DEPARTMENT OF
Managed
Health Care

Timely Access Report

Measurement Year 2018

1-888-466-2219
HAVE A PROBLEM WITH YOUR HEALTH PLAN? CONTACT THE DMHC
HealthHelp.ca.gov

Prepared by the Department of Managed Health Care (DMHC)
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DMHC MISSION, VALUES & GOALS

MISSION

The DMHC protects consumers' health care rights and ensures a stable health care delivery system.

CORE VALUES

- Integrity
- Leadership
- Commitment to Service

GOALS

- Educate and assist California's diverse health care consumers
- Cultivate a coordinated and sustainable health care marketplace
- Regulate fairly, efficiently and effectively
- Foster a culture of excellence throughout the organization

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Executive Summary

Providing timely access to health care services is a health plan's fundamental duty to its enrollees. This report summarizes Measurement Year (MY) 2018 provider appointment availability data submitted by health plans to the California Department of Managed Health Care (DMHC). The charts within this report display, at the health plan level, the percentage of provider responses to appointment availability requests that were within the timely access standards. For MY 2018, the DMHC required full service and behavioral health plans to utilize external vendors to validate the plans' timely access data and conduct a quality assurance review of their Timely Access Compliance Reports (compliance reports).

Health plans must still further improve the accuracy and completeness of their timely access compliance data. Plan compliance data commonly exhibited issues, which included calculation errors and failure to meet target sample sizes. In most cases, the issues did not pose substantial concern for accuracy or reliability. However, six health plans had results excluded from at least one chart due to data reliability concerns. Please see Appendix A for a detailed explanation of the data discrepancies.

Key Survey Findings for Full Service Health Plans:

- The percentage of all surveyed providers who had appointments available within the wait time standards (urgent and non-urgent) ranged from a high of 89 percent to a low of 67 percent (Chart 1).
- For non-urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 94 percent to a low of 71 percent (Chart 5).
- For urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 83 percent to a low of 57 percent (Chart 9).

Key Survey Findings for Behavioral Health Plans:

- The percentage of all surveyed providers who had appointments available within the wait time standards (urgent and non-urgent) ranged from a high of 80 percent to a low of 73 percent (Chart 13).
- For non-urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 90 percent to a low of 82 percent (Chart 17).

- For urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 70 percent to a low of 64 percent (Chart 21).

In 2020, the DMHC will promulgate a regulation to establish a rate of compliance with the timely access standards that all health plans must meet. Once the regulation is adopted, the DMHC will have a standard to which health plans will be held accountable. In subsequent years, the DMHC will be able to compare health plan performance across the plans, as well as individual health plan performance year-over-year.

Know Your Health Care Rights: Timely Access to Care

What to do if you Need Assistance Getting a Timely Appointment:

If you are having trouble getting a timely appointment with a physician or other health care provider, you should first contact your health plan for assistance. If your health plan does not resolve the issue in accordance with timely access to care standards, or you are dissatisfied with your health plan's response, you should contact the DMHC Help Center for assistance at **1-866-466-2219** or **www.HealthHelp.ca.gov**

DMHC Help Center:

The DMHC Help Center has provided assistance to over 2.3 million consumers to resolve problems with their health plans. As part of this assistance, the DMHC Help Center has assisted many people that have experienced difficulty obtaining a timely appointment with a provider.

Introduction and Background

Created by consumer-sponsored legislation in 1999, the California Department of Managed Health Care (DMHC) regulates health plans under the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended (Knox-Keene Act). The mission of the DMHC is to protect consumers' health care rights and ensure a stable health care delivery system. The DMHC accomplishes its mission by ensuring the health care system works for consumers. The DMHC protects the health care rights of more than 26 million Californians by regulating health plans, assisting consumers through a consumer Help Center, educating consumers on their rights and responsibilities, and preserving the financial stability of the managed health care system. Within the provisions of the Knox-Keene Act, health plans are required to make all services readily available at reasonable times to each enrollee consistent with good professional practice and within the timely access standards.

The Timely Access Regulation, which became effective in 2010, requires that health plan networks be sufficient to meet a set of standards, which include specific timeframes under which enrollees must be able to obtain care. These standards include wait times to access urgent and non-urgent care appointments, as well as the availability of telephone triage or screening services during and after regular business hours. It is worth noting that if a health plan offers an enrollee an appointment within the time-elapsed standards and the enrollee chooses to select a later appointment, the health plan has met the standard. Additionally, a licensed health care professional may determine that a later appointment may be appropriate based on the enrollee's condition if the later scheduling will not negatively affect the enrollee's health. To demonstrate performance with the timely access standards, health plans are required to submit annual compliance reports to the DMHC.

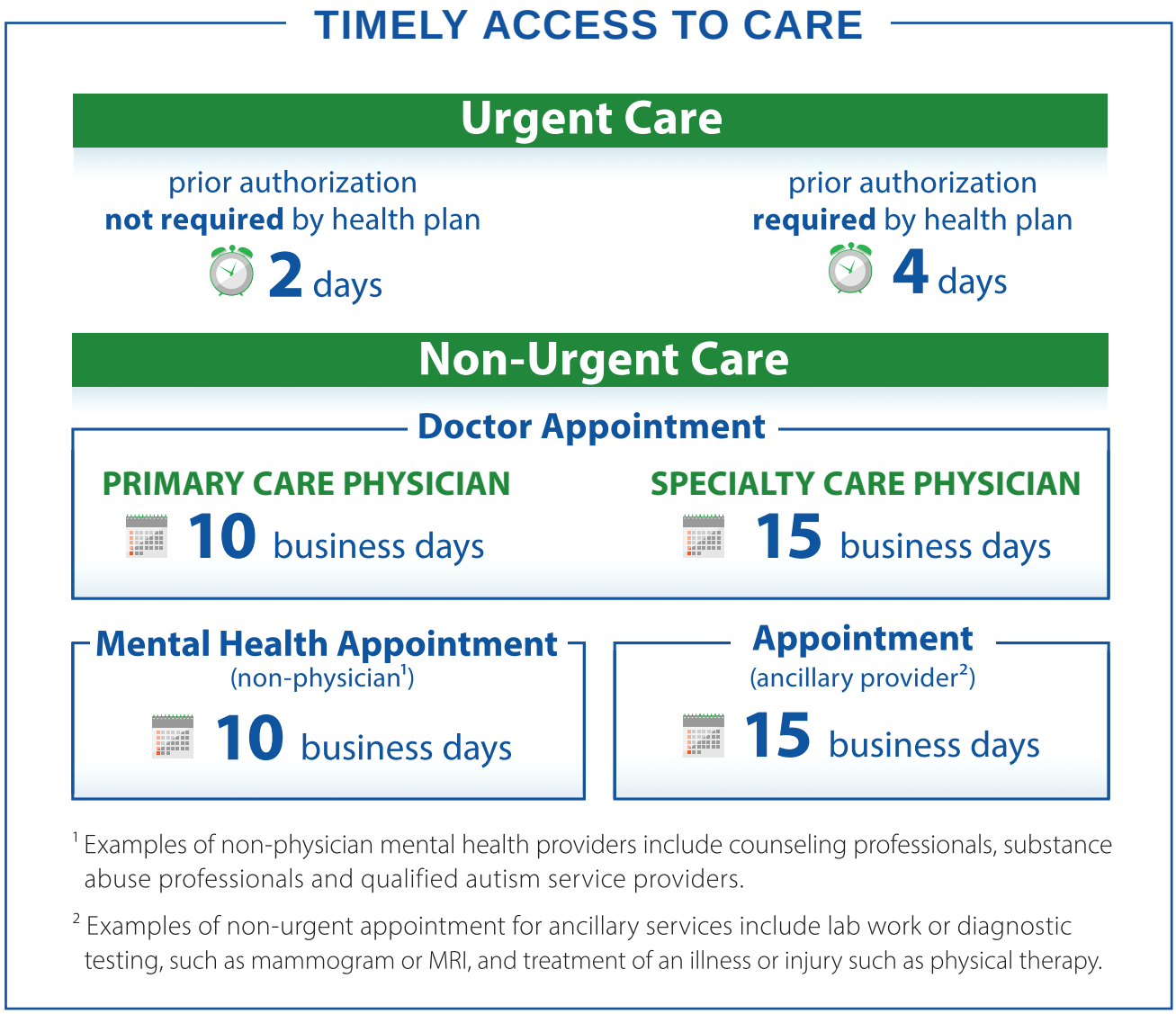
For several years following the promulgation of the Timely Access Regulation, health plans measured appointment wait-times by utilizing a variety of methods, including provider telephone surveys, secret shoppers and practice management software audits. These non-standardized methods produced varying results and made it infeasible for the DMHC to compare appointment availability within the measurement year across health plans using the data submitted in each health plan's compliance report.

To strengthen the DMHC's ability to oversee health plan compliance and begin to compare data, Health and Safety Code section 1367.03 was amended by SB 964 (Hernandez, Chapter 573, Statutes of 2014). SB 964 authorized the DMHC, in consultation with stakeholders, to develop standardized methodologies for measuring compliance with timely access standards. The use of standardized methodologies would result in the submission of accurate and comparable data from health plans. This would improve the DMHC's ability to compare results among health plans and ultimately, develop an acceptable rate of compliance for health plans to meet.

Over the past five years, the DMHC has incorporated feedback from health plans, providers and consumer advocates to make changes to the mandatory methodology health plans are required to follow when collecting data, measuring compliance and submitting timely access compliance reports to the DMHC. The SB 964 Administrative Procedures Act Waiver, which was granted until January 1, 2020, has allowed the DMHC to refine the survey methodology year-over-year.

Timely Access Standards

The specific time elapsed standards are provided in the chart below. It is important to note that there are two separate standards for urgent care, a 2-day standard (when authorization does not have to be obtained in advance from the health plan), and a 4-day standard (when advanced authorization from the health plan must be obtained prior to the delivery of care).



[1] Examples of non-physician mental health providers include counseling professionals, substance abuse professionals and qualified autism service providers.

[2] Examples of non-urgent appointment for ancillary services include lab work or diagnostic testing, such as mammogram or MRI, and treatment of an illness or injury such as physical therapy.

Health plans are required to ensure that each of its provider networks has the capacity to offer enrollees appointments within the established timely access standards. Health plans must also ensure that appointments meet the clinical appropriateness standard, which requires that services be provided in a timely manner that is appropriate for the nature of the individual enrollee's condition, consistent with good professional practice.

In conjunction with the clinical appropriateness standard, the timely access law allows the waiting time for a particular appointment to be extended if the referring or treating licensed health care provider, acting within the scope of his or her practice (and consistent with professionally recognized standards of practice), determines and notes in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee. In addition, preventative care services and periodic follow-up care may be scheduled in advance consistent with professionally recognized standards of practice, in a timeframe determined by the treating health care provider.

Enrollees may access urgently needed services in a variety of different ways depending on the delivery model of the health plan, aside from emergency treatment obtained at an emergency room. For example, many health plan enrollees who require urgent care may obtain same-day appointments through their own primary care provider, or through another doctor within their medical group. Some health plans offer the capability to meet urgent primary care treatment needs by offering advanced access, which is the ongoing availability of primary care services on the same day or the business day following the day of the enrollee's request. Additionally, some health plans contract with and allow enrollees to access urgent care through dedicated urgent care centers located within the enrollee's local service area. These differing methods of meeting enrollee urgent care needs are not measured in the timely access provider survey in this report. The timely access provider survey measures the next available appointment, and these methods of meeting urgent care needs are not considered appointments.

Evolving Methodologies Result In Non-Comparable Year-Over-Year Data

The DMHC has made progressive changes to the mandatory methodology over the past four measurement years in order to improve data accuracy, decrease provider burden and more reliably measure a health plan's ability to offer enrollees an appointment within the timely access standards. As a result of these yearly methodology changes, the data submitted by health plans is not comparable across measurement years. When the mandatory methodology is codified in the amended timely access regulation, health plan data will be comparable across measurement years.

Below are examples of some of the methodology changes from MY 2016 through MY 2019.

MY 2016 to MY 2017

- In MY 2016, providers that did not respond to a survey were presumed to be, and reported as, non-compliant. That changed for MY 2017. Providers may not respond to a survey for a variety of reasons, some of which are not related to whether the provider had an appointment available within the timely access standards (e.g., a provider office that contracts with multiple

health plans may not respond to a second or third telephonic survey, believing they are duplicate surveys). The presumption a provider is non-compliant due to non-response may create data reliability issues. Elimination of the presumption improves data reliability. The methodology was also amended to require health plans to replace non-responding providers with a provider from the oversample to ensure health plans still met a statistical sample size.

- The DMHC required health plans to track and report the number and percentage of non-responding providers in the plan's annual compliance report.

MY 2017 to MY 2018

- In MY 2018, the DMHC eliminated the survey question "Is there another provider in the same physical office who could see the patient sooner?" This question had allowed health plans to replace a provider who did not have an appointment within the applicable time-elapsed standard within a different provider in the same office. This question resulted in many health plans not accurately calculating and reporting results to the DMHC. Removing this question decreased health plan mathematical errors, improved data reliability and eliminated the introduction of data from providers who were not part of the original, random sample. It also eliminated survey bias in favor of health plans that contract with large, multi-provider offices compared to solo practitioners or small groups of providers.

In 2019, the RAND Corporation (RAND) published a research report titled "Options for Improving Timely Access to Care Reporting in California". The RAND report made a number of recommendations, some of which the DMHC had already included in the MY 2019 methodology:

- **Centralized Sampling:** To reduce provider burden, health plans may use a single entity to conduct provider surveys on behalf of many (or all) of the health plans. This recommendation has been incorporated into the DMHC's timely access methodology. Health plans may utilize centralized sampling with the appropriate safeguards in place to ensure data quality.
- **Use of Additional Methods for Data Collection:** The DMHC encourages health plans to use additional methods other than phone calls for obtaining appointment availability information to help reduce the burden on providers. Such methods include providers approved by health plans to offer advanced access to same or next day appointments and appointment availability data extraction from provider practice management software or via email.
- **Improve Communication and Outreach to Providers:** The DMHC encourages coordinated efforts by health plans to advise providers regarding the importance of responding to the survey to increase response rates and reduce provider burden.
- **Include Nurse Practitioners and Physician Assistants in the Sampling Frame:** The methodology allows nurse practitioners and physician assistants to be included in the primary care provider sample. The use of nurse practitioners and physician assistants relieves appointment demand on supervising physicians.

Timely Access Regulations

Following a lengthy stakeholder engagement process over the past five years, the DMHC is amending the existing timely access regulation, including a rate of compliance. The proposed regulation will now include a rate of compliance standard that will be applied to each health plan network rather than aggregated by health plan. This report and all previous DMHC timely access reports display timely access data aggregated by health plan. Once approved by the Office of Administrative Law, the DMHC will begin reporting timely access data by health plan network.

A network is a discrete set of providers the health plan has designated to deliver all covered services to enrollees covered by a health plan in a specific service area. Enrollees access health care services from their health plan through the network to which they are enrolled. Although a health plan may have several networks, enrollees may not have access to providers in the plan's other networks. For example, enrollees covered in a Health Maintenance Organization (HMO) health plan are required, in most circumstances, to obtain health care services from a provider within their network. Enrollees enrolled in Preferred Provider Organization (PPO), Point-of-Service (POS), or Exclusive Provider Organization (EPO) health plans may be able to receive services outside their network, but the enrollee may be required to pay a higher out-of-pocket cost.

Measuring the rate of compliance at the network, rather than the aggregate health plan, will allow the DMHC to:

- Measure enrollees' access to health care services based on the providers available to them. Enrollees are required, in most circumstances, to obtain health care services from a provider within the enrollee's specific network, as opposed to obtaining services from any provider contracted with the health plan.
- Most health plan provider data is submitted to the DMHC by network. In addition to reviewing each health plan's annual timely access data, the DMHC annually reviews each health plan network for adequacy. This annual network review assesses health plan network adequacy by evaluating the numbers, types, and locations of providers in the specific network. Comparing data for both timely access compliance and network adequacy reviews by health plan network will allow the DMHC to better evaluate the health plan's ability to meet the needs of enrollees and identify areas for improvement within each health plan provider network.
- Provide health plans with specific feedback regarding which provider types within a network (e.g., primary care physicians, cardiologists, psychiatrists, etc.) and in which service areas the health plan is not meeting the timely access standards. Providing this targeted feedback will inform health plans where they should focus their efforts to improve timely access to care.
- Allow the DMHC to refer plans that are not meeting the rate of compliance standard to the Office of Enforcement for investigation and potential financial penalties and corrective action.

Additional requirements in the draft timely access regulations include:

- Requiring health plans to utilize an external vendor to validate their timely access data and conduct a quality assurance review of their timely access compliance reports prior to submitting them to the DMHC.
- Defining key terms including network, service area and plan-to-plan contracts.
- Standardizing health plan reporting of timely access and annual network data to ensure consistency and comparability across the industry.
- Requiring each health plan to annually evaluate its ability to provide timely appointments and coordinate appropriate interpreter services by including specific questions in the Enrollee Experience Survey and Provider Satisfaction Survey.
- Codifying the Provider Appointment Availability Survey to ensure health plans report comparable timely access data year-to-year.
- Describing the DMHC's process for identifying non-compliance with timely access and network adequacy standards.
- Providing health plans the opportunity to develop and submit a corrective action plan to address DMHC findings of non-compliance.

How the DMHC Monitors Timely Access

The DMHC utilizes a variety of regulatory oversight tools, in addition to the review of health plan timely access compliance reports, to ensure consumers have timely access to care.

These oversight tools include:

- Monitoring enrollee complaints submitted to the DMHC Help Center to identify trends and take appropriate action, including referrals to the DMHC Office of Enforcement.
- Annually evaluating health plan networks to ensure health plans have an adequate number of providers to offer timely access to care to their enrollees.
- On-site auditing of health plan operations through routine medical surveys. One component of the medical surveys is the assessment of plan compliance with the timely access standards. The DMHC reviews actions taken by a health plan's quality improvement committee in response to access and availability issues identified by health plan enrollees or the DMHC. Network adequacy issues may be identified during the review of enrollee grievances and utilization management files. The DMHC also reviews the plan's quality assurance processes for timely delivery of language assistance services for non-urgent, urgent and emergency health care services. These must include processes for coordinating necessary interpretation services at the time of a scheduled appointment.
- Taking enforcement action against health plans that violate timely access requirements, which may include requiring a corrective action plan.

The DMHC Help Center resolved a total of 614 access to care complaints in 2018, making up 6.5 percent of all complaints received for the year. Generally, with these types of complaints the DMHC Help Center works with the enrollee's health plan to quickly resolve the access issue, and schedule an appointment within the timely access standards and to meet the enrollee's needs.

Between January 1, 2017 and January 15, 2020, the DMHC has issued 29 access related deficiencies to health plans through the medical survey process. Of these 29 deficiencies:

- Fifteen deficiencies were corrected by the health plans at the issuance of the Final Report or Follow-Up Report.
- Eight deficiencies were not corrected at the issuance of the Follow-Up Report and have been referred to the DMHC's Office of Enforcement.
- Four deficiencies are pending the completion of the Follow-Up Survey.
- Two deficiencies were pended to the next routine survey as part of a settlement agreement with the DMHC's Office of Enforcement.

Health Plans Must Also Meet the Following Requirements to Ensure Customers Have Timely Access to Care:

DISTANCE

Provide access to a primary care provider or a hospital within 15 miles or 30 minutes from where enrollees live or work.

AVAILABILITY

Your health plan should have telephone services available on a 24/7 basis.

INTERPRETER

Interpreter services must be coordinated with scheduled appointments for health care services to ensure interpreter services are provided at the time of the appointment.

Timely Access Compliance Report Findings

The timely access survey process is an annual assessment of a health plans ability to offer appointments within the timely access standards. The survey does not measure actual enrollee experiences. The charts within this report utilize the data reported by health plans. The charts display the percentage of surveyed providers who indicated they had appointments available within the appointment wait time standards.

The DMHC requires health plans to annually measure timely access by using the mandatory Provider Appointment Availability Survey and then report the results to the DMHC. The survey uses a randomly selected, statistically reliable sample of providers within a health plan network. Health plans contact the random sample of providers and query them for their next available appointment. The health plans compare the providers' responses to these surveys against the appointment wait time standards and the results are submitted to the DMHC.

Data Sampling Error Rate

To ensure the reliability of a health plan's reported rates, this report presents data where the sampling error was at or below five percentage points. Meeting the target sample size defined by the survey methodology should lead to sampling errors of approximately five percent for each provider type by appointment type. The charts combine data for more than one provider type or appointment type, which increases the sample size and results in lower sampling errors. Sampling errors for rates presented in this report are typically below two percent. Sampling errors exceeding five percent for combined provider type rates indicate the health plan's failure to achieve target sample sizes for multiple provider types. This raises concern that the sample may not be representative of the population of plan providers. Appendix A contains a detailed explanation of any data discrepancies.

Aggregate Rate of Compliance

The charts show provider responses to appointment availability requests for MY 2018. It is important to understand the health plan survey results reflect only a period in time, based on the sample size of surveyed providers who responded.

For example, if a health plan's survey result shows a 75 percent aggregate rate of compliance with a two-percentage point sampling error, this means 75 percent of providers that responded to the survey indicated their next available appointment fell within the appointment wait time standards. Because the result is calculated from a statistical sample of a health plan's providers, we can infer with a high degree of reliability what the actual rate of compliance is for all health plan providers. In this example, we are highly confident that the actual rate of compliance for all plan providers is between 73 and 77 percent.

Full Service Health Plans

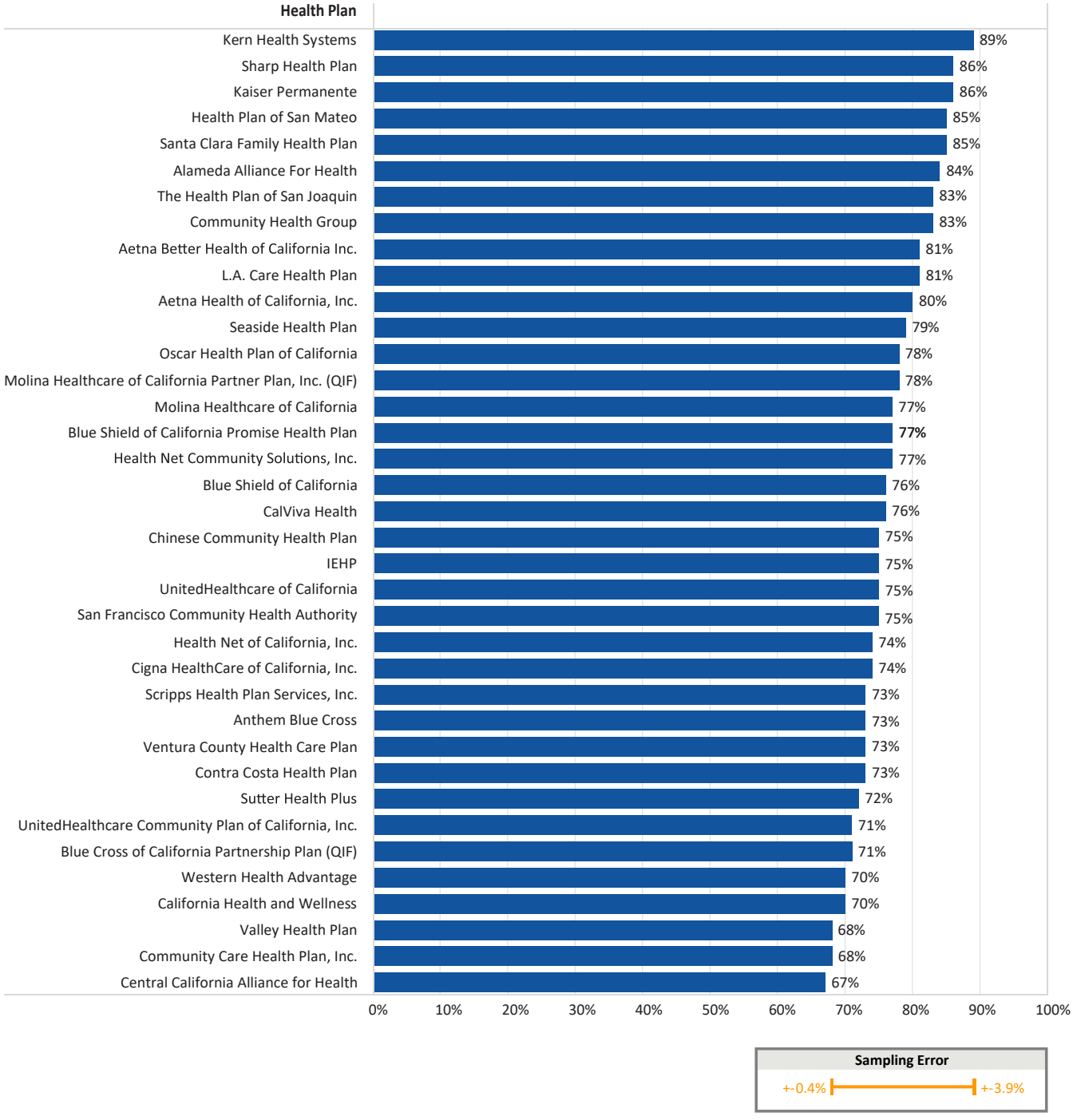
URGENT AND NON-URGENT APPOINTMENTS

Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

Chart 1

Full Service Health Plans

This chart combines health plans' Commercial, Individual/Family and Medi-Cal product survey results, across all provider types (primary care, specialty, non-physician mental health and ancillary) for both urgent and non-urgent appointments.

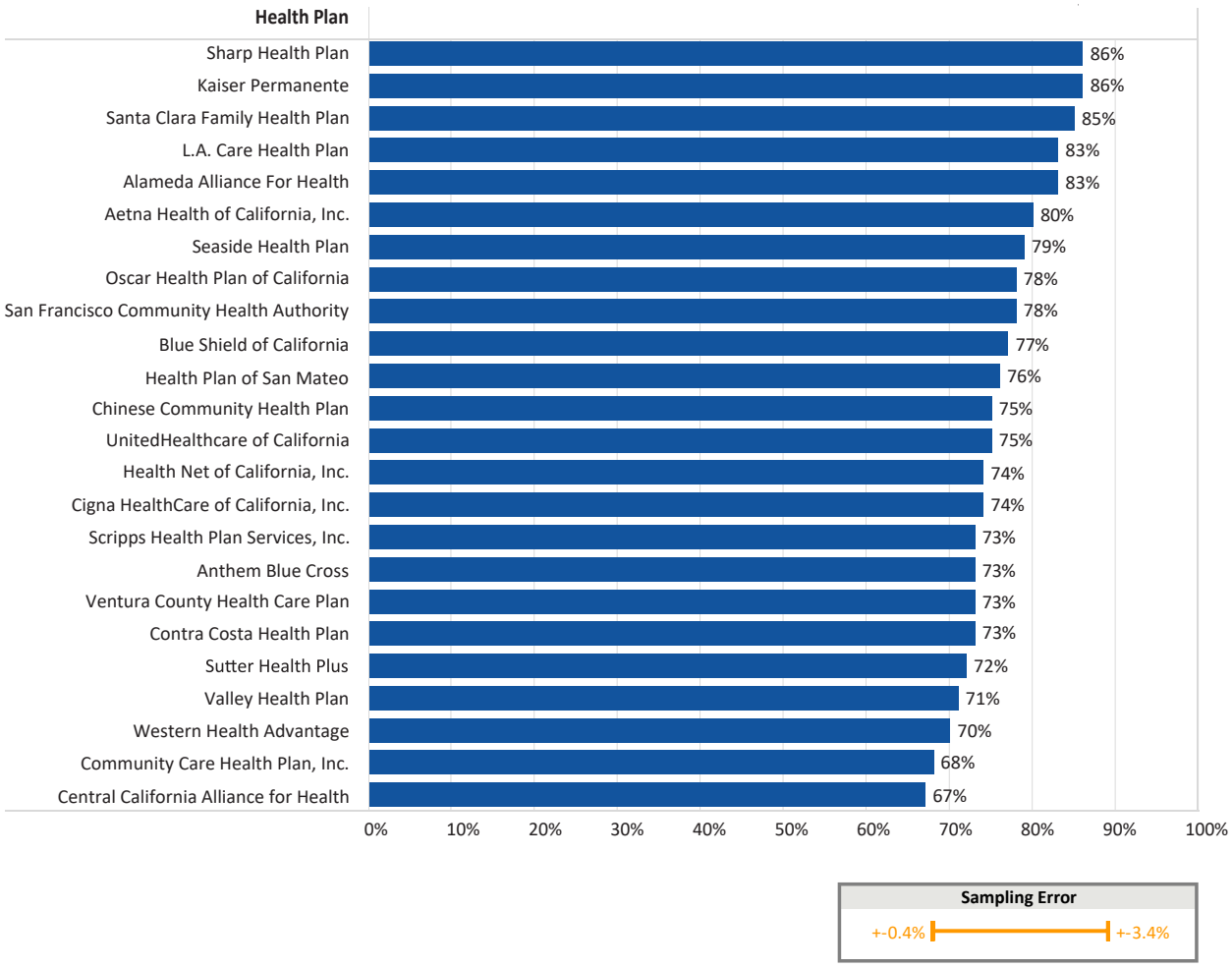


Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

Chart 2

Full Service Health Plans – Commercial

This chart combines health plans' Commercial product survey results, across all provider types (primary care, specialty, non-physician mental health and ancillary) for both urgent and non-urgent appointments.

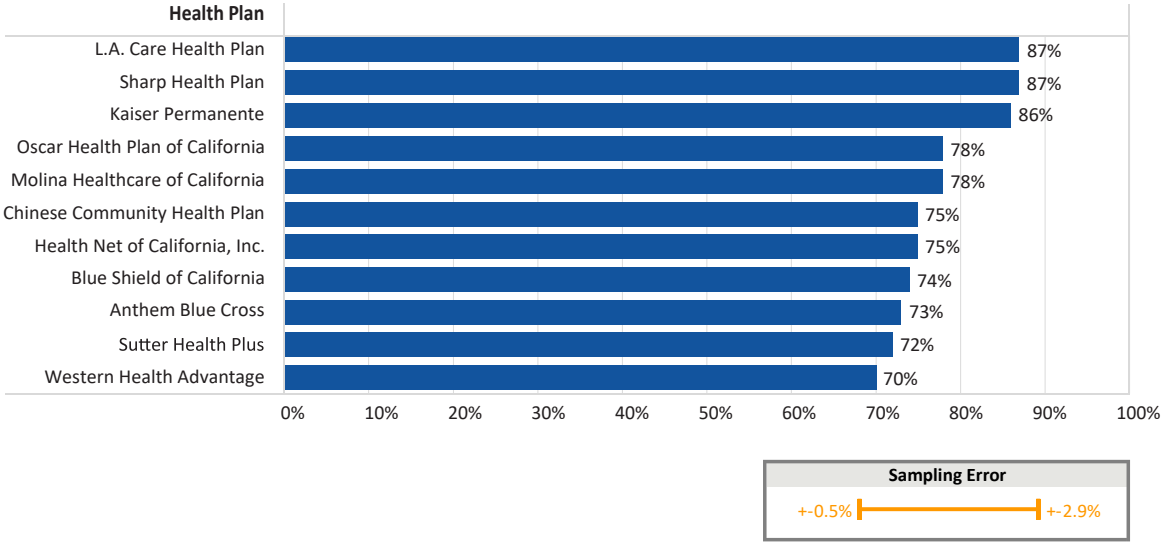


Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

Chart 3

Full Service Health Plans – Individual/Family

This chart combines health plans' Individual/Family product survey results, across all provider types (primary care, specialty, non-physician mental health and ancillary) for both urgent and non-urgent appointments[1].



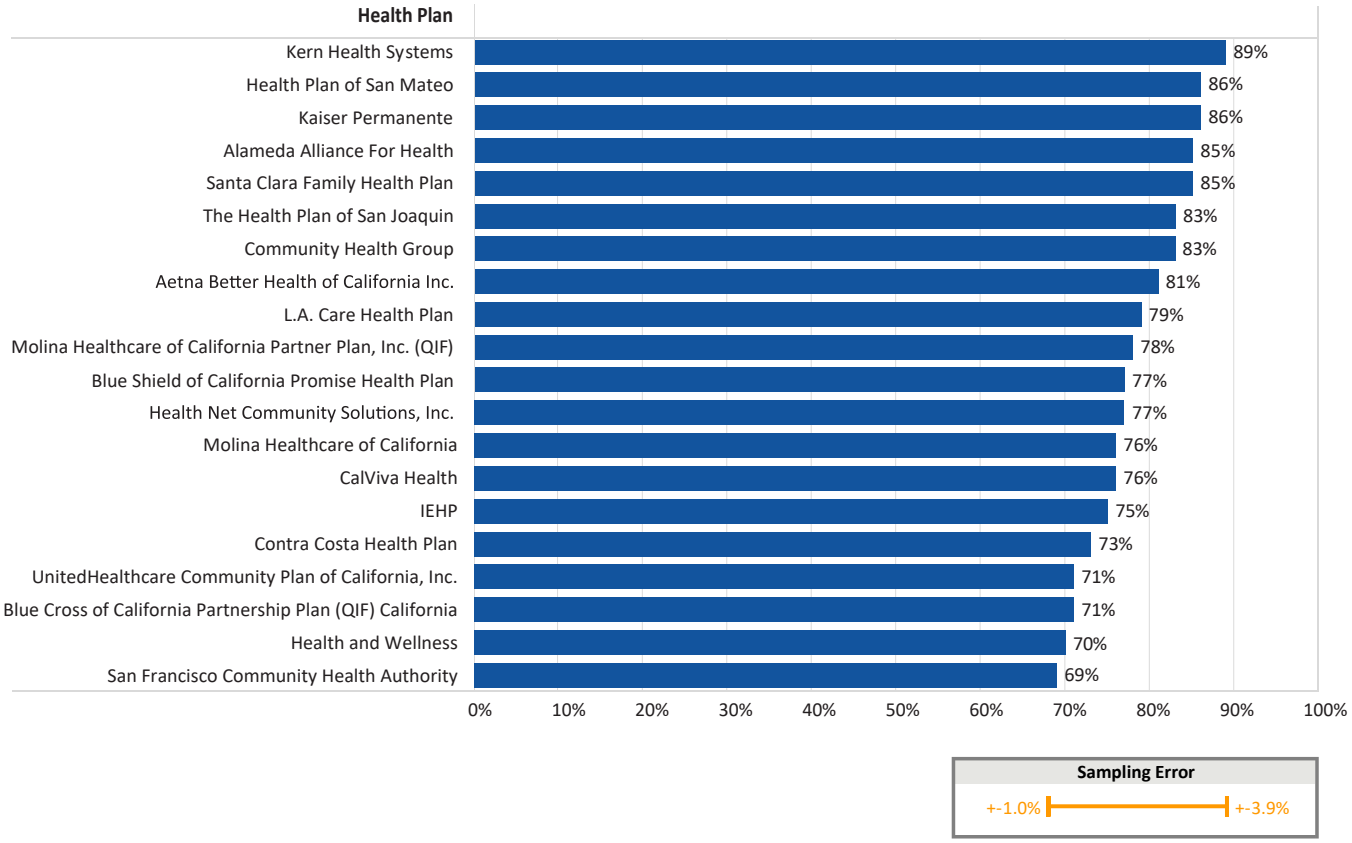
[1] One health plan (Valley Health Plan) is not displayed. See Appendix A.

Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

Chart 4

Full Service Health Plans – Medi-Cal

This chart combines health plans' Medi-Cal product survey results, across all provider types (primary care, specialty, non-physician mental health and ancillary) for both urgent and non-urgent appointments[2].



[2] One health plan (Valley Health Plan) is not displayed. See Appendix A.

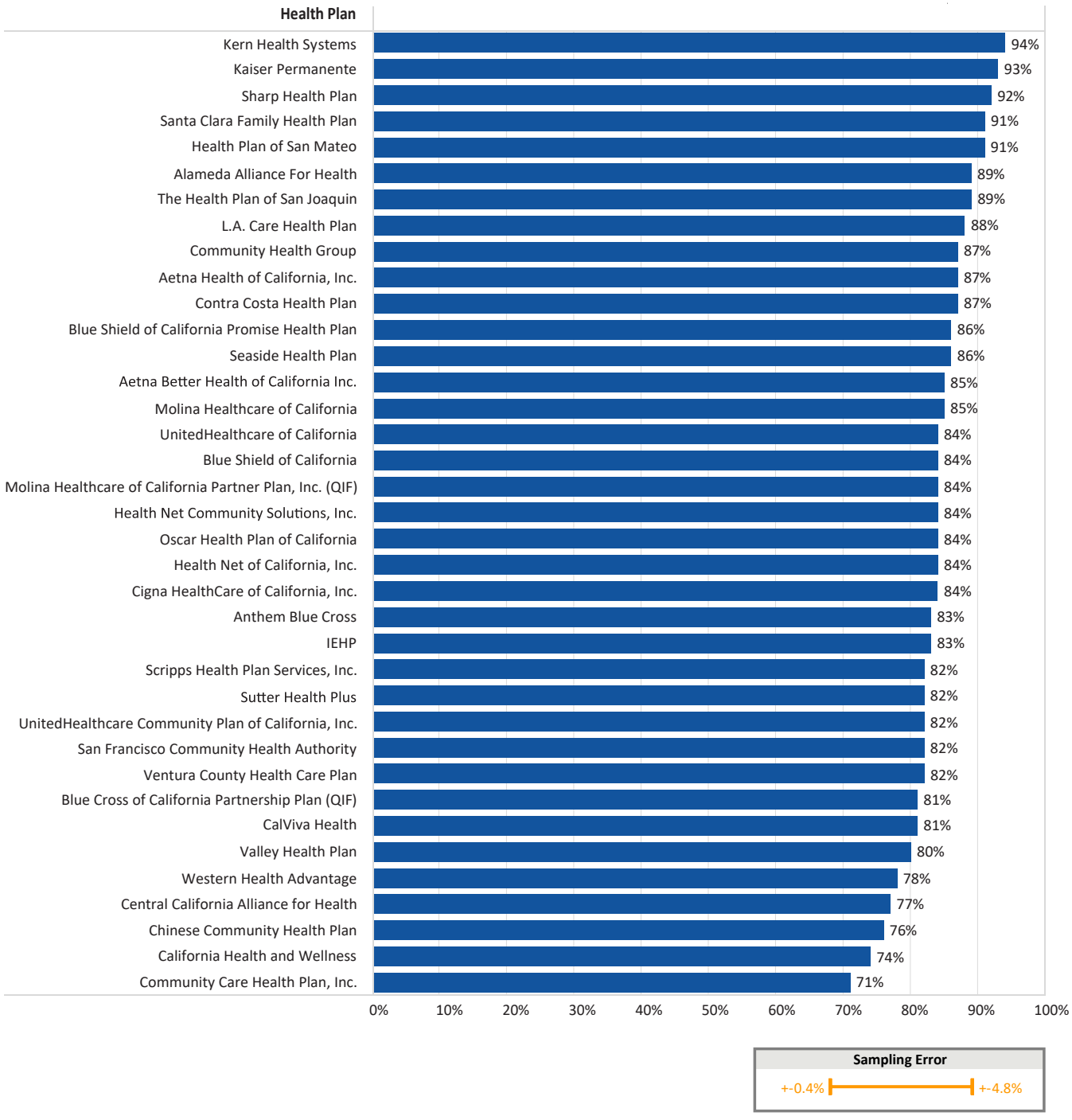
NON-URGENT APPOINTMENTS

Percentage of Surveyed Providers Meeting Non-Urgent Appointment Wait Time Standards

Chart 5

Full Service Health Plans

This chart combines health plans' Commercial, Individual/Family and Medi-Cal product survey results, across all provider types (primary care, specialty, non-physician mental health and ancillary) for non-urgent appointments.

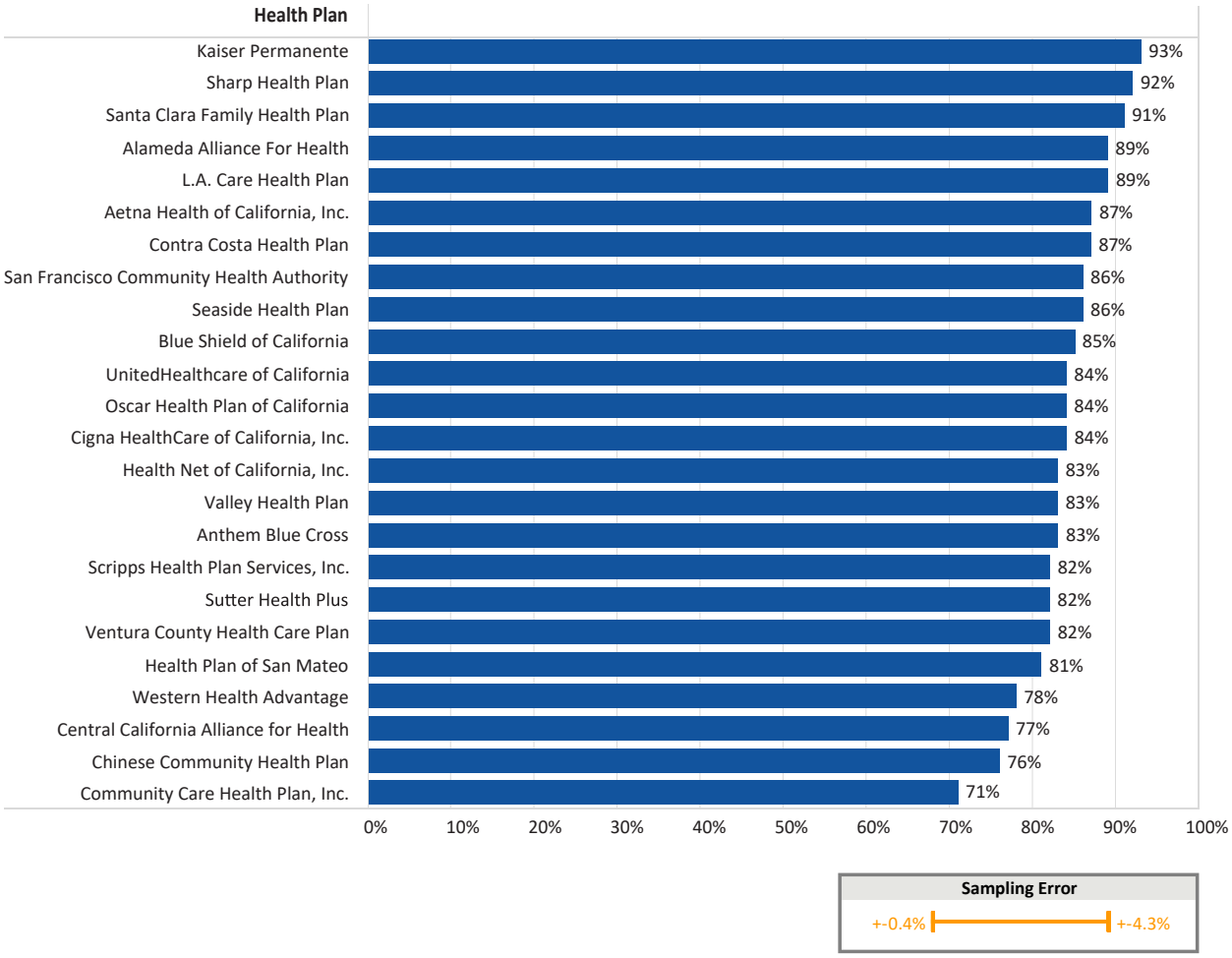


Percentage of Surveyed Providers Meeting Non-Urgent Appointment Wait Time Standards

Chart 6

Full Service Health Plans – Commercial

This chart combines health plans' Commercial product survey results, across all provider types (primary care, specialty, non-physician mental health and ancillary) for non-urgent appointments.

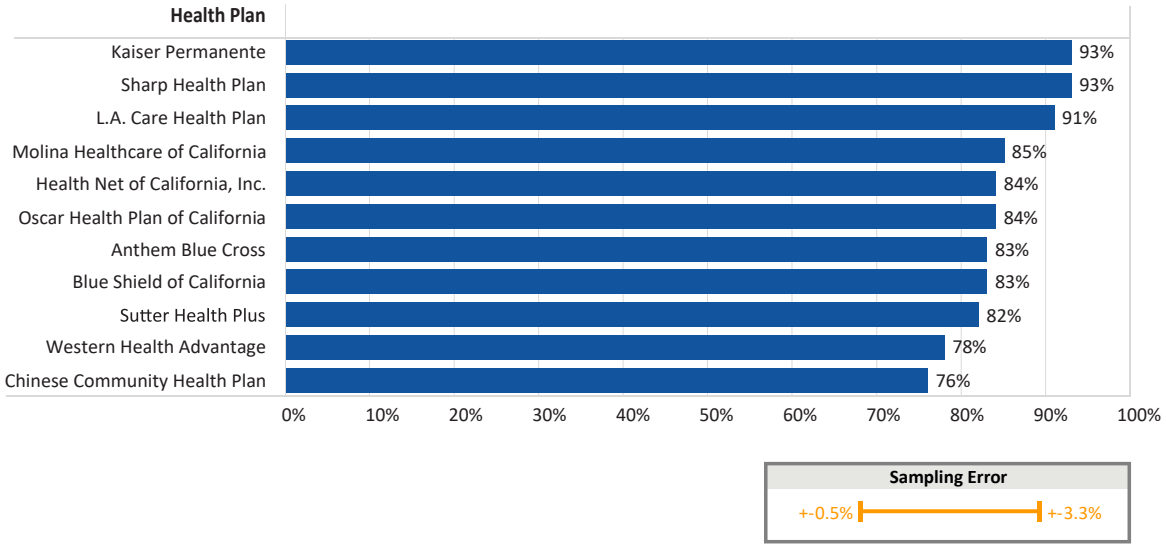


Percentage of Surveyed Providers Meeting Non-Urgent Appointment Wait Time Standards

Chart 7

Full Service Health Plans – Individual/Family

This chart combines health plans' Individual/Family product survey results, across all provider types (primary care, specialty, non-physician mental health and ancillary) for non-urgent appointments[3].



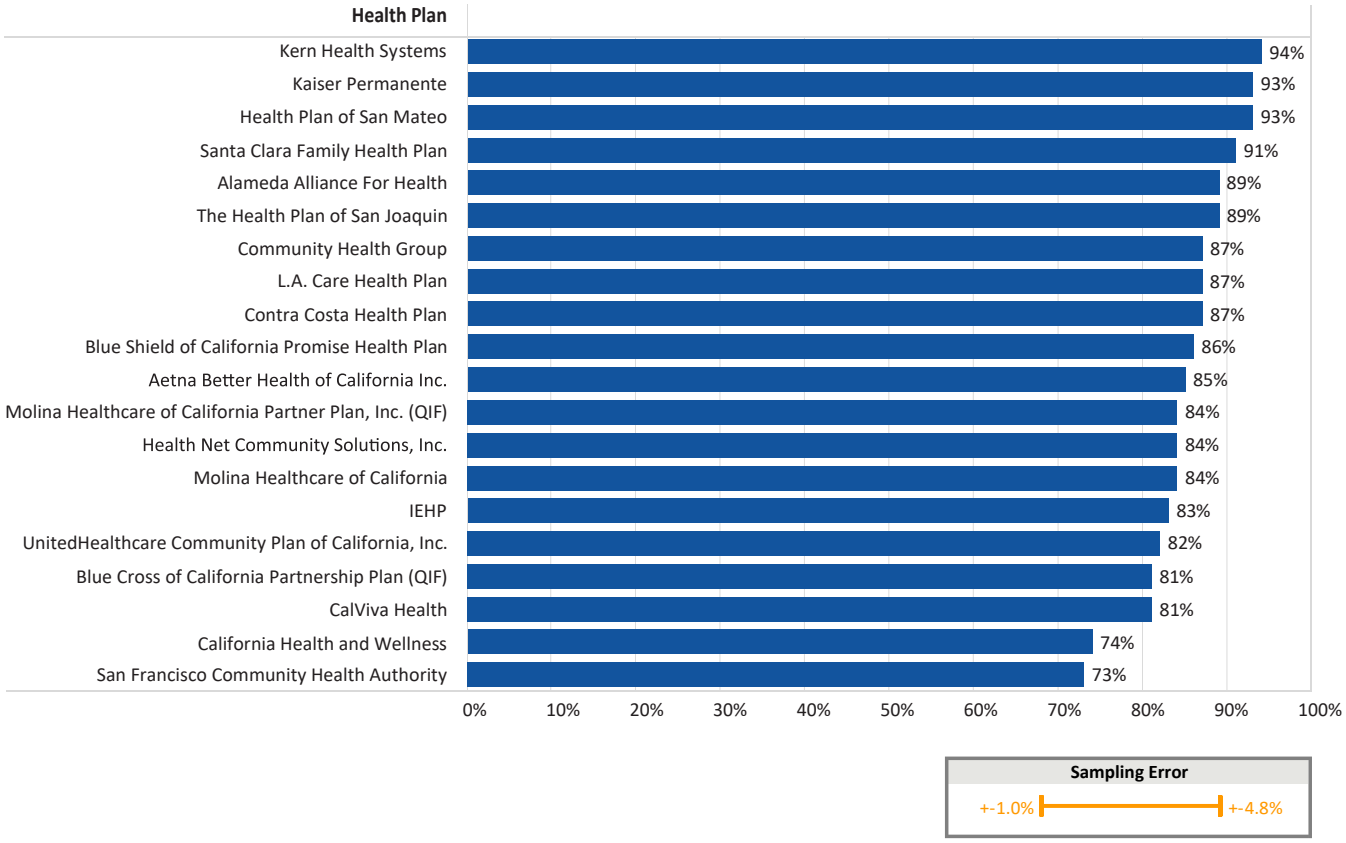
[3] One health plan (Valley Health Plan) is not displayed. See Appendix A.

Percentage of Surveyed Providers Meeting Non-Urgent Appointment Wait Time Standards

Chart 8

Full Service Health Plans – Medi-Cal

This chart combines health plans' Medi-Cal product survey results, across all provider types (primary care, specialty, non-physician mental health and ancillary) for non-urgent appointments[4].



[4] One health plan (Valley Health Plan) is not displayed. See Appendix A.

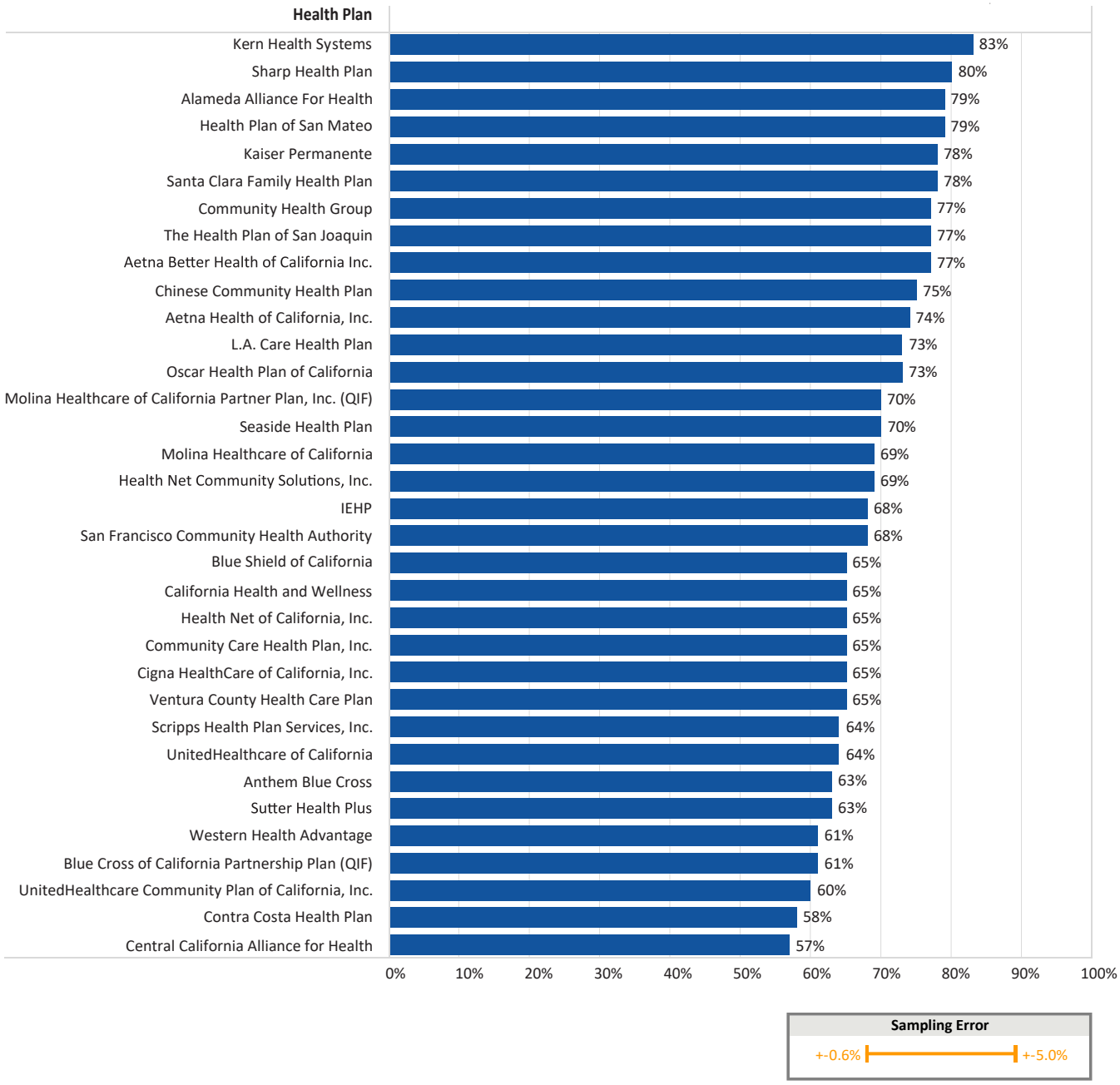
URGENT APPOINTMENTS

Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards

Chart 9

Full Service Health Plans

This chart combines health plans' Commercial, Individual/Family and Medi-Cal product survey results, across provider types (primary care, specialty and non-physician mental health) for urgent appointments[5].



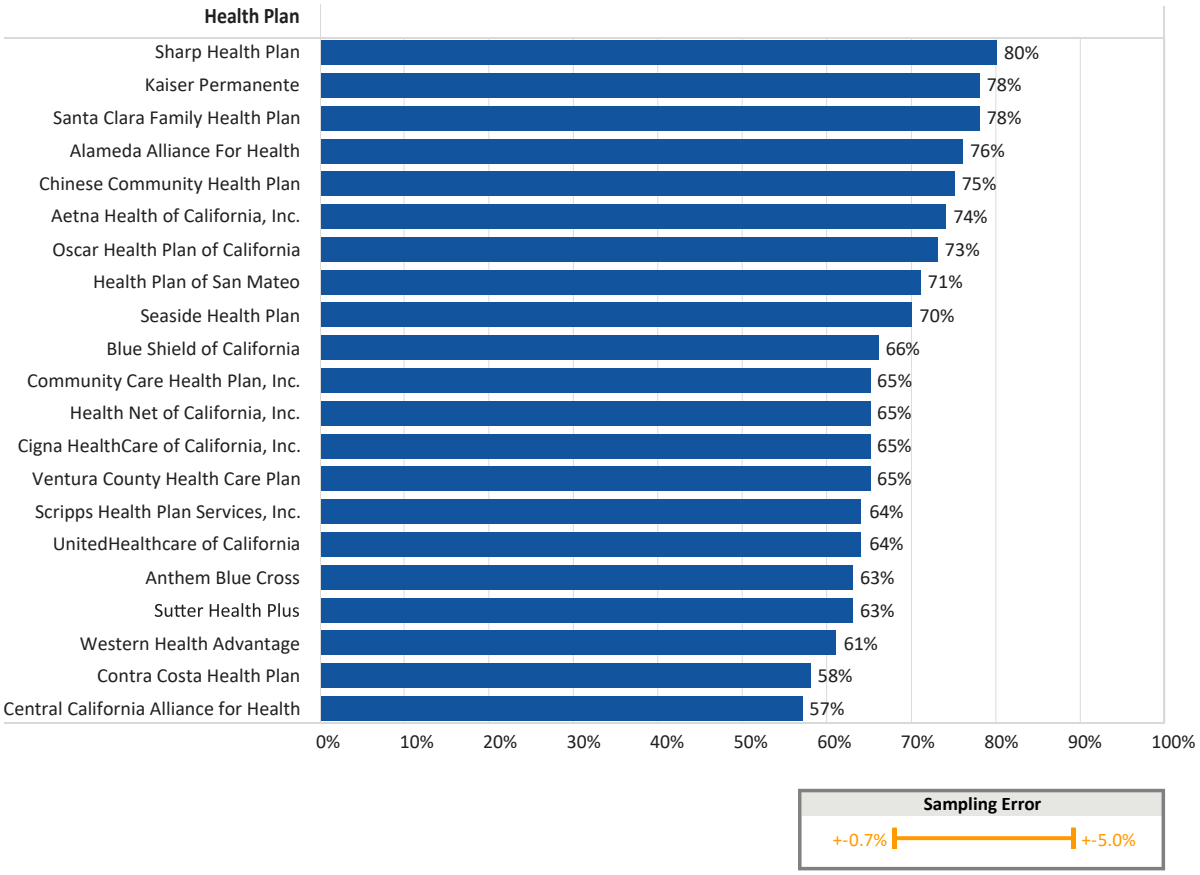
[5] Three health plans (Valley Health Plan, CalViva Health and Blue Shield of California Promise Health Plan) are not displayed. See Appendix A.

Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards

Chart 10

Full Service Health Plans – Commercial

This chart combines health plans' Commercial product survey results, across provider types (primary care, specialty and non-physician mental health) for urgent appointments[6].



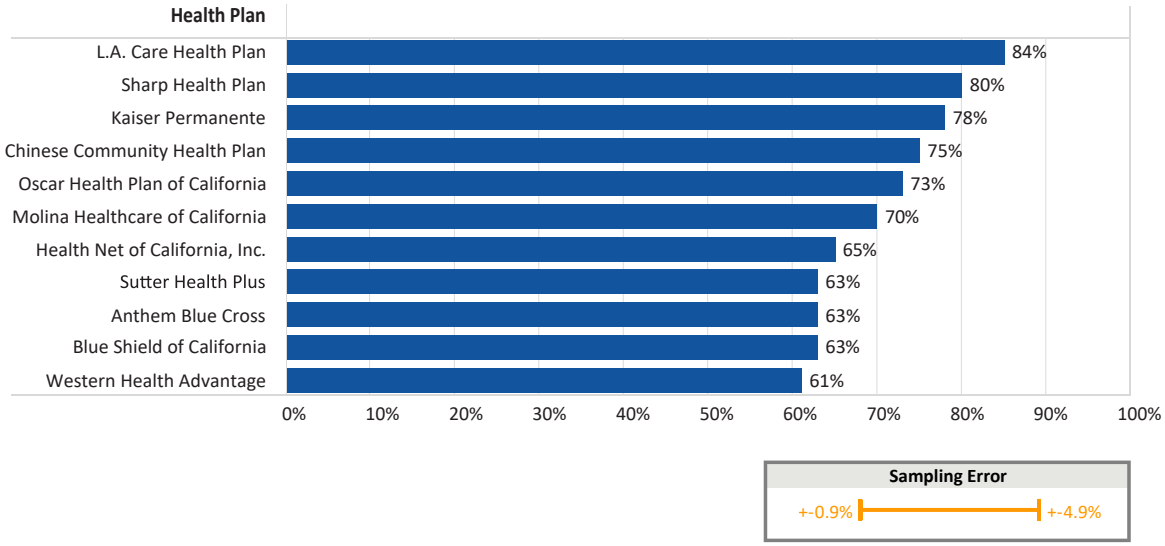
[6] Three health plans (Valley Health Plan, L.A. Care Health Plan and San Francisco Community Health Authority) are not displayed. See Appendix A.

Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards

Chart 11

Full Service Health Plans – Individual/Family

This chart combines health plans' Individual/Family product survey results, across provider types (primary care, specialty and non-physician mental health) for urgent appointments[7].



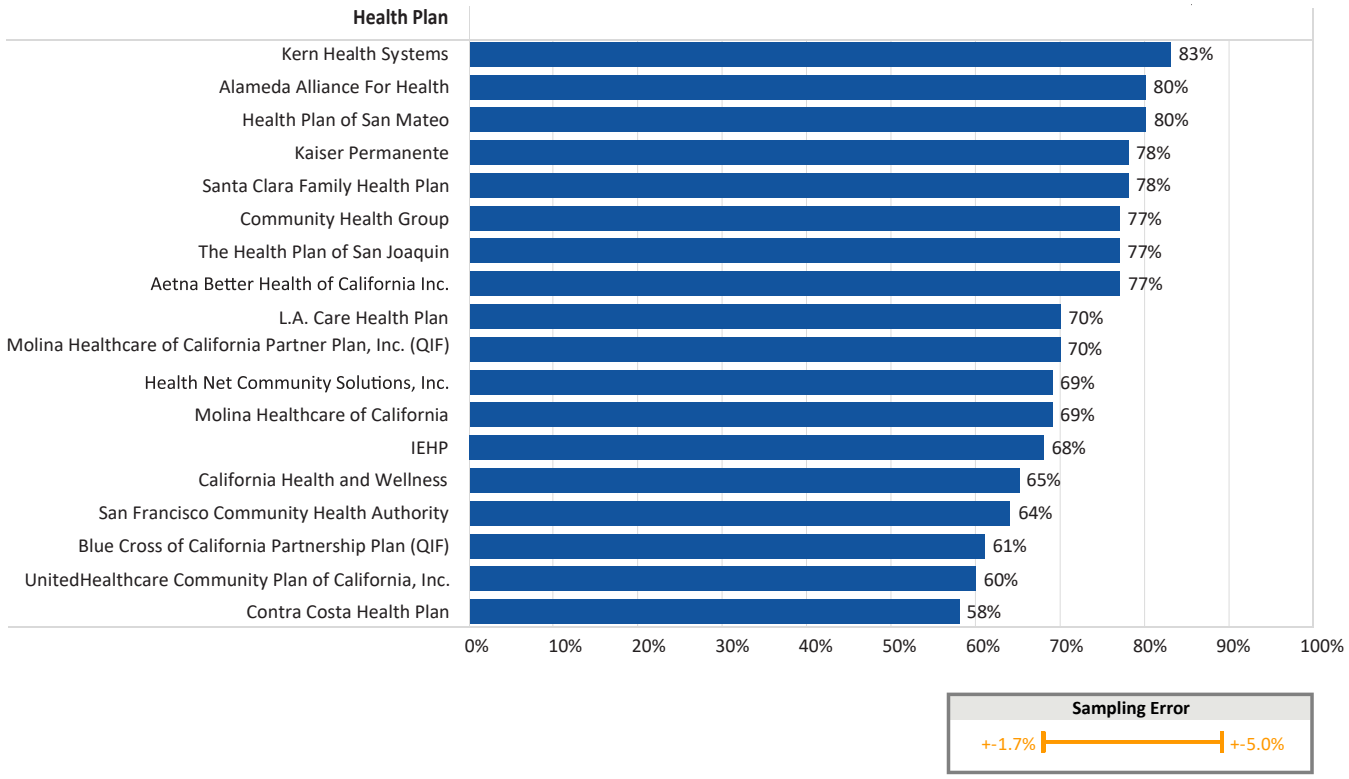
[7] One health plan (Valley Health Plan) is not displayed. See Appendix A.

Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards

Chart 12

Full Service Health Plans – Medi-Cal

This chart combines health plans' Medi-Cal product survey results, across provider types (primary care, specialty and non-physician mental health) for urgent appointments[8].



[8] Three health plans (Valley Health Plan, CalViva Health and Blue Shield of California Promise Health Plan) are not displayed. See Appendix A.

Behavioral Health Plan Survey Data

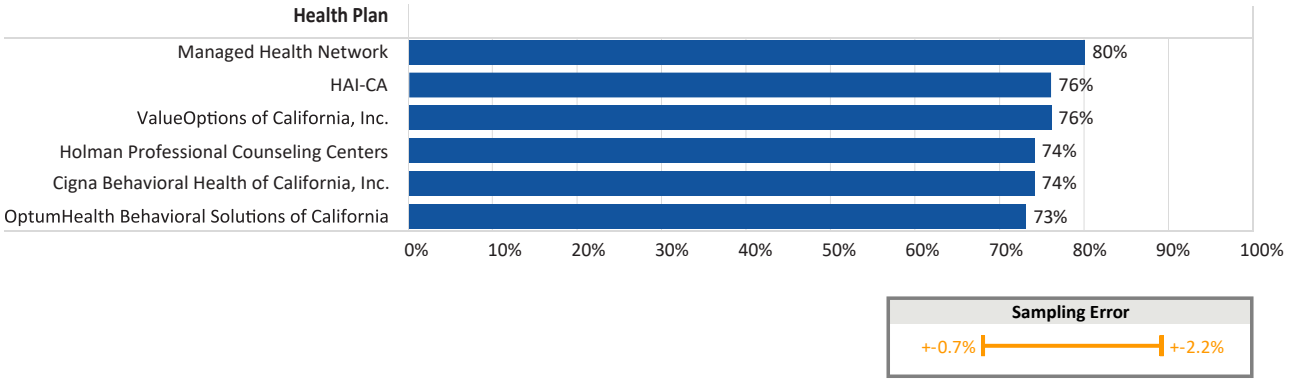
URGENT AND NON-URGENT APPOINTMENTS

Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

Chart 13

Behavioral Health Plans

This chart combines behavioral health plans' Commercial, Individual/Family and Medi-Cal product survey results, across mental health provider types (non-physician mental health, psychiatrist and child and adolescent psychiatrist) for both urgent and non-urgent appointments.

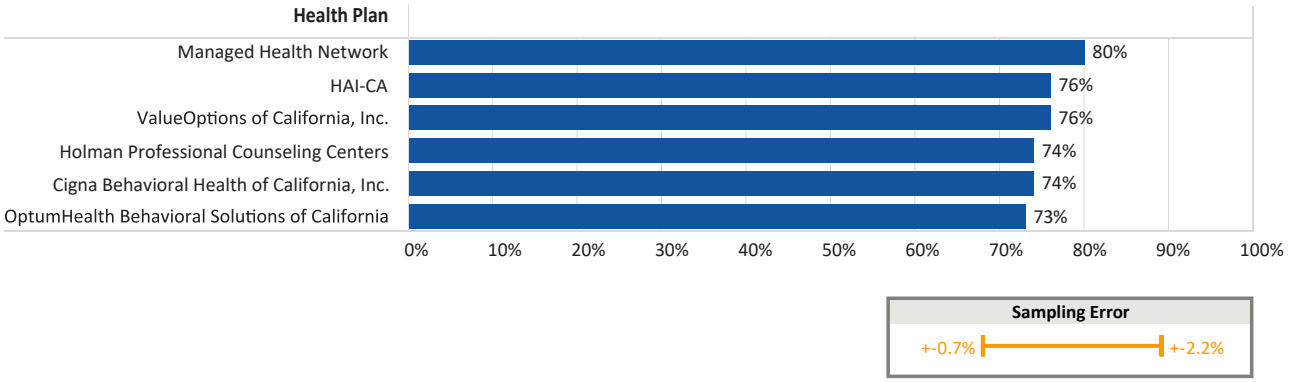


Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

Chart 14

Behavioral Health Plans – Commercial

This chart combines behavioral health plans' Commercial product survey results, across mental health provider types (non-physician mental health, psychiatrist and child and adolescent psychiatrist) for both urgent and non-urgent appointments.

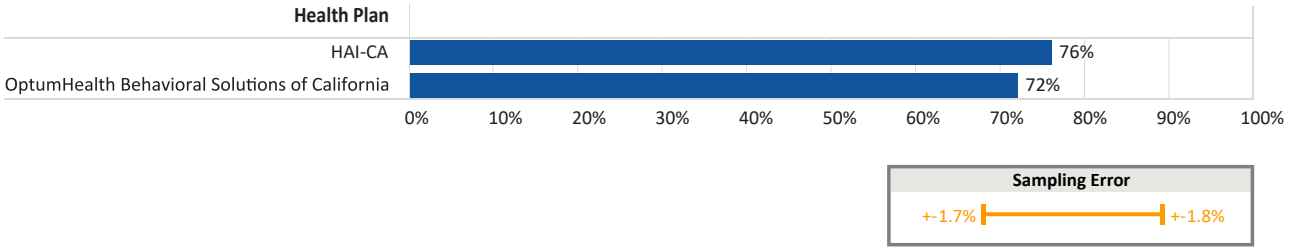


Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

Chart 15

Behavioral Health Plans – Individual/Family

This chart combines behavioral health plans' Individual/Family product survey results, across mental health provider types (non-physician mental health, psychiatrist and child and adolescent psychiatrist) for both urgent and non-urgent appointments.

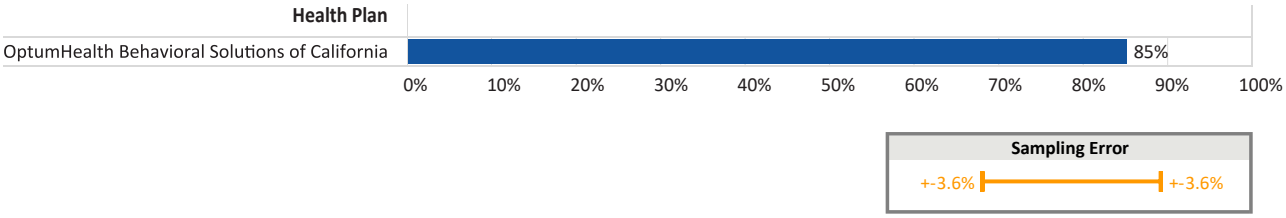


Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

Chart 16

Behavioral Health Plans – Medi-Cal

This chart combines behavioral health plans' Medi-Cal product survey results, across mental health provider types (non-physician mental health psychiatrist and child and adolescent psychiatrist) for both urgent and non-urgent appointments.



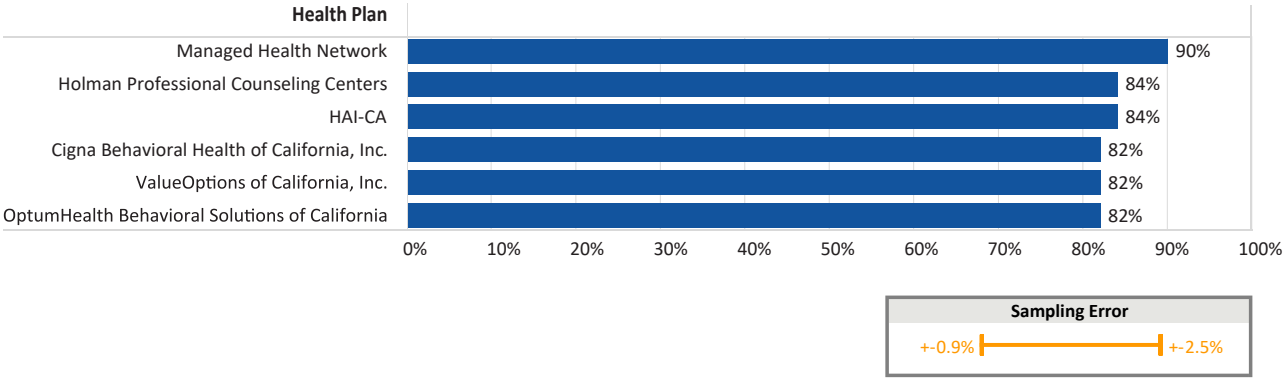
NON-URGENT APPOINTMENTS

Percentage of Surveyed Providers Meeting Non-Urgent Appointment Wait Time Standards

Chart 17

Behavioral Health Plans

This chart combines behavioral health plans' Commercial, Individual/Family and Medi-Cal product survey results, across mental health provider types (non-physician mental health, psychiatrist and child and adolescent psychiatrist) for non-urgent appointments.

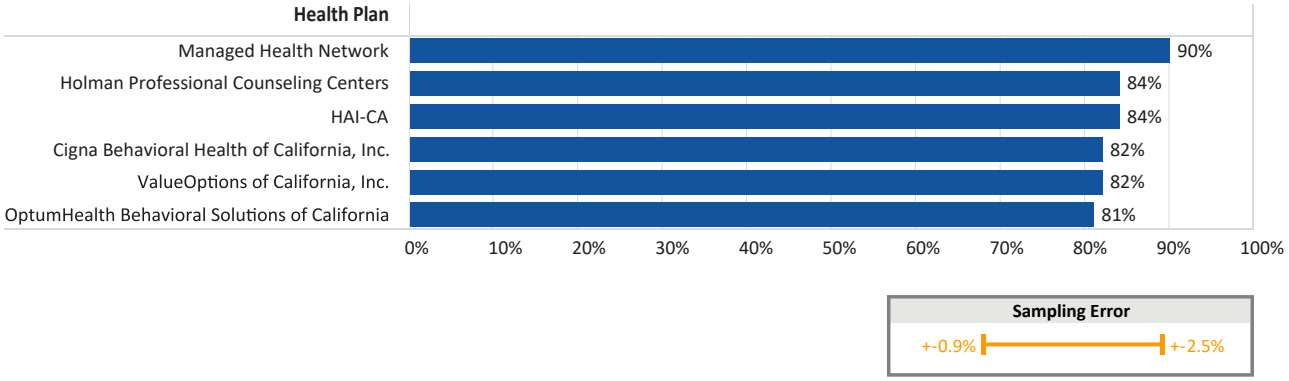


Percentage of Surveyed Providers Meeting Non-Urgent Appointment Wait Time Standards

Chart 18

Behavioral Health Plans – Commercial

This chart combines behavioral health plans' Commercial product survey results, across mental health provider types (non-physician mental health, psychiatrist and child and adolescent psychiatrist) for non-urgent appointments.

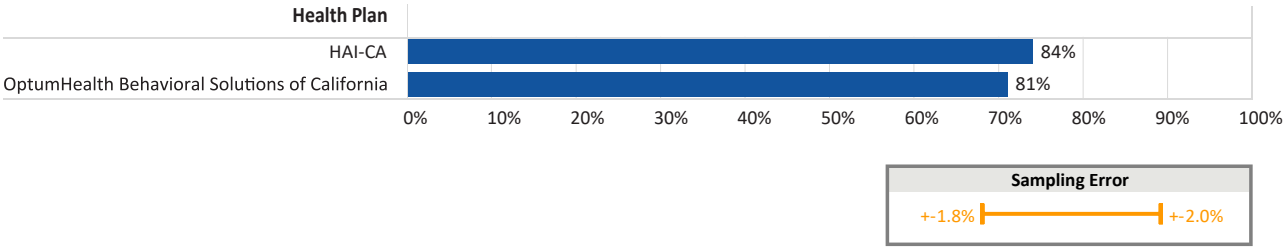


Percentage of Surveyed Providers Meeting Non-Urgent Appointment Wait Time Standards

Chart 19

Behavioral Health Plans – Individual/Family

This chart combines behavioral health plans' Individual/Family product survey results, across mental health provider types (non-physician mental health, psychiatrist and child and adolescent psychiatrist) for non-urgent appointments.

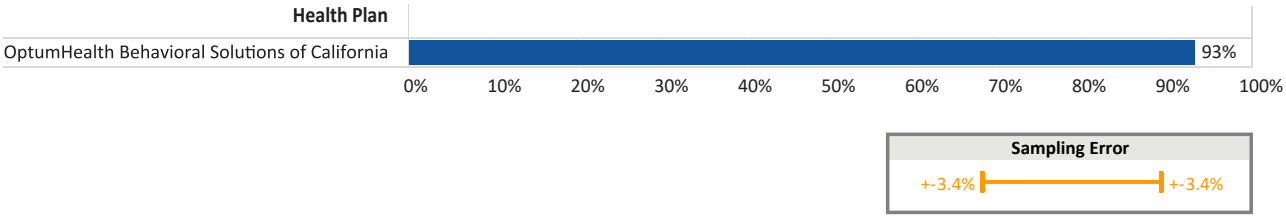


Percentage of Surveyed Providers Meeting Non-Urgent Appointment Wait Time Standards

Chart 20

Behavioral Health Plans – Medi-Cal

This chart combines behavioral health plans' Medi-Cal product survey results, across mental health provider types (non-physician mental health, psychiatrist and child and adolescent psychiatrist) for non-urgent appointments.



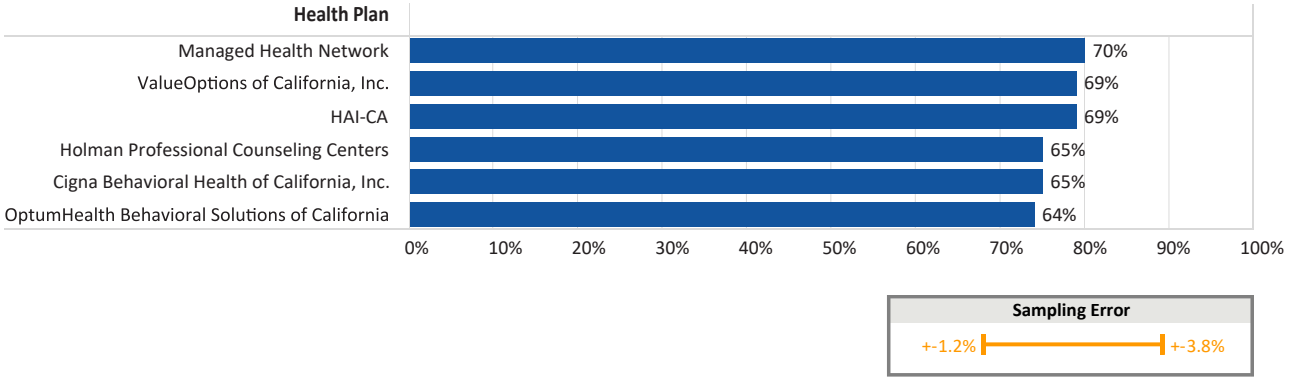
URGENT APPOINTMENTS

Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards

Chart 21

Behavioral Health Plans

This chart combines behavioral health plans' Commercial, Individual/Family and Medi-Cal product survey results, across mental health provider types (non-physician mental health, psychiatrist and child and adolescent psychiatrist) for urgent appointments.

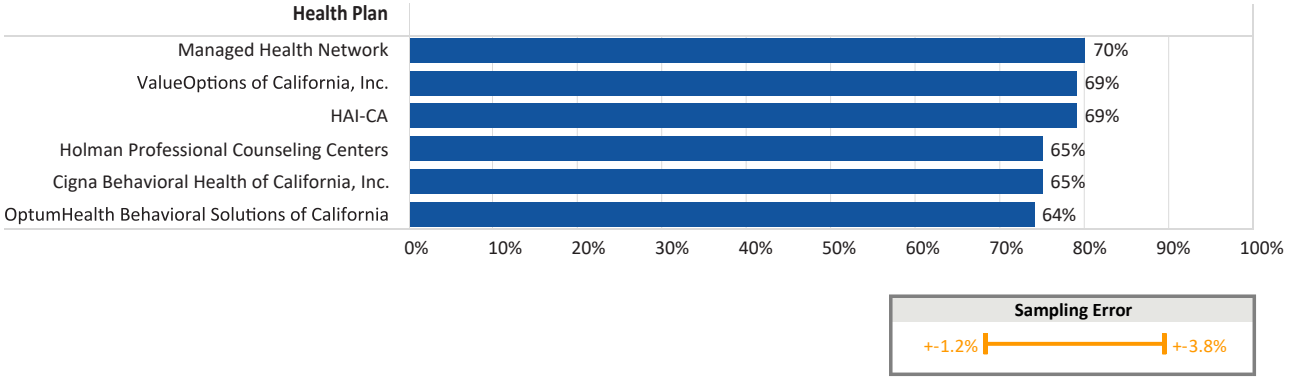


Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards

Chart 22

Behavioral Health Plans – Commercial

This chart combines behavioral health plans' Commercial product survey results, across mental health provider types (non-physician mental health, psychiatrist and child and adolescent psychiatrist) for urgent appointments.



Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards

Chart 23

Behavioral Health Plans – Individual/Family

This chart combines behavioral health plans' Individual/Family product survey results, across mental health provider types (non-physician behavioral health, psychiatrist and child and adolescent psychiatrist) for urgent appointments.

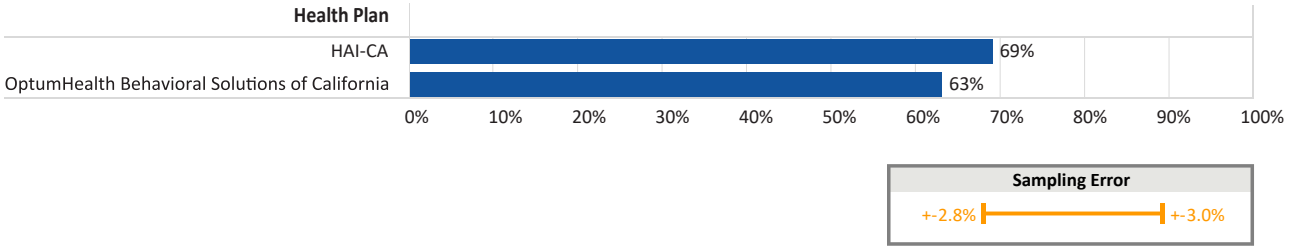


Chart 24

Behavioral Health Plans – Medi-Cal

Due to a sampling error greater than five percent (6.4%), the DMHC is unable to display results for the one applicable Medi-Cal behavioral health plan, OptumHealth Behavioral Solutions of California. Appendix A contains a detailed explanation of any data discrepancies.

Next Steps

To further improve health plan compliance with timely access standards, the DMHC will:

- Require health plans to continue utilizing an external vendor to perform a quality assurance review and include a validation report of the health plans' data prior to submission to the DMHC.
- Provide health plans with feedback on their MY 2018 data. This feedback will include information on how the plans may improve the accuracy of their surveys and data in subsequent years.
- Review stakeholder feedback and submit the amended timely access regulation to the Office of Administrative Law.
- Report timely access data by health plan network.
- Continue to work with, and provide timely access compliance data to the Office of the Patient Advocate (OPA) for incorporation into the OPA Quality of Care Report Card.

Conclusion

Health plans must continue their efforts to improve the accuracy and completeness of their timely access compliance data. For example, all health plans must follow the mandatory methodology, accurately complete compliance calculations and de-duplication processes, complete required surveys in the measurement year and survey enough providers to meet the required sample size. Health plans that fail to comply with the mandatory methodology will be referred to the DMHC Office of Enforcement.

The DMHC's annual review and reporting of timely access data demonstrates the DMHC's continued commitment to its mission of protecting consumers' health care rights and ensuring a stable health care delivery system by increasing and providing comparable timely access data to the public and other interested parties.

The DMHC appreciates the feedback provided by all stakeholders as we revise the draft timely access regulation. As noted previously, the DMHC intends to submit the revised regulation to the Office of Administrative Law in early 2020. This will start the public rulemaking process, and we encourage all stakeholders to participate.

The DMHC will continue collaborative efforts with stakeholders, including health plans, providers and consumer advocates, to further improve enrollee timely access to health care services.

Appendices

Appendix A: Timely Access Compliance Data Discrepancies & Analysis

The charts in this report include data for primary care physicians (PCPs), specialists, non-physician mental health and ancillary providers[9] for both urgent and non-urgent appointments. The charts identify the percentage of appointments where a provider indicated appointment availability within the wait-time standards set forth in the Knox-Keene Act and as required in the MY 2018 Provider Appointment Availability Survey Methodology.

A number of data discrepancies were identified in health plan compliance reports for MY 2018. A description as to whether the analysis excluded, noted, or otherwise re-weighted in connection with the analysis, is discussed in this Appendix.

Data – Survey Methodology

The timely access rates were calculated through survey responses from providers who were contracted with health plans. The surveys identified whether the first available appointment with a provider fell within the timely access standards. A provider may have been surveyed multiple times because they may contract with more than one health plan or they may practice in multiple counties.

Overall Rate

The overall timely access rate is first computed at the county network level. The numerator for overall rate is the sum of the number of providers who responded to having an urgent care appointment within timely access standards and the number of providers who responded to having a non-urgent care appointment within timely access standards. The denominator is the sum of the number of providers who answered the survey for urgent care appointments and the number of providers who answered the survey for non-urgent care appointments. The calculated county network overall rate is then used to calculate a weighted mean by health plan, which is described below.

All Health Plan-Level Rates

For overall, urgent, and non-urgent care appointments, the analysis created a weighted mean of the timely access rate across all health plan county networks, using as weights the number of providers within a county network. Rates for ancillary providers are weighted by the number of service centers within a county network. This provider (or service center) weighting means that a timely access rate for a health plan's county network with 100 providers (or service centers) receives a weight ten times the weight of a rate for a county network with 10 providers (or service centers). This weighting ensures that the overall rates are not biased due to counties with smaller numbers of providers or service centers. The resulting rate, show the expected percentage of appointment requests that meet the standard applicable to the type of provider and type of appointment.

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[9] Specialists consist of cardiologists, endocrinologists, gastroenterologists and adult and child psychiatrists. Ancillary providers consist of MRI, mammography and physical therapist providers. Mental health providers consist of non-physician mental health providers.

Sampling Error

Each chart includes the timely access rates and provides the "sampling error," or the range within which the analysis is 80 percent certain the actual rate falls within the given the sample size[10]. Sampling errors were calculated using a finite population correction. The variability in sampling errors resulted from variation in rates, the varying size in health plan networks and the degree to which target sample sizes were achieved. Multiple factors led to health plans failing to achieve target samples. In some cases, surveyors exhausted the providers on the contact list due to non-response, refusals to participate in the survey, or ineligible providers being listed. In other cases, it appears health plans failed to exhaust all potential respondents, suggesting they did not adequately prepare to replace non-responders. Results are not presented for health plans where the sampling error for the rate was greater than 5 percent, as these results were deemed unreliable. The chart below provides detail on health plan data excluded from the previous charts due to sampling errors greater than 5 percent.

Chart Number	Plan Type	Health Plan Name	Measurement Type	Product	MY 2018 Rate of Compliance	MY 2017 Rate of Compliance	Percentage Point Difference	MY 2018 Sampling Error
Chart 3	Full Service Plan	Valley Health Plan	Urgent/Non-Urgent	Individual/Family	66%	97%	-31%	10.0%
Chart 4	Full Service Plan	Valley Health Plan	Urgent/Non-Urgent	Medi-Cal	56%	N/A	N/A	15.2%
Chart 7	Full Service Plan	Valley Health Plan	Non-Urgent	Individual/Family	78%	99%	-21%	10.8%
Chart 8	Full Service Plan	Valley Health Plan	Non-Urgent	Medi-Cal	70%	N/A	N/A	16.7%
Chart 9	Full Service Plan	CalViva Health	Urgent	Aggregate	70%	76%	-6%	6.1%
Chart 9	Full Service Plan	Blue Shield of California Promise Health Plan	Urgent	Aggregate	67%	N/A	N/A	5.7%
Chart 9	Full Service Plan	Valley Health Plan	Urgent	Aggregate	56%	95%	-39%	5.1%
Chart 10	Full Service Plan	L.A. Care Health Plan	Urgent	Commercial	78%	84%	-6%	5.7%
Chart 10	Full Service Plan	San Francisco Community Health Authority	Urgent	Commercial	69%	74%	-5%	5.4%
Chart 10	Full Service Plan	Valley Health Plan	Urgent	Commercial	59%	96%	-37%	5.1%
Chart 11	Full Service Plan	Valley Health Plan	Urgent	Individual/Family	53%	95%	-42%	17.7%
Chart 12	Full Service Plan	Valley Health Plan	Urgent	Medi-Cal	41%	N/A	N/A	26.8%
Chart 12	Full Service Plan	CalViva Health	Urgent	Medi-Cal	70%	76%	-6%	6.1%
Chart 12	Full Service Plan	Blue Shield of California Promise Health Plan	Urgent	Medi-Cal	67%	N/A	N/A	5.7%
Chart 24	Behavioral Health	OptumHealth Behavioral Solutions of California	Urgent	Medi-Cal	76%	54%	22%	6.4%

Survey and Data Issues

The validation process DMHC conducts and requires of health plans identified numerous data issues. Though issues with the data were common, the examination of the issues revealed they did not substantively impact the statistical results.

Erroneous compliance calculations:

- These are errors in which calculations from raw data did not exactly match rates calculated for some county provider groups. These errors did not show a specific bias and the DMHC-contracted statistician determined them to be non-substantive as the errors led to less than a percentage point difference in results.

[10] The timely access survey is administered to a sample of health plan providers within each county, as defined in the standardized methodology. As a result, the analysis cannot confirm with 100% certainty that the rate computed from the data collected from the sample will be identical to the rate the analysis would have computed if the survey asked every provider in a health plan if they were able to provide an appointment within the appropriate time frame.

De-duplication errors:

- These errors occurred due to health plans not properly de-duplicating providers to a single location in a county when providers had multiple locations, or when duplicated records in the raw data were not properly accounted for in the results. Though these errors may lead to overrepresentation for some providers in the results, a review of duplicated records revealed that they constituted insubstantial shares in the results and did not exhibit a specific bias.

Survey timing:

- Health plans either conducted some surveys outside the measurement year, or failed to conduct two distinct surveys with at least a six-week separation. In cases where only a small number of surveys fell outside the measurement year, the DMHC-contracted statistician determined the results would not substantively impact results. For health plans that did not allow a six-week separation between surveys, the timeframe for the survey provided a sufficient representation of appointments over time.

Target Sample Size:

- Target sample sizes established for the health plan's network in a county were often not met either due to ineligible providers being included in the survey contact list or because providers failed to respond to the survey. Failure to achieve the target sample size occurred mainly in counties with a small number of providers where all or nearly all providers were to be surveyed to produce reliable county-level results. Aggregating results to the health plan level largely overcomes these issues by increasing the total sample size, but some results were still deemed unreliable due to high sampling errors. The omitted results were all urgent care rates, representing urgent care rates for five health plans across Charts 9, 10 and 12. Valley Health Plan had eight results omitted for urgent, non-urgent and blended rates across Charts 3, 4, 7, 8, 9, 10, 11 and 12. While the results were omitted from the above charts, the overall health plan rates presented in Chart 1 include results for all appointment and provider types across all health plan products.

Appendix B: Health Plan Names (Legal & Doing Business As)

Full Service	
Health Plan Legal Name	**Doing Business As (DBA)**
Aetna Better Health of California Inc.	
Aetna Health of California, Inc.	
Alameda Alliance For Health	
Blue Cross of California	Anthem Blue Cross
Blue Cross of California Partnership Plan (QIF)	
Blue Shield of California Promise Health Plan	
California Health and Wellness Plan	California Health and Wellness
California Physicians' Service	Blue Shield of California
Chinese Community Health Plan	
Cigna HealthCare of California, Inc.	
Community Care Health Plan, Inc.	
Community Health Group	
Contra Costa County Medical Services	Contra Costa Health Plan
Fresno-Kings-Madera Regional Health Authority	CalViva Health
Health Net Community Solutions, Inc.	
Health Net of California, Inc.	
Inland Empire Health Plan	IEHP
Kaiser Foundation Health Plan, Inc.	Kaiser Permanente
Kern Health Systems	
Local Initiative Health Authority for Los Angeles County	L.A. Care Health Plan
Molina Healthcare of California	
Molina Healthcare of California Partner Plan, Inc. (QIF)	
Oscar Health Plan of California	
San Francisco Community Health Authority	
San Joaquin County Health Commission	The Health Plan of San Joaquin
San Mateo Health Commission	Health Plan of San Mateo
Santa Clara County	Valley Health Plan
Santa Clara County Health Authority	Santa Clara Family Health Plan
Santa Cruz-Monterey-Merced Managed Medical Care Commission	Central California Alliance for Health
Scripps Health Plan Services, Inc.	
Seaside Health Plan	
Sharp Health Plan	
Sutter Health Plan	Sutter Health Plus
UHC of California	UnitedHealthcare of California
UnitedHealthcare Community Plan of California, Inc.	
Ventura County Health	Ventura County Health Care Plan
Western Health Advantage	
Behavioral Health	
Cigna Behavioral Health of California, Inc.	
Holman Professional Counseling Centers	
Human Affairs International of California	HAI-CA
Managed Health Network	
U. S. Behavioral Health Plan, California	OptumHealth Behavioral Solutions of California
ValueOptions of California, Inc.	

Appendix C: Full Service and Behavioral Health Chart Summary

Full Service Health Plans												
Health Plan Name	Aggregate			Commercial			Individual/Family			Medi-Cal		
	Urgent/Non-Urgent	Non-Urgent	Urgent	Urgent/Non-Urgent	Non-Urgent	Urgent	Urgent/Non-Urgent	Non-Urgent	Urgent	Urgent/Non-Urgent	Non-Urgent	Urgent
Aetna Better Health of California Inc.	81%	85%	77%	*	*	*	*	*	*	81%	85%	77%
Aetna Health of California, Inc.	80%	87%	74%	80%	87%	74%	*	*	*	*	*	*
Alameda Alliance For Health	84%	89%	79%	83%	89%	76%	*	*	*	85%	89%	80%
Anthem Blue Cross	73%	83%	63%	73%	83%	63%	73%	83%	63%	*	*	*
Blue Shield of California	76%	84%	65%	77%	85%	66%	74%	83%	63%	*	*	*
Blue Cross of California Partnership Plan (QIF)	71%	81%	61%	*	*	*	*	*	*	71%	81%	61%
Blue Shield of California Promise Health Plan	77%	86%	*	*	*	*	*	*	*	77%	86%	*
California Health and Wellness	70%	74%	65%	*	*	*	*	*	*	70%	74%	65%
CalViva Health	76%	81%	*	*	*	*	*	*	*	76%	81%	*
Central California Alliance for Health	67%	77%	57%	67%	77%	57%	*	*	*	*	*	*
Chinese Community Health Plan	75%	76%	75%	75%	76%	75%	75%	76%	75%	*	*	*
Cigna HealthCare of California, Inc.	74%	84%	65%	74%	84%	65%	*	*	*	*	*	*
Community Care Health Plan, Inc.	68%	71%	65%	68%	71%	65%	*	*	*	*	*	*
Community Health Group	83%	87%	77%	*	*	*	*	*	*	83%	87%	77%
Contra Costa Health Plan	73%	87%	58%	73%	87%	58%	*	*	*	73%	87%	58%
Health Net Community Solutions, Inc.	77%	84%	69%	*	*	*	*	*	*	77%	84%	69%
Health Net of California, Inc.	74%	84%	65%	74%	83%	65%	75%	84%	65%	*	*	*
Health Plan of San Mateo	85%	91%	79%	76%	81%	71%	*	*	*	86%	93%	80%
IEHP	75%	83%	68%	*	*	*	*	*	*	75%	83%	68%
Kaiser Permanente	86%	93%	78%	86%	93%	78%	86%	93%	78%	86%	93%	78%
Kern Health Systems	89%	94%	83%	*	*	*	*	*	*	89%	94%	83%
L.A. Care Health Plan	81%	88%	73%	83%	89%	*	87%	91%	84%	79%	87%	70%
Molina Healthcare of California Partner Plan, Inc. (QIF)	78%	84%	70%	*	*	*	*	*	*	78%	84%	70%
Molina Healthcare of California	77%	85%	69%	*	*	*	78%	85%	70%	76%	84%	69%
Oscar Health Plan of California	78%	84%	73%	78%	84%	73%	78%	84%	73%	*	*	*
San Francisco Community Health Authority	75%	82%	68%	78%	86%	*	*	*	*	69%	73%	64%
Santa Clara Family Health Plan	85%	91%	78%	85%	91%	78%	*	*	*	85%	91%	78%
Scripps Health Plan Services, Inc.	73%	82%	64%	73%	82%	64%	*	*	*	*	*	*
Seaside Health Plan	79%	86%	70%	79%	86%	70%	*	*	*	*	*	*
Sharp Health Plan	86%	92%	80%	86%	92%	80%	87%	93%	80%	*	*	*
Sutter Health Plus	72%	82%	63%	72%	82%	63%	72%	82%	63%	*	*	*
The Health Plan of San Joaquin	83%	89%	77%	*	*	*	*	*	*	83%	89%	77%
UnitedHealthcare of California	75%	84%	64%	75%	84%	64%	*	*	*	*	*	*
UnitedHealthcare Community Plan of California, Inc.	71%	82%	60%	*	*	*	*	*	*	71%	82%	60%
Valley Health Plan	68%	80%	*	71%	83%	*	*	*	*	*	*	*
Ventura County Health Care Plan	73%	82%	65%	73%	82%	65%	*	*	*	*	*	*
Western Health Advantage	70%	78%	61%	70%	78%	61%	70%	78%	61%	*	*	*

Behavioral Health Plans												
Health Plan Name	Aggregate			Commercial			Individual/Family			Medi-Cal		
	Urgent/Non-Urgent	Non-Urgent	Urgent	Urgent/Non-Urgent	Non-Urgent	Urgent	Urgent/Non-Urgent	Non-Urgent	Urgent	Urgent/Non-Urgent	Non-Urgent	Urgent
Cigna Behavioral Health of California, Inc.	74%	82%	65%	74%	82%	65%	*	*	*	*	*	*
HAI-CA	76%	84%	69%	76%	84%	69%	76%	84%	69%	*	*	*
Holman Professional Counseling Centers	74%	84%	65%	74%	84%	65%	*	*	*	*	*	*
Managed Health Network	80%	90%	70%	80%	90%	70%	*	*	*	*	*	*
OptumHealth Behavioral Solutions of California	73%	82%	64%	73%	81%	64%	72%	81%	63%	85%	93%	*
ValueOptions of California, Inc.	76%	82%	69%	76%	82%	69%	*	*	*	*	*	*

* Health Plan did not report this product or did not meet the sampling error threshold.

DEPARTMENT OF Managed Health Care

Timely Access to Care

In California, health care consumers have the right to an appointment when needed.

The law requires health plans licensed by the DMHC to make primary care providers and hospitals available within specific geographic and time-elapsed standards. Health plans must ensure their network of providers, including doctors, can provide enrollees with an appointment within a specific number of days or hours.

Urgent Care

prior authorization **not required** by health plan
2 days

prior authorization **required** by health plan
4 days

Non-Urgent Care

Doctor Appointment

PRIMARY CARE PHYSICIAN
10 business days

SPECIALTY CARE PHYSICIAN
15 business days

Mental Health Appointment
(non-physician[1])
10 business days

Appointment
(ancillary provider[2])
15 business days

[1] Examples of non-physician mental health providers include counseling professionals, substance abuse professionals and qualified autism service providers.

[2] Examples of non-urgent appointment for ancillary services include lab work or diagnostic testing, such as mammogram or MRI, and treatment of an illness or injury such as physical therapy.

Timely Access to Care Requirements

DISTANCE
Provide access to a primary care provider or a hospital within 15 miles or 30 minutes from where enrollees live or work.

AVAILABILITY
Your health plan should have telephone services available on a 24/7 basis.

INTERPRETER
Interpreter services must be coordinated with scheduled appointments for health care services to ensure interpreter services are provided at the time of the appointment.

Unable to get an Appointment Within the Timely Access Standard?

If you are not able to get an appointment within the timely access standard, you should first contact your health plan for assistance at the toll-free number listed on your health plan card.

The DMHC Help Center is available at 1-888-466-2219 or www.HealthHelp.ca.gov to assist you if your health plan does not resolve the issue. The DMHC Help Center will work with you and your health plan to ensure you receive timely access to care.

If you believe you are experiencing a medical emergency, dial 9-1-1 or go to the nearest hospital. If your health issue is urgent, but not an emergency, and does not require prior approval or authorization from your health plan, you have the right to get care within 48 hours.

The waiting time for an appointment may be extended if a qualified health care provider has determined and made record that a longer waiting time will not be harmful to the enrollee's health.

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