Appointment Wait Time Secret Shopper Survey Technical Guidance for Qualified Health Plan (QHP) Issuers in the Federally-facilitated Exchanges (FFEs)

September 2024

Document Change Log

Background • Telehealth definition has been added for more clarity. Section A. Identifying the Population to Be Surveyed • Information added to denote data elements included in the provider population file. • Information added to note that more than one phone number per provider may be used for no more than three contact attempts. • Information added to the definition of a nonresponsive provider. Third parties are to spend no more than a maximum of 20 minutes of interactive voice response (i.e., phone tree navigation). Section B. Sample Selection • Information added to clarify that providers should be identified by a unique National Provider Identifier in the provider population file. • Information added to clarify that pediatric and adult primary care providers should be combined to create the oversample. Section C. Survey Protocol Development • Information added to indicate that secret shoppers may present as an associate or a representative of a new patient, such as a family member. Section E. Collecting and Documenting Survey Results • New disposition code added for use when secret shopper is asked to consult an online scheduling system or a patient portal to obtain appointment availability. • Information added indicating that more than one contact attempt could be made for the same provider in the same business day if the contact attempts occurred in different parts of the business day. Section G. Submitting Survey Results Data to CMS • Information added noting that all QHP issuers must submit appointment wait time surveys to CMS. • The contact email address for data submission has been updated to AWTReviews@hcmsllc.com. Appendix A. Required Secret Shopper Survey Results • Information added to the file format requirements of data submissions from issuers. • Information added to indicate a reason that a phone number was invalid in results reported (disconnected, not associated with surveyed provider). Appendix B. Valid Survey Disposition Codes • Information added in “instructions for reporting” column for disposition codes “B”,”C”, “K”, and “T” regarding how to format additional information in the “General Notes” field of results reported Appendix D. General Tips and Script Suggestions • This Appendix added to provide script workarounds and general tips with best practices for conducting secret shopper calls.	September 18, 2024

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Technical Assistance and Contact Information

For questions regarding policies and procedures contained in the Appointment Wait Time Secret Shopper Survey Technical Guidance, please contact the Marketplace Service Desk (MSD) via email at CMS_FEPS@cms.hhs.gov or via phone at 1-855-CMS-1515 (1-855-267-1515).

For questions regarding how Qualified Health Plan (QHP) issuers must submit survey data, please email AWTReviews@hcmsllc.com.

Background

In the *2025 Final Letter to Issuers in the FFEs*, published April 10, 2024, the Centers for Medicare & Medicaid Services (CMS) stated that, beginning January 1, 2025, Qualified Health Plan (QHP) issuers, including stand-alone dental plan (SADP) issuers, in the Federally-facilitated Exchanges (FFEs) are required to meet appointment wait time standards established by the FFEs, reflected in Table 1. For the 2025 plan year, QHP issuers, including SADP issuers, must ensure that enrollees seeking an appointment are able to schedule an appointment within the time frames below at least 90% of the time. CMS is particularly concerned with the ability of new patients to schedule appointments with in-network providers; more than half of enrollees on the FFEs newly enroll in QHPs or change their enrollment to a new QHP each year, and these enrollees may need to seek care as a patient who is new to a provider.

Table 1. FFE-established Appointment Wait Times

Provider specialty type	Appointments must be available within
Behavioral Health	10 business days
Primary Care (Routine)	15 business days
Specialty Care (Non-urgent)	30 business days

CMS requires medical QHP issuers offering QHPs in the FFEs to contract with a third-party entity to administer secret shopper surveys to meet the appointment wait time standards. The third-party entity that conducts the surveys must be a separate and distinct entity from the medical QHP issuer. For example, the third-party entity and the issuer cannot be affiliated companies, and they cannot be subsidiaries of the same parent company. To limit the burden on QHP issuers, CMS intends to require that secret shopper surveys be conducted for a QHP issuer's primary care (routine) and behavioral health providers for plan year 2025. CMS expects to require secret shopper surveys to be administered with respect to specialty care (non-urgent) providers in future plan years.

As SADP issuers would generally contract with specialty care (non-urgent) providers, SADP issuers would not be required to contract with a third-party entity to conduct secret shopper surveys for the 2025 plan year.

To demonstrate compliance with these standards, medical QHP issuers must contract with a third-party entity to conduct a secret shopper survey, with surveying beginning on or shortly after January 1 and completed by May 31 of each plan year and report the results of the surveys to CMS as part of QHP issuer compliance and monitoring activities. The third-party entity must conduct secret shopper surveys while presenting as a new patient (i.e., a patient attending their first-ever clinical encounter with a practitioner at the location being surveyed). CMS may require medical QHP issuers to provide CMS with documentation underlying the results of those surveys, for CMS's review. Medical QHP issuers must retain relevant documentation related to the surveys in accordance with the broad record retention policies set forth in 45 CFR 156.705.

A QHP issuer's third-party entity would be required to administer secret shopper surveys to a survey pool, provided to issuers by CMS, that includes a statistically valid representation of providers across the QHP's network that are accessible to consumers within the requisite time and distance standards in

the service area. The third-party entity must identify a statistically valid, minimum sample size for each provider type.

Issuers that fail to have a third-party entity conduct the secret shopper survey, fail to report the results, or report results that do not reflect compliance with the appointment wait time standards (i.e., by reporting results that do not reflect that enrollees seeking an appointment are able to schedule an appointment within the time frames above at least 90% of the time), based on only those providers that count toward the issuer's satisfaction of the time and distance requirements under § 156.230(a)(2)(i)(A), would need to add more contracted providers to the network to achieve alignment with the standards, and/or would need to come into alignment with the standards by contracting with a third-party entity to conduct the surveys and reporting compliant results as appropriate.

In order to assess compliance with the appointment wait time standards, the third-party entities should collect information from provider offices on the availability of both in-person and telehealth appointments. The calculation of the 90% compliance rate for secret shopper surveys of appointment wait times will be based on whichever appointment, in-person or telehealth, has the shortest wait time. For the purpose of the appointment wait time standards, CMS defines telehealth as "professional consultations, office visits, and office psychiatry services through brief communication technology-based service/virtual check-in, remote evaluation of pre-recorded patient information, and inter-professional internet consultation." This aligns with how CMS defines telehealth broadly for network adequacy in the 2023 Final Letter to Issuers in the Federally-facilitated Exchanges (Chapter 2, section 3, iii. Telehealth Services). We acknowledge that telehealth is an important option for some patients to access care, and the data collected in this first year of reporting for appointment wait time compliance will be used to inform decisions regarding how we will measure compliance in future years.

This document provides issuers and their contracted third-party entities with additional technical guidance and secret shopper survey implementation requirements.

A. Identifying the Population to Be Surveyed

Each fall, CMS will provide issuers with a file, referred to subsequently as the "provider population file," that contains the population or "universe" of providers from which QHP issuers' third-party entities must draw a statistically valid, randomized oversample. The provider population file will be derived by CMS from provider data submitted by issuers on the "Network Adequacy Provider" tab in the Network Adequacy template submitted during the annual QHP certification process. The provider population file will include providers, from the list submitted by the issuer, that have been validated and approved by CMS to count toward the issuer's satisfaction of the time and distance standards for the corresponding specialty types (i.e., primary care (routine) and behavioral health). Please note: The provider population file will not include facility provider types (e.g., Outpatient Behavioral Health Clinics), plan IDs, or phone numbers. QHP issuers are responsible for sharing provider phone numbers with their contracted third-party entities. QHP issuers are permitted to share more than one phone number per provider, if applicable and available. CMS will create the provider population file after the final round of QHP certification data submission is complete.

The provider population file that CMS will generate for each issuer will include the following data fields for each individual provider on the issuer's submitted Network Adequacy template that CMS has validated and approved during the QHP certification review process for the corresponding specialty types:

1. Issuer Identification Number
2. Network Identification Number
3. Servicing Specialty Group (Outpatient Clinical Behavioral Health/Primary Care Provider)
4. National Provider Identifier (NPI)
5. Provider Name
6. Street Address
7. Street Address 2
8. City
9. State
10. ZIP Code
11. County Name
12. Specialty Code
13. Specialty

CMS defines primary care (routine) and behavioral health care providers for the purpose of assessing issuer compliance with appointment wait time standards to include providers with the taxonomy codes listed in Tables 2 and 3, which contain taxonomy codes that correspond to each provider type as listed in the Network Adequacy template. **Only providers included in the provider population file may be surveyed.**

Table 2. Primary Care Provider Specialty Types

Primary Care Provider Specialty Types for Primary Care (Routine) Category for Appointment Wait Time Standards		
NUCC taxonomy code	Specialty type codes and descriptions	NUCC display name
207Q00000X	Family Medicine (002)	Family Medicine Physician
207QA0000X	Family Medicine (002)	Adolescent Medicine (Family Medicine) Physician
207QA0505X	Family Medicine (002)	Adult Medicine Physician
207QB0002X	Family Medicine (002)	Obesity Medicine (Family Medicine) Physician
208D00000X	General Practice (001)	General Practice Physician
207QG0300X	Geriatrics (004)	Geriatric Medicine (Family Medicine) Physician
207RG0300X	Geriatrics (004)	Geriatric Medicine (Internal Medicine) Physician
207R00000X	Internal Medicine (003)	Internal Medicine Physician
207RA0000X	Internal Medicine (003)	Adolescent Medicine (Internal Medicine) Physician

Primary Care Provider Specialty Types for Primary Care (Routine) Category for Appointment Wait Time Standards		
NUCC taxonomy code	Specialty type codes and descriptions	NUCC display name
207RB0002X	Internal Medicine (003)	Obesity Medicine (Internal Medicine) Physician
363LA2200X	Primary Care - Advanced Registered Nurse Practitioner (006)	Adult Health Nurse Practitioner
363LF0000X	Primary Care - Advanced Registered Nurse Practitioner (006)	Family Nurse Practitioner
363LP2300X	Primary Care - Advanced Registered Nurse Practitioner (006)	Primary Care Nurse Practitioner
363A00000X	Primary Care - Physician Assistant (005)	Physician Assistant
363AM0700X	Primary Care - Physician Assistant (005)	Medical Physician Assistant
208000000X	Primary Care – Pediatric (101)	Pediatrics Physician
2080A0000X	Primary Care – Pediatric (101)	Pediatric Adolescent Medicine Physician

Note. NUCC = National Uniform Claim Committee.

Table 3. Behavioral Health Provider Specialty Types

Behavioral Health Provider Specialty Types for Behavioral Health Category for Appointment Wait Time Standards		
NUCC taxonomy code	Specialty type codes and description	NUCC display name
101YA0400X	Addiction (Substance Use Disorder) Counselor (106)	Addiction (Substance Use Disorder) Counselor
207LA0401X	Addiction Medicine Physician (800)	Addiction Medicine (Anesthesiology) Physician
207QA0401X	Addiction Medicine Physician (800)	Addiction Medicine (Family Medicine) Physician
207RA0401X	Addiction Medicine Physician (800)	Addiction Medicine (Internal Medicine) Physician
2083A0300X	Addiction Medicine Physician (800)	Addiction Medicine (Preventive Medicine) Physician
103K00000X	Behavioral Analyst (801)	Behavioral Analyst
363LP0808X	Behavioral Health - Advanced Practice Registered Nurse (108)	Psychiatric/Mental Health Nurse Practitioner
364SP0808X	Behavioral Health - Advanced Practice Registered Nurse (108)	Psychiatric/Mental Health Clinical Nurse Specialist

Behavioral Health Provider Specialty Types for Behavioral Health Category for Appointment Wait Time Standards		
NUCC taxonomy code	Specialty type codes and description	NUCC display name
101Y00000X	Counselor (Mental Health and Professional) (107)	Counselor
101YM0800X	Counselor (Mental Health and Professional) (107)	Mental Health Counselor
101YP2500X	Counselor (Mental Health and Professional) (107)	Professional Counselor
106H00000X	Marriage and Family Therapist (105)	Marriage & Family Therapist
103T00000X	Psychologist (103)	Psychologist
103TA0400X	Psychologist (103)	Addiction (Substance Use Disorder) Psychologist
103TA0700X	Psychologist (103)	Adult Development & Aging Psychologist
103TB0200X	Psychologist (103)	Cognitive & Behavioral Psychologist
103TC0700X	Psychologist (103)	Clinical Psychologist
103TC1900X	Psychologist (103)	Counseling Psychologist
103TC2200X	Psychologist (103)	Clinical Child & Adolescent Psychologist
103TE1100X	Psychologist (103)	Exercise & Sports Psychologist
103TF0000X	Psychologist (103)	Family Psychologist
103TF0200X	Psychologist (103)	Forensic Psychologist
103TH0004X	Psychologist (103)	Health Psychologist
103TH0100X	Psychologist (103)	Health Service Psychologist
103TM1800X	Psychologist (103)	Intellectual & Developmental Disabilities Psychologist
103TP0016X	Psychologist (103)	Prescribing (Medical) Psychologist
103TP0814X	Psychologist (103)	Psychoanalysis Psychologist
103TP2701X	Psychologist (103)	Group Psychotherapy Psychologist
103TR0400X	Psychologist (103)	Rehabilitation Psychologist
103TS0200X	Psychologist (103)	School Psychologist
104100000X	Social Worker (102)	Social Worker
1041C0700X	Social Worker (102)	Clinical Social Worker
1041S0200X	Social Worker (102)	School Social Worker

Note. NUCC = National Uniform Claim Committee.

B. Sample Selection

A QHP issuer's third-party entity must survey a minimum number of providers of each provider specialty type included in the provider population file (i.e., primary care (routine) and behavioral health). The minimum number of providers that must be surveyed, based on the total number of providers of a specific specialty type in an issuer's QHP provider network, has been identified by CMS to produce maximum confidence limits of +/- 5% for an expected compliance rate of 90% with a 95% confidence level for the issuer's QHP provider network per service area. Individual providers are identified by unique National Provider Identifier (NPI). Please refer to Table 4 to determine the minimum sample size to be surveyed for each provider type from each of an issuer's QHP provider networks.

The required sampling approach is summarized in the following steps and illustrated in Figure 1: Overview of Survey Sampling Process.

1. **Select the Oversample:** CMS acknowledges that network adequacy provider data submitted by an issuer in the Network Adequacy template during the certification process are a point-in-time representation of an issuer's QHP provider networks. Thus, to account for providers that are nonresponsive or ineligible when surveys are conducted, a QHP issuer's third-party entity must select a statistically valid random oversample of providers from the provider population file that is 50% larger than the minimum sample sizes identified in Table 4. QHP issuers' third-party entities should round-up to the nearest whole number when calculating the size of the oversample population. If there are not enough providers in an issuer's provider population file to draw a full oversample that is 50% larger than the required minimum sample, then the third-party entity must create a reserve sample from the remaining providers that were not included in the minimum sample. Pediatric primary care providers and adult primary care providers will be delineated in the provider population file. QHP issuers' third-party entities must combine all the taxonomies within these categories to create the oversample of primary care providers for a network. Pediatric or adult primary care providers should not be sampled separately.
2. **Draw the Minimum Sample:** For each issuer's QHP provider network, the QHP issuer's third-party entity must draw, from the oversample population, a random, statistically valid, minimum sample size for surveying of each provider type (i.e., primary care (routine) and behavioral health).
3. **As Applicable, Utilize the Reserve Sample:** If the minimum sample includes ineligible or nonresponsive providers, replacements must be drawn from the reserve sample. If the reserve sample is exhausted, and if additional providers remain in the provider population file, QHP issuers' third-party entities must add additional providers of that same provider type to the oversample via random selection. The QHP issuer's third-party entity must continue to add providers to the oversample using a random selection process until either the required minimum number of providers per QHP provider network/service area are surveyed or all providers within the QHP provider network/service area for the applicable provider type have been surveyed.

For example, if an issuer's QHP provider network contains 108 individual primary care providers, as identified by unique NPI, then the minimum sample size that must be surveyed for the primary care provider type for that issuer's QHP provider network is 62. The QHP issuer's third-party entity must select one randomized oversample of 93 primary care (routine) providers (consisting of the minimum sample of 62 plus a reserve sample of 31).

Table 4. Minimum Survey Sample Sizes

Number of specialty category providers in issuer's QHP provider network	Minimum sample size to be surveyed	Number of specialty category providers in issuer's QHP provider network	Minimum sample size to be surveyed	Number of specialty category providers in issuer's QHP provider network	Minimum sample size to be surveyed
1	1	26–30	25	251–260	91
2	2	31–35	29	261–270	92
3	3	36–40	32	271–280	93
4	4	41–45	35	281–290	94
5	5	46–50	37	291–300	95
6	6	51–60	43	301–325	98
7	7	61–70	47	326–350	100
8	8	71–80	51	351–375	102
9	9	81–90	55	376–400	103
10	10	91–100	59	401–425	105
11	11	101–110	62	426–450	106
12	12	111–120	65	451–475	108
13	12	121–130	68	476–500	109
14	13	131–140	70	501–600	113
15	14	141–150	73	601–700	116
16	15	151–160	75	701–800	119
17	16	161–170	77	801–900	120
18	17	171–180	79	901–1,000	122
19	17	181–190	81	1,001–2,000	130
20	18	191–200	83	2,001–3,000	133
21	19	201–210	84	3,001–4,000	134
22	20	211–220	86	4,001–5,000	135
23	20	221–230	87	5,001–10,000	137
24	21	231–240	88	10,001–15,000	138
25	22	241–250	90	15,001–50,000	138

A provider is ineligible to be surveyed (and therefore must be replaced by a randomly selected provider from the reserve sample) if:

1. At the time of the call, the provider is no longer contracted with the issuer as an in-network provider.
2. At the time of the call, the provider is not practicing and classified as a primary care provider specialty type or behavioral health provider specialty type according to the specialty types/descriptions listed in Tables 2 and 3.

If a provider is determined to be ineligible upon the first contact attempt, no additional contact attempts should be made, and the provider must be replaced by a randomly selected provider of the same specialty type from the reserve sample.

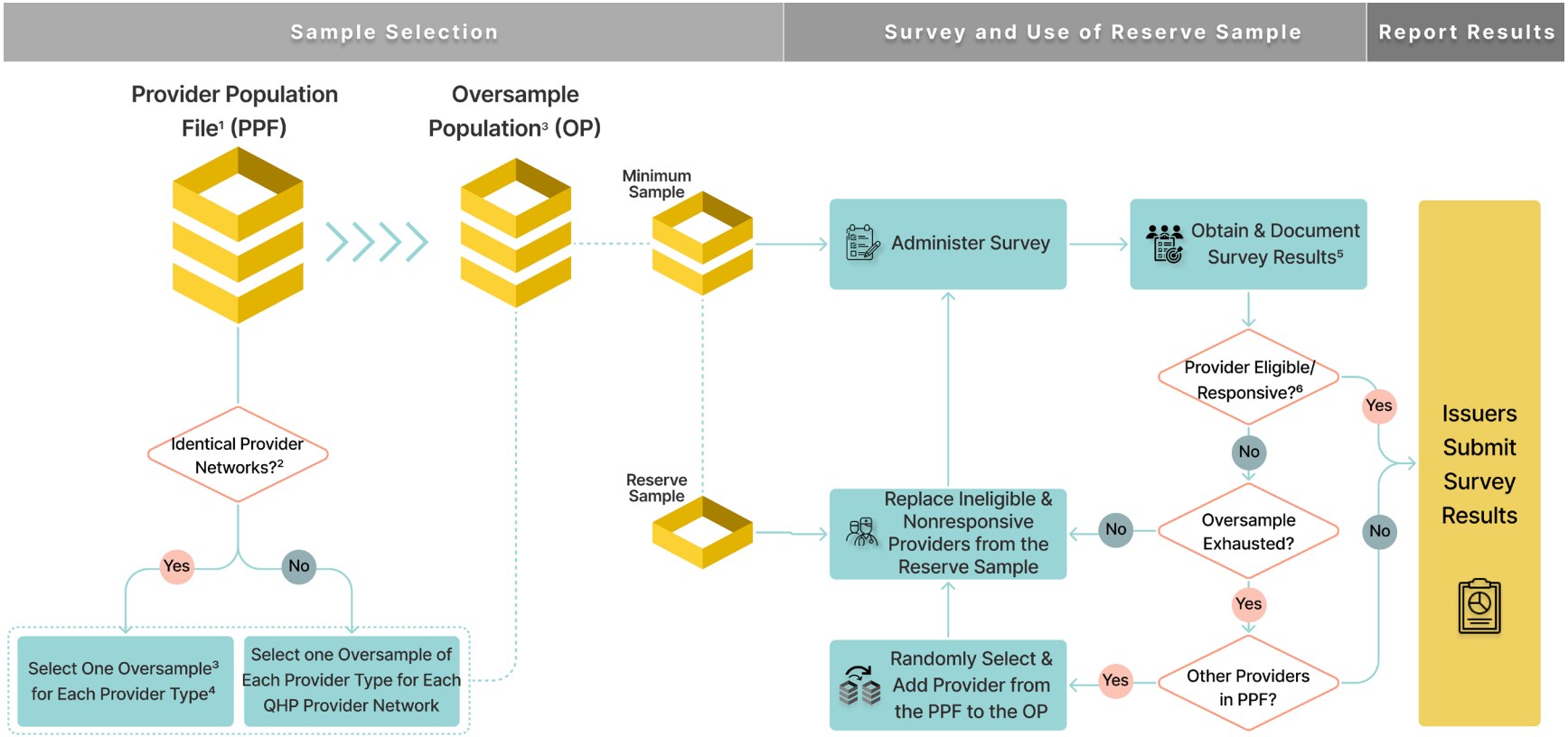
Additionally, if a provider is nonresponsive, they must be replaced by a randomly selected provider from the reserve sample. A provider is defined as nonresponsive if any of the following dispositions are documented for each of three contact attempts associated with the same provider:

1. The provider was nonresponsive: The phone rang for 5 minutes without an answer.
2. The provider was nonresponsive: The phone number is not valid (for example, the number is disconnected, or the phone number is not associated with the provider). If a provider's phone number is not valid, the secret shopper should not make two additional contact attempts using that same invalid phone number before replacing the provider with another provider from the reserve sample. The secret shopper may use more than one phone number to complete a maximum of three contact attempts per provider.
3. The provider was nonresponsive: A voicemail greeting was received during regular business hours, not during a designated lunch hour, and the voicemail system was not part of an appointment scheduling procedure.
4. The provider was nonresponsive: The secret shopper was placed on hold by the provider's office for more than 15 minutes. Third-party entities' secret shoppers should engage with interactive voice response (IVR) systems; however, they are not expected to navigate a phone tree for more than 20 minutes, inclusive of the 15 minutes they may be placed on hold.
5. The provider was nonresponsive: The call could not be completed due to communication issue(s) such as poor call connectivity.

If a QHP issuer has multiple, identical provider networks (for example, the same provider network is associated with several plan variations offered by the same issuer), then only one statistically valid, randomized oversample of each provider type must be drawn and used for surveying the minimum required number of providers of each provider type. The oversample can be used for all identical provider networks.

If a QHP has multiple, *nonidentical* provider networks, then a statistically valid, randomized oversample population of each provider type must be drawn from the provider population file for each issuer's QHP provider network. If the same provider is included in the oversample population drawn for more than one issuer's QHP provider networks and a survey result is obtained from that provider, then that result can be reported and applied for that same provider for each sample in which the provider appears.

Figure 1. Overview of Survey Sampling Process



1. The provider population file will be derived by CMS from provider data submitted by issuers on the "Network Adequacy Provider" tab in the Network Adequacy template submitted during the annual QHP certification process.
2. For identical QHP provider networks, see Section B.
3. The oversample population is a statistically valid, randomly selected population of providers that is 50% above the minimum sample that must be surveyed based on QHP provider network size. This oversample consists of a minimum sample to be surveyed and a reserve sample. QHP issuers' third-party entities will draw from the reserve sample to replace providers that are nonresponsive or ineligible.
4. CMS defines primary care (routine) and behavioral health care providers for purposes of AWT standards to include providers with the taxonomy codes listed in the Tables 2 & 3.
5. If the same provider is included in the oversample population drawn for more than one unique issuer network and a survey result is obtained from that provider, then that result can be reported for each sample in which the provider appears.
6. For ineligible and nonresponsive providers, please see Section B.

C. Survey Protocol Development

QHP issuers must work with their third-party entities to develop and finalize a secret shopper survey protocol that reasonably approximates an enrollee's experience as a new patient attempting to obtain appointment availability from a provider. The protocol must be appropriately designed to obtain an offer for a first available appointment and adhere to the following minimum requirements:

1. The third-party entity must conduct secret shopper surveys while presenting as a new patient (i.e., a patient attending their first-ever clinical encounter with a practitioner at the location being surveyed). This may include posing as a representative or associate of a new patient (i.e., a patient or a family member of a patient). The survey script must be designed such that the secret shopper confirms whether the provider specifically offers primary care (routine) and/or behavioral health services at the location being surveyed.
2. The survey script must be designed such that the secret shopper ascertains whether the provider offers both in-person appointments and telehealth appointments, offers only telehealth appointments, or offers only in-person appointments. If a provider offers both in-person and telehealth appointments for new patients, and the first (i.e., soonest) available appointment offered is a telehealth appointment, then the secret shopper must also obtain appointment availability information for the next available in-person appointment.

   Alternatively, if a provider offers both in-person and telehealth appointments for new patients, and the first (i.e., soonest) available appointment offered is an in-person appointment, then the secret shopper must also obtain appointment availability information for the next available telehealth appointment.
3. The survey protocol must be designed such that the secret shopper does not actually accept an offered appointment (therefore precluding actual patients from being able to access that appointment). For example, once an appointment is offered to the secret shopper, the secret shopper can say that they need to consult their calendar before confirming and then end the call.

QHP issuers and their third-party entities may consider a protocol that uses simulated enrollee profiles (consisting of, for example, plan identification numbers and/or other simulated identifying information) if the QHP issuer and the QHP issuer's third-party entity determine this approach is feasible and/or believe this approach would increase the likelihood that providers would provide appointment availability information to secret shoppers. Neither simulated enrollee profiles nor survey scripts used by secret shoppers should convey the existence of an urgent medical need.

QHP issuers and their third-party entities may refer to the example script responses or "workarounds" and general tips contained in Appendix D when developing their secret shopper survey scripts and protocols. These examples may be useful when secret shoppers encounter certain scenarios, such as being asked by a provider's office for an insurance identification number, patient employer, or other identifying information.

D. Survey Administration

Secret shopper calls must begin on or shortly after January 1 and must be completed by May 31 of the plan year. All outgoing secret shopper calls must be conducted between 8:00 a.m. and 5:00 p.m. in the providers' respective time zones.

The secret shopper may not contact a provider's office more than three times to obtain appointment availability information. For example, if the first contact attempt for a provider fails due to the provider being nonresponsive as defined in the disposition codes enumerated in Appendix B, the secret shopper may attempt to call that same provider's office two additional times, for a maximum of three contact attempts.

E. Collecting and Documenting Survey Results Data

QHP issuers must instruct their third-party entities to document secret shopper survey results for each provider surveyed and/or contacted to be surveyed using the fields, definitions, and disposition codes as described in Appendices A and B. Additionally, QHP issuers' third-party entities must adhere to the following guidelines when documenting and reporting survey results:

Scenario	Response to Scenario
If a surveyed provider indicates that the date and time of the first available appointment depends upon whether the appointment is conducted in person or via telehealth, the secret shopper must …	Document the first available appointment in the results reported, use the first available appointment to calculate the actual wait time length associated with the contact attempt (documented in the "Time_Elapsed" field in the results reported), and indicate the appointment format according to Appendix A.
If the surveyed provider indicates they have an appointment available at a later time and date than with an equivalent provider and the secret shopper is offered an appointment with such equivalent provider, the secret shopper must …	Document the first available appointment offered with the equivalent provider in the results reported according to Appendices A and B. An equivalent provider is defined as another in-network provider of the same specialty type within the same practice location.
If a provider reports they are not currently accepting new patients, the secret shopper must …	Ask whether there is a waiting list and/or estimated period during which the provider is not accepting new patients. For example, the secret shopper may ask a follow-up question such as "Do you know when Dr. Smith will start accepting new patients again?" and/or "Is there a waiting list for new patient appointments, and if so, how long does it typically take to get off the waiting list?" If the provider/provider's office does not know when the provider will start accepting new patients and/or is unable to provide estimated information about a waiting list or future appointment availability, the secret shopper must document the appointment wait time as "N/A" in the "Time_Elapsed" field in the results reported, indicate that the provider does not have an appointment available within the applicable standard in the "Compliance_Indicator" field in the results reported, and note the appropriate disposition code(s) in the results reported. If the provider/provider's office clearly indicates, for example, that the provider will start accepting new patients again in 3 months, the secret shopper must document the appointment wait time (in the "Time_Elapsed" field in the results reported) by calculating the number of business days from the date of the call that resulted in an appointment offered and 3 months out from that date, indicate that the provider does not have an appointment available within the applicable standard, and note the appropriate disposition code(s) in the results reported.

Scenario	Response to Scenario
If the provider reports that patients are served on a walk-in or same-day basis, the secret shopper must …	Ask the provider to provide the date that a patient walking in at the time of the call would be seen. Document that day's date as the date of the soonest available appointment offered and enter "0" in the "Time_Elapsed" field in the results reported.
If the provider is not scheduling appointments at the time of the survey because they are temporarily unavailable due to vacation, sabbatical, parental leave, personal issue, etc., the secret shopper must …	Ask whether there is an estimated future point in time wherein the provider will again be able to offer new patient appointments. For example, the secret shopper may ask a follow-up question such as, "Do you know when Dr. Smith will be back from vacation and when her first available appointment would be?" If the provider/provider's office does not know when the provider will again offer new patient appointments and/or is unable to provide estimated information, the secret shopper must document the appointment wait time as "N/A" in the "Time_Elapsed" field in the results reported, indicate that the provider does not have an appointment available within the applicable standard (in the "Compliance_Indicator" field in results reported), and note the appropriate disposition code(s) in the results reported. If the provider/provider's office clearly indicates, for example, that the provider will be offering new patient appointments in 3 weeks, the secret shopper must document the appointment wait time (in the "Time_Elapsed" field in the results reported) by calculating the number of business days from the date of the call that resulted in an appointment offered and 3 weeks out from that date, indicate that the provider does not have an appointment available within the applicable standard, and note the appropriate disposition reason code(s) in the results reported.
If the secret shopper encounters communication difficulties when calling a provider, such as poor call quality and/or not being able to hear the call recipient, the secret shopper must …	End the call and document the appropriate disposition code associated with the contact attempt (G). The secret shopper must wait until at least the next part of the same business day before initiating the next contact attempt for the same provider. For example, if the first contact attempt occurred at 9:30 a.m., the secret shopper must not initiate the second contact attempt until at least 1:00 p.m. or later on the same business day (accounting for a lunch hour of 12:00 p.m. to 1:00 p.m.). Similarly, if the first contact attempt occurred at 2:00 p.m., the secret shopper must not initiate the second contact attempt for the same provider until at least 8:00 a.m. or later on the next business day.
If, as part of scheduling procedure for new patient appointments, a provider requires the secret shopper to leave a voicemail with identifying information in order to receive a call back and initiate scheduling, the secret shopper must …	Not leave a voicemail and document the appropriate disposition code associated with the contact attempt (Q). The secret shopper must document the appointment wait time as "N/A" in the "Time_Elapsed" field in the results reported and mark "N/A" in the "Compliance Indicator" field in the results reported. The secret shopper must not initiate remaining contact attempts and must exclude the provider from the compliance rate calculation and replace the provider with a randomly selected provider of the same specialty type (primary care or behavioral health) from the reserve sample.

Scenario	Response to Scenario
If, as part of scheduling procedure for new patient appointments, a provider requires the secret shopper to consult an online scheduling tool and/or use an online patient portal to view appointment availability, the secret shopper must …	Not view an online scheduling tool and must document the appropriate disposition code associated with the contact attempt (U). The secret shopper must document the appointment wait time as "N/A" in the "Time_Elapsed" field in the results reported and mark "N/A" in the "Compliance Indicator" field in the results reported. The secret shopper must not initiate remaining contact attempts and must exclude the provider from the compliance rate calculation and replace the provider with a randomly selected provider of the same specialty type (primary care or behavioral health) from the reserve sample.

Appointment wait times must be calculated (and documented in the "Time_Elapsed" field in the results reported) by counting the number of full business days between the date of the call during which a request for an appointment was successfully executed and the date of the first available appointment. When calculating appointment wait time length in business days, QHP issuers' third-party entities must adhere to the following rules:

- Start counting the number of days from the next following day.
- Exclude Federal holidays and weekends (Saturdays and Sundays) because these are not considered business days.
- When calculating appointment wait time length in business days, exclude the first day (e.g., the day of the request) and count the last day.

Table 5. Example Appointment Wait Time Calculation

Sun.	Mon.	Tue.	Wed.	Thur.	Fri.	Sat.
	(0) Call	(1)	(2)	(3)	(4)	
Sun.	**Mon.**	**Tue.**	**Wed.**	**Thur.**	**Fri.**	**Sat.**
	Federal Holiday	(5) First available appointment				

F. Calculating Compliance Rate and Other Figures Based on Results

QHP issuers' third-party entities must calculate and report the following:

1. The compliance rate for the wait time standard for each provider type, for each issuer's QHP provider network according to the following formula:

   Numerator: Number of providers that offered appointments within the time elapsed standard as reflected by provider survey results with any of the following disposition codes: A, B, J, K, S, T and accompanying Compliance_Indicator of "Y." For disposition code definitions, see Appendix B.

   Denominator: Total number of eligible providers surveyed.

Compliance Rate Calculation Example:

Issuer Beta's provider population file indicates the issuer's single QHP provider network contains 525 primary care (routine) providers. Therefore, the QHP issuer's third-party entity must randomly select an oversample of 170 primary care (routine) providers from the provider population file to include the minimum sample to be surveyed (113) plus a reserve sample of an additional 57 primary care (routine) providers. The QHP issuer's third-party entity surveys 113 primary care (routine) providers via secret shopper protocol. No providers in the minimum sample were ineligible or nonresponsive. Thus, no providers in the minimum sample were replaced with providers from the reserve sample.

The survey results (expressed by combinations of disposition codes and compliance indicators per provider surveyed) are as follows:

- 64 providers offered an appointment within the maximum time elapsed standard (Disposition Code A, Compliance_Indicator Y).
- 5 surveyed providers offered an appointment with an equivalent provider that was not within the time elapsed standard (Disposition Code B, Compliance_Indicator N).
- 5 surveyed providers offered an appointment with an equivalent provider within the time elapsed standard (Disposition Code B, Compliance_Indicator Y).
- 5 providers were temporarily unavailable due to vacation, parental leave, personal issue, illness, etc.; an appointment was not offered with an equivalent provider; and estimated availability and/or waitlist information was provided. The availability and/or waitlist information provided is not within the time elapsed standard (Disposition Code T, Compliance_Indicator N).
- 1 provider was not currently accepting new patients, and an appointment was not offered with an equivalent provider (Disposition Code H, Compliance Indicator N).
- 8 providers were currently not accepting new patients, an appointment was not offered with an equivalent provider, and estimated availability and/or waitlist information was provided. The availability and/or waitlist information provided was within the time elapsed standard (Disposition Code J, Compliance_Indicator Y).
- 25 providers were not currently accepting new patients; appointments were offered with equivalent providers, and the appointments offered were within the time elapsed standard (Disposition Code K, Compliance_Indicator Y).

Compliance Rate Numerator: 64 (Disposition Code A, Compliance_Indicator Y) + 5 (Disposition Code B, Compliance_Indicator Y) + 8 (Disposition Code J, Compliance_Indicator Y) + 25 (Disposition Code K, Compliance_Indicator Y) = **102**

Compliance Rate Denominator: 113

Compliance Rate = (102/113) × 100 = **90.2%**

2. The percentage of nonresponsive and ineligible providers, according to the following formula:

   Numerator: Number of providers that were deemed nonresponsive or ineligible as classified by any of the following disposition codes: C, D, E, F, G, L, M as call outcomes documented for each of the three contact attempts (if three contact attempts were required to be made) and Compliance_Indicator of "N/A."

   Denominator: Total number of providers contacted.

Percentage of Nonresponsive and Ineligible Providers Calculation Example:

Issuer Delta's provider population file indicates the issuer's single QHP provider network contains 249 behavioral health providers. Therefore, the QHP issuer's third-party entity must randomly select an oversample of 135 behavioral health providers from the provider population file to include the minimum sample (90) plus a reserve sample of an additional 45 behavioral health providers. The survey results (expressed by combinations of disposition codes and compliance indicators per provider surveyed) are as follows:

- **25 providers offered an appointment within the time elapsed standard (Disposition Code A, Compliance_Indicator Y).**
- **25 providers were ineligible to be surveyed because they were no longer contracted with the issuer as an in-network provider at the time of the survey call (Contact 1 Disposition Code L, Compliance_Indicator N/A)**
- **10 providers were nonresponsive because their phone numbers were not valid (Contact 1 Disposition Code C and Compliance_Indicator N/A).**
- **10 providers offered an appointment with an equivalent provider within the time elapsed standard (Disposition Code B, Compliance_Indicator Y).**
- **50 providers offered an appointment within the time elapsed standard (Disposition Code A, Compliance_Indicator Y)**
- **5 providers offered an appointment that was not within the time elapsed standard (Disposition Code A, Compliance Indicator_N).**
  - **Percentage of nonresponsive and ineligible providers numerator:** 25 (Contact 1 Disposition Code L, Compliance_Indicator N/A) + 10 (Contact 1 Disposition Code C, Compliance_Indicator N/A) = **35**
  - **Percentage of nonresponsive and ineligible providers denominator:** 25 + 25 + 10 + 10 + 50 + 5 = **125**
  - **Percentage of nonresponsive and ineligible providers:** 35/125 × 100 = **28%**
  - **Compliance rate numerator:** 25 (Disposition Code A, Compliance_Indicator Y) + 10 (Disposition Code B, Compliance_Indicator Y) + 50 (Disposition Code A, Compliance_Indicator Y) = **85**
  - **Compliance rate denominator:** 25 + 10 + 50 + 5 = **90**
  - **Compliance rate:** 85/90 × 100 = **94.4%**

The compliance rate numerator, denominator, and result must be calculated and reported for each appointment wait time standard for each QHP provider network. For example, if an issuer has two, nonidentical QHP provider networks, the QHP issuer's third-party entity must calculate (and the QHP issuer must report) four compliance rates identified by QHP provider network ID: one compliance rate for the primary care (routine) appointment wait time standard for each of the two QHP provider networks and one compliance rate for the behavioral health appointment wait time standard for each of the two QHP provider networks.

Similarly, the numerator, denominator and result for the percentage of nonresponsive and ineligible providers must be calculated and reported for each QHP provider network. For example, if a QHP

issuer has two, nonidentical QHP provider networks, the QHP issuer's third-party entity must calculate (and the QHP issuer must report) two percentages of nonresponsive and ineligible providers, identified by QHP provider network ID.

G. Submitting Survey Results Data to CMS

QHP issuers must submit secret shopper survey results (according to Appendix A) for each QHP provider network serving enrollees in the service area to CMS during QHP issuer compliance and monitoring activities. All QHP issuers must submit their secret shopper survey policy and/or process documentation along with the secret shopper survey results. For example, issuers must submit third-party entity contracts in addition to their appointment wait time survey results. As part of this process, the issuer must submit the data and documentation from the completed secret shopper surveys through a secure file submission portal (hereinafter referred to as "the Portal"). Valid survey results and accompanying calculations are due to CMS by the second Friday of June each year. Each issuer's unique link to the Portal will be provided by a CMS contractor within the data request distributed to the QHP issuer. The QHP issuer must provide at least one (and no more than two) accurate email addresses for specific points of contact who will be given access to CMS requests through the Portal. CMS will provide additional instructions for the file formats and file-naming conventions within the data submission request submitted to the QHP issuer by email or through the Portal. Additional submission details and requirements that will be listed in these instructions are outlined below.

1. Issuers will be sent a unique link to access the Portal.
2. The Portal has a series of requirements that the issuer must follow. To start, the issuer will use their unique link to access the Portal to begin each submission session. The Portal allows a maximum file size of 20 GB per file; however, multiple files can be uploaded per submission session. Additionally, each file name must not exceed 25 characters. Files may be rejected if the file naming convention is not followed. To better facilitate both data entry and review, files must be zipped by category for each requested item. The following file types will be denied: EXE, MSI, and BIN.
3. Issuers will be asked to validate all information before submission to confirm that the documents submitted are accurate, complete, and readable.

For further questions on how QHP issuers must submit survey data, please email AWTReviews@hcmsllc.com.

Appendix A. Required Secret Shopper Survey Results

QHP issuers' third-party entities must collect and document secret shopper survey results for each provider surveyed/contacted to be surveyed using the fields, definitions, and disposition codes described in this appendix and Appendix B. The required file formats for secret shopper survey results submission are Excel (.xlsx) or CSV. Compliance rate fields and percentage of nonresponsive and ineligible providers calculation fields may be listed in a tab or file that is separate from provider-level data fields.

Column Field	Field Code	Definition/Instructions
National Provider Identifier (NPI)	NPI	Enter the provider's NPI
Provider Name (First Name, Last Name)	Prov_Name	Enter the provider's First and Last Name
Specialty Type	Spec_Type	Enter the applicable Specialty Type Code of the Outpatient Clinical Behavioral Health or Primary Care practitioner from the list below: • Outpatient Clinical Behavioral Health Specialty Type Codes include 102, 103, 105, 106, 107, 108, 800, and 801 • Primary Care Specialty Type Codes include 001, 002, 003, 004, 005, 006, 101
Street Address 1	Street_Add_1	Enter the provider's street address.
Street Address 2	Street_Add_2	Enter the additional street address for the provider, if applicable.
City	City	Enter the city of the provider's office.
State	State	Enter the state of the provider's office.
County	County	Enter the county of the provider's office.
Zip	Zip	Enter the ZIP code of the provider's office.
Network ID	Net_ID	Enter the QHP provider network ID in which the provider is contracted.
Contact 1 Provider Phone Number	Prov_Phone_1	Enter the phone number that the QHP issuer's third-party entity's secret shopper used to contact the provider for contact attempt 1.

Column Field	Field Code	Definition/Instructions
Contact 1 Date	Contact_1_Date	Enter the date of the first contact attempt, formatted as MM/DD/YYYY. If the first contact attempt resulted in a valid survey disposition, record the disposition code in the "Contact1 Disposition" field. If more than one contact attempt was made, record the additional contact attempt dates, times, and disposition codes in the appropriate fields. If the provider was determined to be ineligible after the first contact attempt (because the provider was no longer contracted with the issuer as an in-network provider or the provider is not classified as either a primary care (routine) provider or behavioral health provider), no additional contact attempts should be made. If the provider was nonresponsive because the phone number was invalid (the phone number was disconnected and/or the provider is not associated with the phone number), no additional contact attempts should be made.
Contact 1 Time	Contact_1_Time	Enter "AM" for contact attempts conducted between the hours of 8:00 a.m. and 11:59 a.m. Enter "PM" for contact attempts conducted between the hours of 12:00 p.m. and 5:00 p.m.
Contact 1 Disposition Code	Contact_1_Disposition	Enter the disposition code for Contact 1.
Contact 2 Provider Phone Number	Prov_Phone_2	Enter the phone number that the QHP issuer's third-party entity's secret shopper used to contact the provider for contact attempt 2.
Contact 2 Date	Contact_2_Date	If more than one contact attempt was made, record the date of the second contact attempt, formatted as MM/DD/YYYY. If the first contact attempt resulted in a valid survey disposition code, this field does not need to be reported.
Contact 2 Time	Contact_2_Time	Enter "AM" for contact attempts conducted between the hours of 8:00 a.m. and 11:59 a.m. Enter "PM" for contact attempts conducted between the hours of 12:00 p.m. and 5:00 p.m.

Column Field	Field Code	Definition/Instructions
Contact 2 Disposition Code	Contact_2_Disposition	Enter the disposition code for Contact 2.
Contact 3 Date	Contact_3_Date	If more than two contact attempts were made, record the date of the third and final contact attempt, formatted as MM/DD/YYYY. If the first or second contact attempt(s) resulted in a valid survey disposition code, this field does not need to be reported.
Contact 3 Provider Phone Number	Prov_Phone_3	Enter the phone number that the QHP issuer's third-party entity's secret shopper used to contact the provider for contact attempt 3.
Contact 3 Time	Contact_3_Time	Enter "AM" for contact attempts conducted between the hours of 8:00 a.m. and 11:59 a.m. Enter "PM" for contact attempts conducted between the hours of 12:00 p.m. and 5:00 p.m.
Contact 3 Disposition Code	Contact_3_Disposition	Enter the disposition code for Contact 3.
Date of First Available (i.e., Soonest) Appointment Offered	End_Date	If the valid survey disposition code for the surveyed provider is one of the following: A, B, J, K, T, U and appointment availability information was obtained and/or an appointment was offered by or on behalf of either the surveyed provider or an equivalent provider, record the date of the first available (i.e., soonest) appointment offered, formatted as MM/DD/YYYY.
Format of First (i.e., Soonest) Available Appointment Offered	End_Format	If the first available appointment offered by or on behalf of either the surveyed provider or an equivalent provider is a telehealth appointment, enter "T" in this field. If the first available (i.e., soonest) available appointment offered by or on behalf of either the surveyed provider or an equivalent provider is an in-person appointment, enter "P" in this field.

Column Field	Field Code	Definition/Instructions
Type(s) of Appointments Offered by Provider Indicator	Types_Offered	The secret shopper must ascertain whether or not the provider offers both in-person and telehealth appointments for new patients, solely telehealth appointments for new patients, or solely in-person appointments for new patients and must document this information using one of the following entries: TO = Provider offers only telehealth appointments for new patients and does not offer in-person appointments. PO = Provider offers only in-person appointments for new patients and does not offer telehealth appointments. B = Provider offers both in-person and telehealth appointments for new patients.
Date of Next Available Appointment Offered	Next_Avail_Date	If a provider offers both in-person and telehealth appointments for new patients, and the first (i.e., soonest) available appointment offered is a **telehealth appointment**, then the secret shopper must obtain appointment availability information for the next available **in-person** appointment and record the date of the next available in-person appointment in this field. Alternatively, if a provider offers both in-person and telehealth appointments for new patients, and the first (i.e., soonest) available appointment offered is an **in-person appointment**, then the secret shopper must obtain appointment availability information for the next available **telehealth** appointment and record the date of the next available telehealth appointment in this field.
Time Elapsed Between Date of Call That Resulted in Appointment Offered and the First Available (i.e., Soonest) Appointment Offered	Time_Elapsed	Enter the number of business days (excluding weekends and Federal holidays) between the date of the call that resulted in an appointment offered and the date of the first (i.e., soonest) available appointment offered. Enter only whole numbers in this field.

Column Field	Field Code	Definition/Instructions
Was appointment offered within the time elapsed standard?	Compliance_Indicator	If the time elapsed (in full business days) between the date of the call that resulted in an appointment offered and the date and time of the first (i.e., soonest) available appointment offered is equal to or less than the minimum time elapsed standard, enter "Y." If the value exceeds the minimum time elapsed standard, enter "N." If the provider was nonresponsive or ineligible to be surveyed, enter "N/A."
General Notes	Comments	This is a free text field for the QHP issuer's third-party entity to provide additional information about the contact attempts and/or notable findings. See "instructions for reporting" column in "Appendix B. Valid Survey Disposition Codes" for specific instructions on how to format the provision of additional information in this field as required by certain disposition codes.
Compliance Rate Numerator	Compliance_Rate_Numerator	Number of providers that offered appointments within the time elapsed standard as reflected by provider survey results with disposition codes: A, B, J, K, T, U and accompanying Compliance_Indicator of "Y." For a definition of each of these codes, please see Appendix B.
Compliance Rate Denominator	Compliance_Rate_Denominator	Total number of eligible providers surveyed,
Compliance Rate[1]	Compliance_Rate	Result of dividing the Compliance_Rate Numerator by the Compliance_Rate_Denominator.
Percentage of Nonresponsive and Ineligible Providers Numerator	Nonresponse_Numerator	Number of providers that were deemed nonresponsive or ineligible as reflected by provider survey results with disposition codes: C, D, E, F, G, L, M as call outcomes documented for each of the three contact attempts (if three contact attempts were required to be made) and accompanying Compliance_Indicator of "N/A."
Percentage of Nonresponsive and Ineligible Providers Denominator	Nonresponse_Denominator	Total number of providers contacted.

Column Field	Field Code	Definition/Instructions
Percentage of Nonresponsive and Ineligible Providers[2]	Percent_Nonresponsive	Result of dividing the Nonresponse_Numerator by the Nonresponse_Denominator.

[1] As described above, QHP issuers' third-party entities must calculate the compliance rate for each appointment wait time standard for each issuer's QHP provider network. For example, if a QHP issuer has two, nonidentical QHP provider networks, the QHP issuer's third-party entity must calculate (and the QHP issuer must report) four compliance rates, identified by QHP provider network ID: one compliance rate for the primary care (routine) appointment wait time standard for each of the two QHP provider networks and one compliance rate for the behavioral health appointment wait time standard for each of the two QHP provider networks.

[2] As described above, QHP issuers' third-party entities must calculate the numerator, denominator, and the result of dividing the percentage of nonresponsive and ineligible providers numerator by the percentage of nonresponsive and ineligible providers denominator for the percentage of nonresponsive and ineligible providers for each QHP provider network. For example, if an issuer has two, nonidentical QHP provider networks, the QHP issuer's third-party entity must calculate (and the QHP issuer must report) two percentages of nonresponsive and ineligible providers, identified by QHP provider network ID.

Appendix B. Valid Survey Disposition Codes

Code	Code definition	Instructions for reporting	Instructions for compliance rate calculation	Instructions for percentage of nonresponsive and ineligible providers calculation	Replace with provider from reserve sample?
A	Appointment availability information obtained (i.e., an appointment was offered) with the surveyed provider.	Document this disposition code in the corresponding contact attempt's "Disposition Code" field. Calculate and record the appointment wait time length and record the number of business days in the Time_Elapsed field. For the "Compliance_Indicator" field: If the time elapsed (in full business days) between *the date of the call that resulted in an appointment offered* and the date and time of the first available (i.e., soonest) appointment offered is equal to or less than the minimum time elapsed standard, enter "Y." If the value exceeds the minimum time elapsed standard, enter "N."	Include the provider in the numerator if an appointment is available within time elapsed standard (as reflected by a Compliance_Indicator of "Y.") Do not include the provider in the numerator if an appointment is not available within time elapsed standard (as reflected by a Compliance_Indicator of "N.") Include the provider in the denominator regardless of Compliance_Indicator.	Do not include the provider in the numerator. Include the provider in the denominator.	No.

Code	Code definition	Instructions for reporting	Instructions for compliance rate calculation	Instructions for percentage of nonresponsive and ineligible providers calculation	Replace with provider from reserve sample?
B	Appointment availability information obtained (i.e., an appointment was offered) from or on behalf of an equivalent provider, not the surveyed provider.	Document this disposition code in the corresponding contact attempt's "Disposition Code" field. Record the equivalent provider's name and specialty type (either "PCP" for primary care provider or "BH" for behavioral health provider) in the "General Notes" field. The format for entry into the "General Notes" field is "Contact Attempt # - Disposition Code - Text Directed For The Disposition Code". For example: "Contact1-B-BH-Provider Name". Calculate and record the appointment wait time length and record the number of business days in the Time_Elapsed field. For the "Compliance_Indicator" field: If the time elapsed (in full business days) between *the date of the call that resulted in an appointment offered* and the date and time of the first available (i.e., soonest) appointment offered is equal to or less than the minimum time elapsed standard, enter "Y." If the value exceeds the minimum time elapsed standard, enter "N."	Include the provider in the numerator if an appointment is available within the time elapsed standard (as reflected by a Compliance_Indicator of "Y.") Do not include the provider in the numerator if an appointment is not available within time elapsed standard (as reflected by a Compliance_Indicator of "N.") Include the provider in the denominator regardless of Compliance_Indicator.	Do not include the provider in the numerator. Include the provider in the denominator.	No.

Code	Code definition	Instructions for reporting	Instructions for compliance rate calculation	Instructions for percentage of nonresponsive and ineligible providers calculation	Replace with provider from reserve sample?
C	Provider was nonresponsive: Phone number not valid (for example, the phone number is disconnected and/or the phone number is not associated with the provider).	Document this disposition code in the corresponding contact attempt's "Disposition Code" field. If a provider's phone number is not valid, the secret shopper should not make two additional contact attempts using the same invalid phone number. However, the secret shopper may complete additional contact attempts, not to exceed three, using different phone numbers. In the "General Notes" field, record why the phone number was invalid. For example, if the phone number was disconnected or no longer in service, document "phone number disconnected" in the General Notes field for the contact attempt. If the phone number was not associated with the provider, document "phone number not associated with provider" in the General Notes field for the contact attempt. The format for entry into the "General Notes" field is "Contact Attempt # - Disposition Code - Text Directed For The Disposition Code". For example: "Contact1-C-phone number disconnected". For the Compliance_Indicator field: Enter "N/A."	Exclude from the calculation; do not include the provider in either the numerator or the denominator.	Include the provider in the numerator and denominator.	Yes, replace the provider after the first contact attempt.

Code	Code definition	Instructions for reporting	Instructions for compliance rate calculation	Instructions for percentage of nonresponsive and ineligible providers calculation	Replace with provider from reserve sample?
D	Provider was nonresponsive: Provider's phone rang for 5 minutes without answer.	Document this disposition code in the corresponding contact attempt's "Disposition Code" field. Determine whether all three contact attempts resulted in nonresponsive and ineligible disposition codes. • If that is the case, for the "Compliance_Indicator" field, enter "N/A." • If that is not the case, follow the instructions for reporting associated with the disposition code that resulted from the responsive and eligible contact attempt.	Determine whether all three contact attempts resulted in nonresponsive and ineligible disposition codes. • If that is the case, exclude the provider from compliance calculation; do not include the provider in the numerator or denominator. • If that is not the case, follow the instructions for compliance rate calculation for the disposition code associated with the responsive or eligible contact attempt to determine whether the provider should be included in the numerator and denominator.	Determine whether all three contact attempts resulted in nonresponsive and ineligible disposition codes. • If that is the case, include the provider in the numerator and denominator. • If that is not the case, do not include the provider in the numerator and include in the denominator.	Determine whether all three contact attempts resulted in nonresponsive and ineligible disposition codes. • If that is the case, yes, replace the provider. • If that is not the case, no, do not replace the provider.

Code	Code definition	Instructions for reporting	Instructions for compliance rate calculation	Instructions for percentage of nonresponsive and ineligible providers calculation	Replace with provider from reserve sample?
E	Provider was nonresponsive: Voicemail greeting received during regular business hours, not during a designated lunch hour, and the voicemail greeting was not part of an appointment scheduling procedure.	Document this disposition code in the corresponding contact attempt's "Disposition Code" field. Determine whether all three contact attempts resulted in nonresponsive and ineligible disposition codes. • If that is the case, for the "Compliance_Indicator" field, enter "N/A." • If that is not the case, follow the instructions for reporting associated with the disposition code that resulted from the responsive and eligible contact attempt.	Determine whether all three contact attempts resulted in nonresponsive and ineligible disposition codes. • If that is the case, exclude from compliance calculation; do not include the provider in the numerator or denominator. • If that is not the case, follow the instructions for compliance rate calculation for the disposition code associated with the responsive or eligible contact attempt to determine whether the provider should be included in the numerator and denominator.	Determine whether all three contact attempts resulted in nonresponsive disposition codes. • If that is the case, include the provider in the numerator and denominator. • If that is not the case, do not include the provider in the numerator and include the provider in the denominator.	Determine whether all three contact attempts resulted in nonresponsive and ineligible disposition codes. • If that is the case, yes, replace the provider. • If that is not the case, no, do not replace the provider.

Code	Code definition	Instructions for reporting	Instructions for compliance rate calculation	Instructions for percentage of nonresponsive and ineligible providers calculation	Replace with provider from reserve sample?
F	Provider was nonresponsive: secret shopper was placed on hold for more than 15 minutes or secret shopper was navigating a phone tree/IVR for 20 minutes, inclusive of the 15 minutes they may be placed on hold.	Document this disposition code in the corresponding contact attempt's "Disposition Code" field. Determine whether all three contact attempts resulted in nonresponsive and ineligible disposition codes. • If that is the case, for the "Compliance_Indicator" field, enter "N/A." • If that is not the case, follow the instructions for reporting associated with the disposition code that resulted from the responsive and eligible contact attempt.	Determine whether all three contact attempts resulted in nonresponsive and ineligible disposition codes. • If that is the case, exclude from compliance calculation; do not include the provider in the numerator or denominator. • If that is not the case, follow the instructions for compliance rate calculation for the disposition code associated with the responsive or eligible contact attempt to determine whether the provider should be included in the numerator and denominator.	Determine whether all three contact attempts resulted in nonresponsive disposition codes. • If that is the case, include the provider in the numerator and denominator. • If that is not the case, do not include the provider in the numerator and include the provider in the denominator.	Determine whether all three contact attempts resulted in nonresponsive and ineligible disposition codes. • If that is the case, yes, replace the provider. • If that is not the case, no, do not replace the provider.

Code	Code definition	Instructions for reporting	Instructions for compliance rate calculation	Instructions for percentage of nonresponsive and ineligible providers calculation	Replace with provider from reserve sample?
G	Provider was nonresponsive: Call could not be completed due to communication issue(s) such as poor call connectivity.	Document this disposition code in the corresponding contact attempt's "Disposition Code" field. Determine whether all three contact attempts resulted in nonresponsive and ineligible disposition codes. • If that is the case, for the "Compliance_Indicator" field, enter "N/A." • If that is not the case, follow the instructions for reporting associated with the disposition code that resulted from the responsive and eligible contact attempt.	Determine whether all three contact attempts resulted in nonresponsive and ineligible disposition codes. • If that is the case, exclude from compliance calculation; do not include the provider in the numerator or denominator. • If that is not the case, follow the instructions for compliance rate calculation for the disposition code associated with the responsive or eligible contact attempt to determine whether the provider should be included in the numerator and denominator.	Determine whether all three contact attempts resulted in nonresponsive disposition codes. • If that is the case, include the provider in the numerator and denominator. • If that is not the case, do not include the provider in the numerator and include the provider in the denominator.	Determine whether all three contact attempts resulted in nonresponsive and ineligible disposition codes. • If that is the case, yes, replace the provider. • If that is not the case, no, do not replace the provider.
H	Provider is not currently accepting new patients; appointment not offered with equivalent provider.	Document this disposition code in the corresponding contact attempt's "Disposition Code" field. Record the appointment wait time length as "N/A" in the "Time_Elapsed" field. For the "Compliance_Indicator" field: Enter "N."	Do not include the provider in the numerator. Include the provider in the denominator.	Do not include the provider in the numerator. Include the provider in the denominator.	No.

Code	Code definition	Instructions for reporting	Instructions for compliance rate calculation	Instructions for percentage of nonresponsive and ineligible providers calculation	Replace with provider from reserve sample?
I	Provider is not currently accepting new patients, appointment not offered with equivalent provider, and no estimated availability and/or waitlist information provided.	Document this disposition code in the corresponding contact attempt's "Disposition Code" field. Record the appointment wait time length as "N/A" in the "Time_Elapsed" field. For the "Compliance_Indicator" field: Enter "N."	Do not include the provider in the numerator. Include the provider in the denominator.	Do not include the provider in the numerator. Include the provider in the denominator.	No.
J	Provider is not currently accepting new patients, appointment not offered with equivalent provider, and estimated availability and/or waitlist information was provided.	Document this disposition code in the corresponding contact attempt's "Disposition Code" field. Calculate and record the appointment wait time length and record the number of business days in the Time_Elapsed field. If the time elapsed (in full business days) between the date of the call that resulted in an appointment offered and the date and time of the first available (i.e., soonest) appointment offered is equal to or less than the minimum time elapsed standard, enter "Y." If the value exceeds the minimum time elapsed standard, enter "N."	Include the provider in the numerator if an appointment is available within the time elapsed standard (as reflected by a Compliance_Indicator of "Y.") Do not include the provider in the numerator if an appointment is not available within time elapsed standard (as reflected by a Compliance_Indicator of "N.") Include the provider in the denominator regardless of Compliance_Indicator.	Do not include the provider in the numerator. Include the provider in the denominator.	No.

Code	Code definition	Instructions for reporting	Instructions for compliance rate calculation	Instructions for percentage of nonresponsive and ineligible providers calculation	Replace with provider from reserve sample?
K	Provider is not currently accepting new patients; appointment was offered with equivalent provider.	Document this disposition code in the corresponding contact attempt's "Disposition Code" field. Record the equivalent provider's name and specialty type (either "PCP" for primary care (routine) provider or "BH" for behavioral health provider) in the "General Notes" field. The format for entry into the "General Notes" field is "Contact Attempt # - Disposition Code - Text Directed For The Disposition Code". For example: "Contact1-K-PCP Provider Name". Calculate and record the appointment wait time length and record the number of business days in the Time_Elapsed field. If the time elapsed (in full business days) between *the date of the call that resulted in an appointment offered* and the date and time of the first available (i.e., soonest) appointment offered is equal to or less than the minimum time elapsed standard, enter "Y." If the value exceeds the minimum time elapsed standard, enter "N."	Include the provider in the numerator if an appointment is available within the time elapsed standard (as reflected by a Compliance_Indicator of "Y.") Do not include the provider in the numerator if an appointment is not available within time elapsed standard (as reflected by a Compliance_Indicator of "N.") Include the provider in the denominator regardless of Compliance_Indicator.	Do not include the provider in the numerator. Include the provider in the denominator.	No.

Code	Code definition	Instructions for reporting	Instructions for compliance rate calculation	Instructions for percentage of nonresponsive and ineligible providers calculation	Replace with provider from reserve sample?
L	Provider is ineligible: Provider is not contracted with QHP issuer as in-network provider and/or is not accepting the secret shopper's insurance at the time of the call.	Document this disposition code in the corresponding contact attempt's "Disposition Code" field. The secret shopper should not make additional contact attempts. Results fields pertaining to additional contact attempts do not need to be reported or populated. For the Compliance_Indicator field: Enter "N/A." If possible, enter additional descriptive information about the provider in the "Comments" field.	Exclude from the calculation; do not include the provider in either the numerator or denominator.	Include the provider in the numerator and denominator.	Yes, replace the provider after the contact attempt that resulted in this disposition code.
M	Provider is ineligible: At the time of the call, the provider is not classified as a primary care provider specialty type or behavioral health provider specialty type according to the specialty types/descriptions contained in Tables 2 and 3.	Document this disposition code in the corresponding contact attempt's "Disposition Code" field. The secret shopper should not make additional contact attempts. Results fields pertaining to additional contact attempts do not need to be reported or populated. For the Compliance_Indicator field: Enter "N/A." If possible, enter additional descriptive information about the provider the "Comments" field.	Exclude from the calculation; do not include the provider in either the numerator or denominator.	Include the provider in the numerator and denominator.	Yes, replace the provider after the contact attempt that resulted in this disposition code.

Code	Code definition	Instructions for reporting	Instructions for compliance rate calculation	Instructions for percentage of nonresponsive and ineligible providers calculation	Replace with provider from reserve sample?
N	Referral required as prerequisite in order to offer an appointment.	Document this disposition code in the corresponding contact attempt's "Disposition Code" field. The secret shopper should not make additional contact attempts. Results fields pertaining to additional contact attempts do not need to be reported or populated. For the Compliance_Indicator field: Enter "N/A." If possible, enter additional descriptive information about the call in the "Comments" field.	Exclude from the calculation; do not include the provider in either the numerator or the denominator.	Do not include the provider in the numerator. Include the provider in the denominator.	Yes, replace the provider after the contact attempt that resulted in this disposition code.
O	Provider's office required more information than secret shopper was able to reasonably provide in order to offer appointment availability.	Document this disposition code in the corresponding contact attempt's "Disposition Code" field. The secret shopper should not make additional contact attempts. Results fields pertaining to additional contact attempts do not need to be reported or populated. For the Compliance_Indicator field: Enter "N/A." If possible, enter additional descriptive information about the call, such as which pieces of information were requested by the provider's office, in the "Comments" field.	Exclude from the calculation; do not include the provider in either the numerator or the denominator.	Do not include the provider in the numerator. Include the provider in the denominator.	Yes, replace the provider after the contact attempt that resulted in this disposition code.

Code	Code definition	Instructions for reporting	Instructions for compliance rate calculation	Instructions for percentage of nonresponsive and ineligible providers calculation	Replace with provider from reserve sample?
P	Other: None of the provided disposition codes describe the call outcome and no appointment availability information was obtained.	Document this disposition code in the corresponding contact attempt's "Disposition Code" field. Determine whether all three contact attempts resulted in nonresponsive and ineligible disposition codes. • If that is the case, for the "Compliance_Indicator" field, enter "N/A." • If that is not the case, follow the instructions for reporting associated with the disposition code that resulted from the responsive and eligible contact attempt.	Determine whether all three contact attempts resulted in nonresponsive and ineligible disposition codes. • If that is the case, exclude from compliance calculation; do not include the provider in the numerator or denominator. • If that is not the case, follow the instructions for compliance rate calculation for the disposition code associated with the responsive or eligible contact attempt to determine whether the provider should be included in the numerator and denominator.	Determine whether all three contact attempts resulted in nonresponsive disposition codes. • If that is the case, include the provider in the numerator and denominator. • If that is not the case, do not include the provider in the numerator and include the provider in the denominator.	Determine whether all three contact attempts resulted in nonresponsive and ineligible disposition codes. • If that is the case, yes, replace the provider. • If that is not the case, no, do not replace the provider.

Code	Code definition	Instructions for reporting	Instructions for compliance rate calculation	Instructions for percentage of nonresponsive and ineligible providers calculation	Replace with provider from reserve sample?
Q	Provider's office requires secret shopper to leave a voicemail with specific details to receive a call back from the office to proceed with scheduling.	Document this disposition code in the corresponding contact attempt's "Disposition Code" field. The secret shopper should not make additional contact attempts. Results fields pertaining to additional contact attempts do not need to be reported or populated. For the Compliance_Indicator field: Enter "N/A." If possible, enter additional descriptive information about the call, such as which pieces of information were requested by the provider's office, in the "Comments" field.	Exclude from the calculation; do not include the provider in either the numerator or denominator.	Do not include the provider in the numerator. Include the provider in the denominator.	Yes, replace this provider after the contact attempt that resulted in this disposition code.
R	Provider is temporarily unavailable due to vacation, parental leave, personal issue, illness, etc. Appointment not offered with equivalent provider; no estimated availability and/or waitlist information provided.	Document this disposition code in the corresponding contact attempt's "Disposition Code" field. Record the appointment wait time length as "N/A" in the "Time_Elapsed" field. For the "Compliance_Indicator" field: Enter "N."	Do not include the provider in the numerator. Include the provider in the denominator.	Do not include the provider in the numerator. Include the provider in the denominator.	No

Code	Code definition	Instructions for reporting	Instructions for compliance rate calculation	Instructions for percentage of nonresponsive and ineligible providers calculation	Replace with provider from reserve sample?
S	Provider is temporarily unavailable due to vacation, parental leave, personal issue, illness, etc. Appointment not offered with equivalent provider; estimated appointment availability and/or waitlist information was provided.	Document this disposition code in the corresponding contact attempt's "Disposition Code" field. Calculate and record the appointment wait time length and record the number of business days in the Time_Elapsed field. For the "Compliance_Indicator" field: If the time elapsed (in full business days) between the date of the call that resulted in an appointment offered and the date and time of the first available (i.e., soonest) appointment offered is equal to or less than the minimum time elapsed standard, enter "Y." If the value exceeds the minimum time elapsed standard, enter "N."	Include the provider in the numerator if an appointment is available within the time elapsed standard (as reflected by a Compliance_Indicator of "Y.") Do not include the provider in the numerator if an appointment is not available within time elapsed standard (as reflected by a Compliance_Indicator of "N.") Include the provider in the denominator regardless of Compliance_Indicator.	Do not include the provider in the numerator. Include the provider in the denominator.	No.

Code	Code definition	Instructions for reporting	Instructions for compliance rate calculation	Instructions for percentage of nonresponsive and ineligible providers calculation	Replace with provider from reserve sample?
T	Provider is temporarily unavailable due to vacation, parental leave, personal issue, illness, etc., appointment was offered with equivalent provider.	Document this disposition code in the corresponding contact attempt's "Disposition Code" field. Record the equivalent provider's name and specialty type (either "PCP" for primary care (routine) provider or "BH" for behavioral health provider) in the "General Notes" field. The format for entry into the "General Notes" field is "Contact Attempt # - Disposition Code - Text Directed For The Disposition Code". For example: "Contact1-T-BH-Provider Name". Calculate and record the appointment wait time length and record the number of business days in the Time_Elapsed field. If the time elapsed (in full business days) between the date of the call that resulted in an appointment offered and the date and time of the first available (i.e., soonest) appointment offered is equal to or less than the minimum time elapsed standard, enter "Y." If the value exceeds the minimum time elapsed standard, enter "N."	Include the provider in the numerator if an appointment is available within the time elapsed standard (as reflected by a Compliance_Indicator of "Y.") Do not include the provider in the numerator if an appointment is not available within time elapsed standard (as reflected by a Compliance_Indicator of "N.") Include the provider in the denominator regardless of Compliance_Indicator.	Do not include the provider in the numerator. Include the provider in the denominator.	No

Code	Code definition	Instructions for reporting	Instructions for compliance rate calculation	Instructions for percentage of nonresponsive and ineligible providers calculation	Replace with provider from reserve sample?
U	Provider's office requires secret shopper to consult an online scheduling tool and/or use an online patient portal to view appointment availability.	Document this disposition code in the corresponding contact attempt's "Disposition Code" field. The secret shopper should not make additional contact attempts. Results fields pertaining to additional contact attempts do not need to be reported or populated. For the Compliance_Indicator field: Enter "N/A."	Exclude from the calculation; do not include the provider in either the numerator or denominator.	Do not include the provider in the numerator. Include the provider in the denominator.	Yes, replace this provider after the contact attempt that resulted in this disposition code.

Appendix C. Key Terms

The terms listed in this section are defined for the purpose of implementing the appointment wait time secret shopper surveys. These definitions are not meant to establish a new meaning for these terms outside of this technical guidance document.

- **Equivalent provider.** An equivalent provider is defined as another in-network provider practicing and classified as the same specialty type within the same practice location and/or serving enrollees in the same service area.
- **Facility provider types.** For the purposes of this guidance document, a facility provider type is not an individual provider and may include, but is not limited to, the following: Federally Qualified Health Centers (FQHCs); outpatient health programs/facilities operated by Indian tribes; tribal organizations; programs operated by urban Indian organizations; Ryan White HIV/AIDS program provider facilities; Title X family planning clinics and Title X "look-alike" family planning clinics; Indian Health Service (IHS) provider facilities, Indian tribal facilities, tribal organization facilities, and urban Indian organization facilities; disproportionate share hospitals (DSH); DSH-eligible hospitals; children's hospitals; rural referral centers; sole community hospitals; freestanding cancer centers; critical access hospitals; sexually transmitted disease (STD) clinics; tuberculosis (TB) clinics; hemophilia treatment centers; black lung clinics; ambulatory surgical centers; skilled nursing facilities; long-term care hospitals; rural health centers; and ambulatory surgical centers. The provider population file will not include facility provider types.
- **Ineligible provider.** A provider who is ineligible to be surveyed (and therefore must be replaced by a randomly selected provider from the reserve sample) if, at the time of the call, the provider is: (a) no longer contracted with the issuer as an in-network provider and/or (b) the provider is not practicing and classified as a primary care provider specialty type or behavioral health provider specialty type according to the specialty types/descriptions listed in Tables 2 and 3.
- **Nonresponsive provider.** A provider is defined as nonresponsive if any of the following dispositions are documented for each of three contact attempts associated with the same provider: (a) The provider's phone rang for 5 minutes without an answer; (b) The provider's phone number is not valid (for example, the number is disconnected or the phone number is not associated with the provider). If a provider's phone number is not valid, the secret shopper should not make two additional contact attempts before replacing the provider with another provider from the reserve sample; (c) A voicemail greeting was received during regular business hours, not during a designated lunch hour, and the voicemail greeting was not part of an appointment scheduling procedure; (d) The secret shopper was placed on hold for more than 15 minutes; or (e) the call could not be completed due to communication issue(s) such as poor call connectivity.
- **Oversample.** A statistically valid, randomly selected population of providers that is 50% above the minimum sample that must be surveyed based on QHP provider network size. This oversample consists of a minimum sample to be surveyed and a **reserve sample**. QHP issuers' third-party entities will draw from the reserve sample to replace providers that are nonresponsive or ineligible.

- **Provider population file.** A file that CMS will provide to issuers in fall 2024 containing the population or "universe" of providers from which to draw a randomized oversample (consisting of minimum sample to be surveyed and a reserve sample). The population of providers contained in this file will be derived from provider data submitted by issuers on the "Network Adequacy Provider" tab in their Network Adequacy template, submitted during the QHP certification process. The provider population file will include submitted providers that CMS has validated and approved to count toward the issuer's satisfaction of the time and distance standards for the corresponding specialty types.
- **Surveyed provider.** An individual, eligible and responsive provider contacted by a secret shopper to be surveyed.
- **Telehealth.** For this purpose, CMS defines telehealth as "professional consultations, office visits, and office psychiatry services through brief communication technology-based service/virtual check-in, remote evaluation of pre-recorded patient information, and inter-professional internet consultation."

Appendix D. General Tips and Script Suggestions

General Tips:

- If third-party entities' secret shoppers are asked to provide information they could not reasonably know, they can say that they do not know and can offer to bring the information to the office when they come in for an appointment. If they are required to provide information before appointment availability can be provided, third-party entities' secret shoppers may indicate that they can call back with the information and ask what is the soonest day and time they can get an appointment.
- If third-party entities' secret shoppers are successful in obtaining a date and time for the next available appointment, secret shoppers should **be sure the appointment is not being held for the secret shopper before getting off the phone**.
- If appointment schedulers'/providers' offices find it challenging to provide information about the earliest available appointment to the secret shopper without the secret shopper stating that they have one or more specific medical conditions, third-party entities' secret shoppers may consider asking what the soonest available appointment would be for a general visit. For example, secret shoppers may consider adding that they are new to the area and are trying to get established with a provider.
- If QHP issuers develop survey call scripts with their third-party entities that reference medical conditions, the survey scripts should appropriately match the secret shopper or simulated family member (e.g., gender, sex, age, race) in the survey protocol.
- If third-party entities' secret shoppers are asked about a patient preference for a male or female doctor with an equivalent provider, third-party entities' secret shoppers are encouraged to indicate that they have no preference.

Script Suggestions:

The following is a list of questions and suggested responses that third-party entities' secret shoppers may consider using:

Appt Scheduler: I need your social security number in order to make an appointment.
Secret shopper: I never give that out over the phone. I will bring it in when I come.
Alternate: I don't know it by heart and don't have it with me. I can bring it when I come in.

Appt Scheduler: I need your insurance number in order to make an appointment.
Secret shopper: I don't have it with me. I'll bring it into the appointment with me.
Alternate: I can find it later and call back, but can you just tell me what day and time you can give me an appointment for? I'm trying to work out my schedule.
Alternate: I understand that you will need to check my insurance first before you can firm this up, but can you tell me when the soonest appointment is that you could schedule me for? I need to plan childcare well in advance.

Appt Scheduler: I don't find you in the insurance system.
Secret shopper: I am newly moved to the state, and they told me it could take a few days to show up in the system.

Appt Scheduler: We're busy right now—somebody will call you back later.
Secret shopper: Actually, I'm on someone else's phone—can you give me a time when I can call you back?
Alternate: I can't take calls unless I'm on break. What would be a good time I can try back?

Appt Scheduler: Who is your employer—where is your insurance coming from?
Secret Shopper: My insurance is through my spouse. We just moved here and now I'm not going to be able to remember the exact name of their new firm. It's something-or-other Systems. My spouse is a sales representative.

If asked for an address for spouse's place of work:
Secret shopper: (He's /She's) a sales representative and doesn't really have a fixed office.
Alternate: I don't actually know the address. But I can find it and bring it in.

If asked for a phone number for spouse:
Secret shopper: (He/She) only has (his/her) work cell and I can't give out that number. Can I have (him/her) call you later?
Alternate: (He/She) just got a new phone and I don't know the number by heart yet.