result in the "Rate of Compliance with [applicable standard]" field on the *Results Template*. If a sample was taken, but more providers were surveyed than required to meet the required target sample size for a County/Network, the health plan shall only use the providers in the order they were randomly selected for each network to meet the target sample size when completing the *Raw Data Template* and calculating the information on the *Results Template*.

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

Urgent Appointments

- Add together the total number of compliant providers based on Calculation 1. Record this number in either the "Number of Providers with an Urgent Care Appointment with no Prior Auth within 48 Hours" field or the "Number of Providers with an Urgent Care Appointment with Prior Auth within 96 Hours" field (as applicable). This number is used as the numerator to calculate the percentage of providers with an urgent appointment available.
- Calculate the total number of responding providers, which includes compliant and non-compliant providers. Record this number (the denominator) in the "Number of Providers Responded to an Urgent Care Appointment with no Prior Auth within 48 Hours" field or the "Number of Providers Responded to an Urgent Care Appointment with Prior Auth within 96 Hours" field (as applicable). This number is used as the denominator to calculate the percentage of providers with an urgent appointment available.

[17] For Ancillary Providers the question in the Survey Tool related to the next available non-urgent care appointment is Question 1. For all other Provider Survey Types, the question related to the next available non-urgent care appointment is Question 2. For Ancillary Providers, conduct the compliance calculations using the same instructions for non-urgent appointments but replace "Question 2" with "Question 1" in these instructions.

- Do not count "NA" responses in the denominator or numerator for the 48 or 96 hour standards for urgent care appointments.
- The formula in the *Results Template* automatically divides the numerator by the denominator to calculate the percentage of providers with an urgent appointment available, which is automatically recorded in the rate of compliance field for urgent appointments

Non-Urgent Appointments

- Add the total number of compliant providers from Calculation 2. Record this number in either the "Number of Providers with a Non-Urgent Care Appointment within 10 Days" field or the "Number of Providers with a Non-Urgent Care Appointment within 15 Days" field (as applicable). This number is used as the numerator to calculate the percentage of providers with a non-urgent appointment available.
- Calculate the total number of responding providers, which includes compliant and non-compliant providers. Record this number (the denominator) in the "Number of Providers Responded to a Non-Urgent Care Appointment within 10 Days" field or the "Number of Providers Responded to a Non-Urgent Care Appointment within 15 Days" field (as applicable). This number is used as the denominator to calculate the percentage of providers with a non-urgent appointment available.
- Do not count "NA" responses in the denominator or numerator for the 10 or 15 business day standards for non-urgent care appointments.
- The formula in the Results Template automatically divides the numerator by the denominator to calculate the percentage of providers with an urgent appointment available, which is automatically recorded in the rate of compliance field for non-urgent appointments.

The Results Template may also include formulas that calculate a weighted rate of compliance for each of the health plan's networks for all urgent appointments, non-urgent appointments, and for each of the five Provider Survey Types. The Results Template will include an explanation of how each item is calculated in the Instructions Tab.

Calculating the Percentage of Ineligible and Non-Responding Providers

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 *Results Template*.[18] The *Results Template* includes a formula to calculate both percentages. To use these formulas, the health plan shall record on the *Results Template* the numerator for each Provider Survey Type in each County/Network, in accordance with the following instructions:

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

Ineligible Providers

For each County/Network for each Provider Survey Type:

- Count the number of providers identified as ineligible from the sample and any oversample on the *Raw Data Template*. Record this number on the *Results Template* in the "Number of Ineligible Providers" field. This field is used as the numerator to calculate the percentage of ineligible providers.
- The *Results Template* 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.
- The *Results Template* formula then divides the numerator by the denominator to calculate and record the percentage of ineligible providers on the *Results Template* in the "Percentage of Ineligible Providers" field.

Non-Responding Providers

For each County/Network for each Provider Survey Type:

- Count the number of providers identified as non-responding in the sample and in the oversample from the *Raw Data Template*. Record this number on the *Results Template* in the "Number of Non-Responding Providers" field. This field is used as the numerator to calculate the percentage of non-responding providers.
- The *Results Template* automatically adds the "Total Number of Providers Responded to Survey" and the "Number of Non-Responding Providers" to calculate the denominator.
- The *Results Template* formula then automatically divides the numerator by the denominator to calculate and record the percentage of non-responding providers on the *Results Template* in the "Percentage of Non-Responding Providers" field.

Step 9: Create Quality Assurance Report

Each health plan shall have a quality assurance process to ensure that it followed the PAAS Methodology and PAAS Template Instructions, 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, pursuant to Section 1396.

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 MY 2019 PAAS data and processes. This review and the quality assurance process shall be completed prior to submission of the *Timely Access Compliance Report* to the Department, on or before April 1, 2020. At a minimum, the external vendor's review shall ensure all of the following:

- The health plan used the Department-issued *PAAS Templates* for MY 2019.
- The health plan reported results for all applicable networks, including those networks solely maintained for use by another health plan in a plan-to-plan arrangement.

- The health plan identified, surveyed and recorded survey responses in the *Raw Data Template* for unique providers, in accordance with the Methodology.
- For any plan-to-plan arrangements, the primary health plan's line-of-business associated with each network used by a secondary health plan is consistent with the line-of-business reported by the secondary health plan.
- The health plan reported survey results for all Provider Survey Types that were required to be surveyed, as applicable, based on the composition of the health plan's network as of December 31 of the prior year.
- The Timely Access Compliance Report (including the Contact List Template, the Raw Data Template, and the Results Template) accurately reflects and reports compliance for providers who were under contract with and part of the health plan's Department-regulated network(s) on December 31 of the prior year.
- All outcomes and calculations, including the rates of compliance and compliance determinations, recorded on the Raw Data Template and the Results Template are accurately calculated and recorded, consistent with, and supported by data entered on the health plan's *Raw Data Template* (including those calculations embedded on the *Results Templates*).
- The administration of the survey followed the Department's mandatory PAAS Methodology for MY 2019, including, but not limited to, conducting the survey during the appropriate measurement year and ensuring adherence to all target sample sizes and other parameters required under the Methodology, Survey Tool and PAAS Template instructions, in accordance with Section 1367.03, subd. (f)(3).

As part of its *Timely Access Compliance Report*, the health plan shall submit a *Quality Assurance Report,* prepared by an external vendor, outlining the results of the review. The Quality Assurance Report shall at a minimum include:

- Details regarding the review of each verification item identified above.
- A summary of the findings from the review, including completion of the DMHC-issued Addendum to the Quality Assurance Report.
- Identification of any changes and/or corrections made as a result of the data and quality assurance review.
- Any explanations for issues identified, including those determined to be compliant with this Methodology.
- For any identified errors or issues that the health plan did not correct or is unable to correct, the health plan shall explain why it was unable to comply with the MY 2019 PAAS Methodology and identify steps to be taken by the health plan to ensure compliance during future reporting years. (See Section 1367.03, subd. (f)(3).)

The *Quality Assurance Report* and any accompanying health plan explanations shall be submitted in the Comment/Narrative section of the Department's Timely Access Reporting Web Portal.

Step 10: Submit the Health Plan's Timely Access Compliance Report

On April 1, 2020, as part of its annual *Timely Access Compliance Report*, each health plan shall submit the following items to the Department for each of the applicable Provider Survey Types:

- *Contact List Template,*
- *Raw Data Template*, and
- *Results Template*

In addition, each health plan is required to submit all applicable items set forth in the *Timely Access Compliance Report Instructions*. The health plan's *Timely Access Compliance Report* shall be submitted through the Department's Timely Access Reporting Web Portal. Please refer to the *Timely Access Compliance Report Instructions*, available on the Department's Timely Access web page, for further details regarding submission of each required element. Any questions may be sent to the Timely Access email inbox.

Language Assistance Program Assessment Addendum

Health plans shall assess provider perspectives and concerns with the health plan's language assistance program regarding:

- The coordination of appointments with an interpreter.
- The availability of an appropriate range of interpreters.
- The training and competency of available interpreters.

These additional required questions—designed to elicit providers concerns and perspectives—must be included in the health plan's Annual Provider Satisfaction Survey. (*See* Rule 1300.67.2.2, subd. (c)(4) and (d)(2)(C).)

Any redlined revisions to the Provider Satisfaction Survey and policies and procedures to implement these requirements shall be filed as an Exhibit J-13 in eFile within 30 calendar days of the amendment, pursuant to Section 1352, subd. (a) and Rule 1300.52, subd. (e).

Results for the current year and a comparison of the prior year's results shall be reported with the health plan's *Timely Access Compliance Report* in the Provider Satisfaction Survey Results section of the Timely Access Reporting Web Portal. In addition, health plans are required to utilize information obtained that relates to provider perspectives and concerns in this area in connection with the health plan's timely access monitoring quality assurance activities and language assistance program compliance monitoring. (*See* Section 1367.01, Rule 1300.67.2.2, subd. (d), and Rules 1300.67.04, subds. (c)(2)(E) and (c)(4)(A).)

Appendix 1: Sample Size Chart

To determine the required number of completed surveys, identify the target sample size[19] for each network by identifying the total number of contracted providers in the County/Network in the "Number of Providers in County/Network" column and the corresponding required target sample size.

Number of Contracted Providers in County/Network	Required Target Sample Size	Number of Contracted Providers in County / Network	Required Target 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

[19] Sample sizes were calculated to produce confidence limits of +- 5% for an expected compliance rate of 85% with a 95% confidence level. These target sample sizes are expected to produce maximum confidence limits of +- 5% for county/networks.

Sample Size Chart Continued

Number of Contracted Providers in County / Network	Required Target Sample Size
111 – 115	73
116 – 120	75
121 – 125	77
126 – 130	79
131 – 135	81
136 – 140	82
141 – 145	84
146 – 150	86
151 – 155	87
156 – 160	89
161 – 165	90
166 – 170	92
171 – 175	93
176 – 180	95
181 – 185	96
186 – 190	97
191 – 195	98
196 – 200	100
201 – 205	101
206 – 210	102
211 – 215	103
216 – 220	104
221 – 225	105
226 – 230	107
231 – 235	108
236 – 240	109
241 – 245	110
246 – 250	111
251 – 255	112
256 – 265	113
266 – 270	114
271 – 275	115
276 – 280	116
281 – 285	117
286 – 290	118
291 – 300	119
301 – 305	120
306 – 310	121
311 – 315	122
316 – 325	123

Number of Contracted Providers in County / Network	Required Target Sample Size
326 - 330	124
331 - 340	125
341 - 345	126
346 - 355	127
356 - 360	128
361 - 370	129
371 - 380	130
381 - 385	131
386 - 395	132
396 - 405	133
406 - 415	134
416 - 425	135
426 - 435	136
436 - 445	137
446 - 455	138
456 - 465	139
466 - 480	140
481 - 490	141
491 - 505	142
506 - 515	143
516 - 530	144
531 - 545	145
546 - 560	146
561 - 575	147
576 - 590	148
591 - 605	149
606 - 620	150
621 - 640	151
641 - 660	152
661 - 675	153
676 - 695	154
696 - 720	155
721 - 740	156
741 - 765	157
766 - 790	158
791 - 815	159
816 - 840	160
841 - 870	161
871 - 900	162
901 - 935	163

Sample Size Chart Continued

Number of Contracted Providers in County / Network	Required Target Sample Size
936 - 970	164
971 - 1005	165
1006 - 1045	166
1046 - 1085	167
1086 - 1130	168
1131 - 1175	169
1176 - 1225	170
1226 - 1280	171
1281 - 1340	172
1341 - 1405	173
1406 - 1475	174
1476 - 1550	175
1551 - 1635	176
1636 - 1725	177
1726 - 1825	178
1826 - 1940	179
1941 - 2065	180
2066 - 2205	181
2206 - 2370	182
2371 - 2550	183
2551 - 2765	184
2766 - 3015	185
3016 - 3305	186
3306 - 3660	187
3661 - 4090	188
4091 - 4635	189
4636 - 5330	190
5331 - 6265	191
6266 - 7580	192
7581 - 9565	193
9566 - 12920	194
12921 - 41649	195
41650 and above	196