DEPARTMENT OF
Managed
Health Care

Timely Access Report

Measurement Year 2019

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) 2019 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 2019, 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 shortcomings, which included sampling errors, de-duplication errors, compliance calculation errors, and failures to meet target sample sizes. In most cases, the issues did not pose substantial concern for accuracy or reliability. However, two health plans (Valley Health Plan and MemorialCare Select Health Plan) had results excluded from at least one chart due to data reliability concerns and failure to meet the sampling error of five percent or less. One health plan, OptumHealth Behavioral Solutions of California also failed to meet the sampling error of five percent or less but for comparison purposes, OptumHealth Behavioral Solutions of California results have been included in charts 20 and 24. 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 94 percent to a low of 52 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 96 percent to a low of 60 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 92 percent to a low of 45 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 79 percent to a low of 66 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 87 percent to a low of 73 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 72 percent to a low of 59 percent (Chart 21).

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 2.4 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.

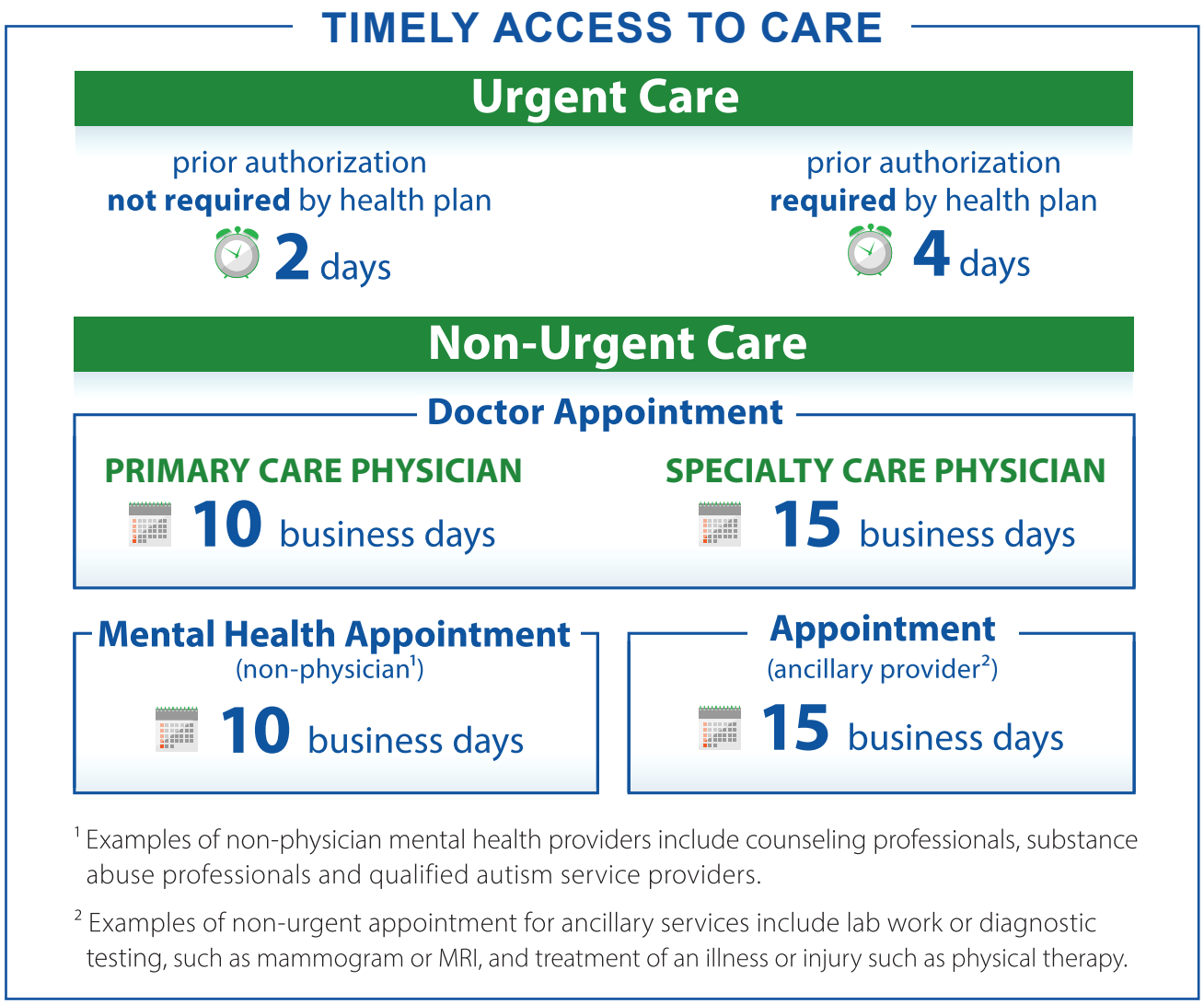
To strengthen the DMHC's ability to oversee health plan compliance and begin to compare data, Health and Safety Code section 1367.03 was amended by SB 964 (Hernandez, Chapter 573, Statutes of 2014). SB 964 authorized the DMHC, in consultation with stakeholders, to develop standardized methodologies for 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.

The DMHC 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.

The DMHC submitted the amended timely access regulation to the Office of Administrative Law on June 12, 2020. Once the amended regulation is adopted, the DMHC will have a rate of compliance standard to which health plans will be held accountable. Once the regulation is adopted, the DMHC will be able to better hold health plans accountable through reviewing individual health plan performance to the rate of compliance and comparing health plan performance across all plans.

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 48-hour (2 days) standard applies when authorization does not have to be obtained in advance from the health plan. A 96-hour (4 days) standard applies when 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 wait time for an 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 wait 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 appointment availability survey and are not displayed in this report. The timely access provider appointment availability survey measures the next available appointment and these additional 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 year-to-year changes to the mandatory methodology 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 subsequent 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 that 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.

MY 2018 to MY 2019

- In MY 2019 the DMHC expanded the survey to include telehealth providers.
- The DMHC also expanded the survey to include all specified in-network providers, without regard to whether the provider is located inside or outside of the health plan's approved network service area[1]. This change ensured that the rates of compliance represented the health plan's full network available to an enrollee.
- The DMHC made a number of changes to improve the statistical reliability of health plan data, in particular to ensure comparability across plans. This includes clarifying instructions to distinguish between a provider temporarily not offering appointments at the time of the survey (e.g., the provider is out on leave) and a provider who does not offer appointments when providing health care services (e.g., an emergency room physician). The Department also clarified the Non-Physician Mental Health Care Providers required to be included in the survey based on the type of license the provider holds. As a result of these changes, the comparability of the data across health plans has improved in MY 2019.
- The DMHC excluded holidays from the non-urgent appointment timeframes to better align with the business day standards set forth in the timely access regulation.
- The DMHC included a provision that allows health plans to deem primary care providers compliant, without surveying the provider, if the provider offers same day or next business day appointments as part of an established advanced access program. Using existing processes to confirm that providers offer appointments within the timely access standards reduces the burden on providers. Any impact of this change to rates of compliance are likely minimal,

[1]For instance, if the health plan is approved by the DMHC to offer health care services to enrollees who work or reside in San Francisco County (the service area), the health plan must now include survey results for any counties outside of San Francisco in which network providers are located (e.g., providers located in Marin County, San Mateo County and other states via telehealth must be included in the survey, even though the service area only includes San Francisco County).

as advanced access providers represent a small share of plan providers, and primary care providers typically show high compliance rates[2].

Timely Access Regulations

Following a lengthy stakeholder engagement process over several years, the DMHC is in the process of amending the existing timely access regulation. The proposed regulation will 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 level, rather than the aggregate health plan level, 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.
- Compare data for both timely access compliance and network adequacy. 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.

[2] In order to use this provision, the health plan must confirm through another verification process that the provider offers enrollees appointments on the same day or next business day. In addition, the health plan's verification process must be approved by the Department. The following health plans used the advanced access deeming provision in MY 2019 survey results data: Community Health Group Partnership Plan, L.A. Care Health Plan and L.A. Care Health Plan Joint Powers Authority.

- Allow the DMHC to better hold health plans accountable to the timely access standards through referring plans that do not meet the rate of compliance standard to the DMHC Office of Enforcement for investigation and enforcement action including 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 1,219 access to care complaints in 2019, making up 9.7% of all complaint issues resolved for the year[3]. 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 October 30, 2020, the DMHC has issued 40 access-related deficiencies to health plans through the medical survey process. Of these 40 deficiencies:

- Twenty deficiencies were corrected by the health plans at the issuance of the Final Report or Follow-Up Report.
- Four deficiencies were not corrected at the issuance of the Follow-Up Report and have been referred to the DMHC's Office of Enforcement.
- Fourteen 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.

[3] Some of the increase in resolved Help Center access complaints from MY 2018 (614 complaints) to MY 2019 (1,219 complaints) is attributed to the DMHC Help Center updating its Customer Relationship Management (CRM) platform in October of 2018, which provided the Department with improved capabilities in capturing complaint data. This includes the ability to capture up to three complaint categories or "issues" per complaint, where previously the Department would typically capture one.

Timely Access Compliance Report Findings

The timely access survey process is an annual assessment of a health plan's 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 compliance 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 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 2019. The charts present the provider responses by: combining all products together, Commercial Products (e.g., large or small group employer-sponsored health plans), Individual/Family Products (e.g., individual or family health plans purchased privately or through the Covered California Exchange), and Medi-Cal Products. It is important to understand the health plan survey results reflect only the period in time in which a provider was surveyed, 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

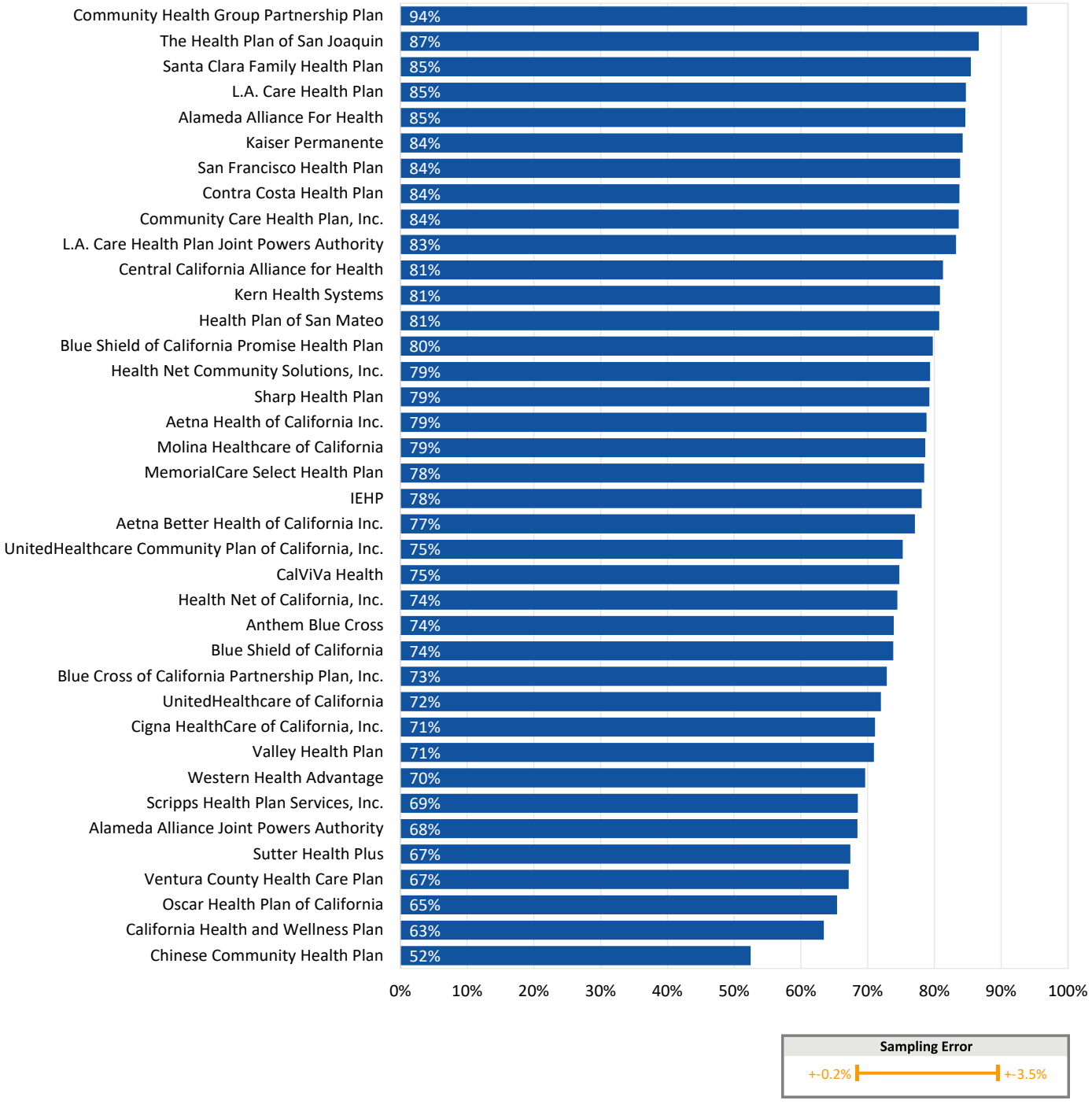
URGENT AND NON-URGENT APPOINTMENTS

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.

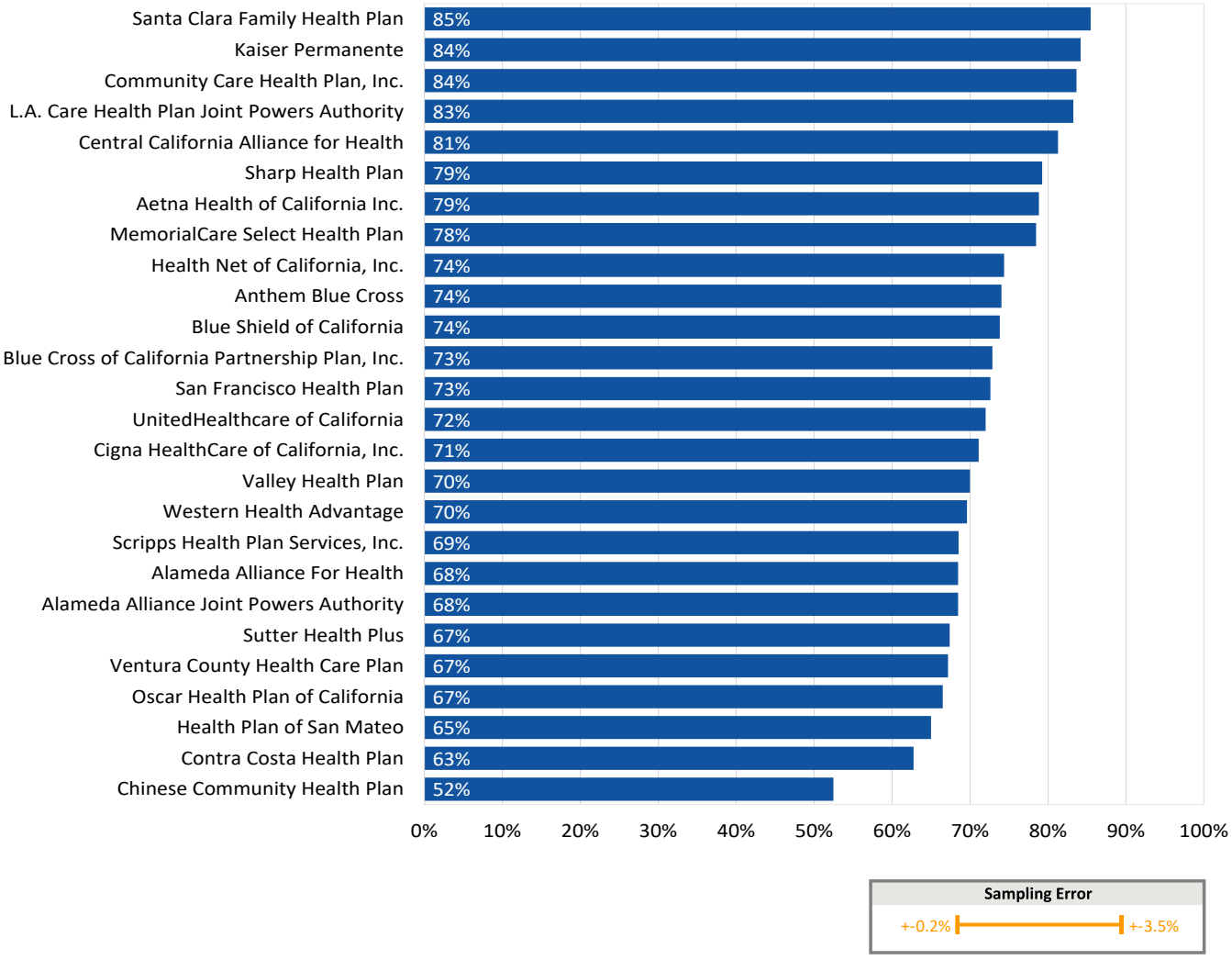


Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

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.

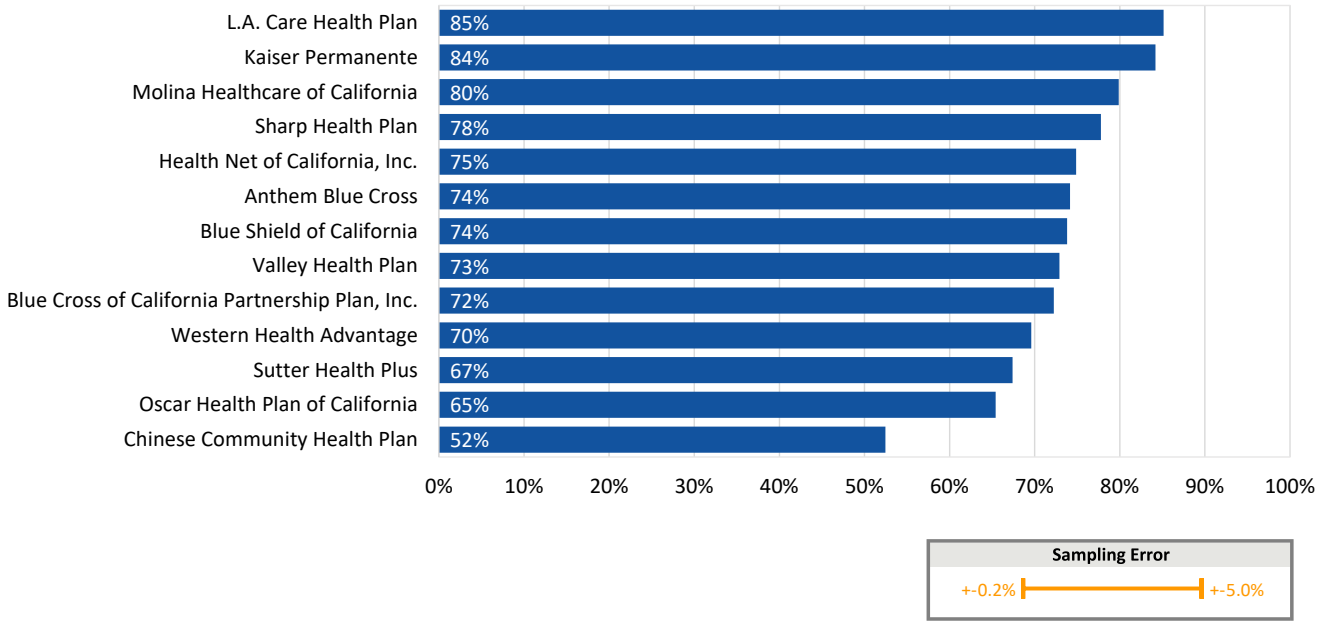


Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

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.

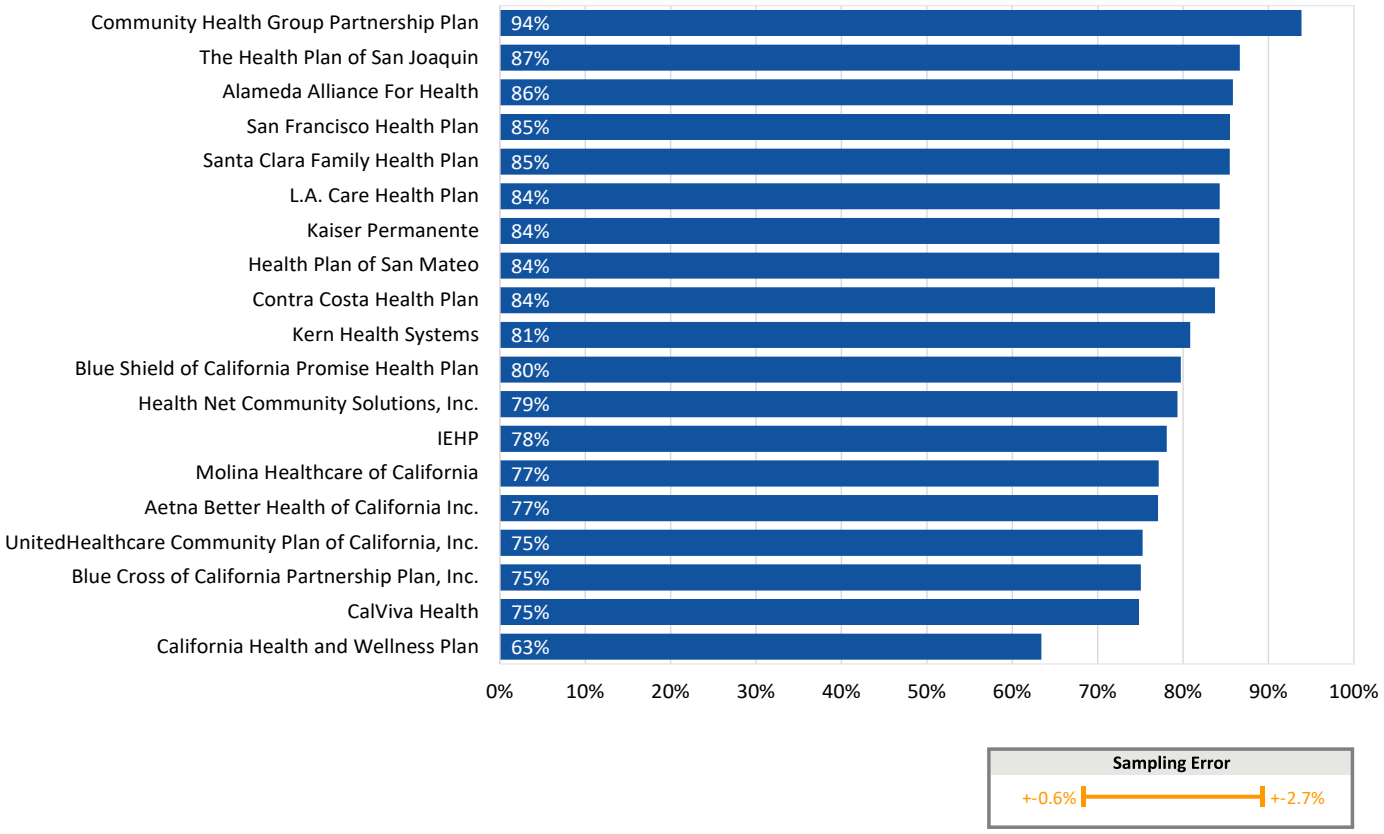


Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

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[4].



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

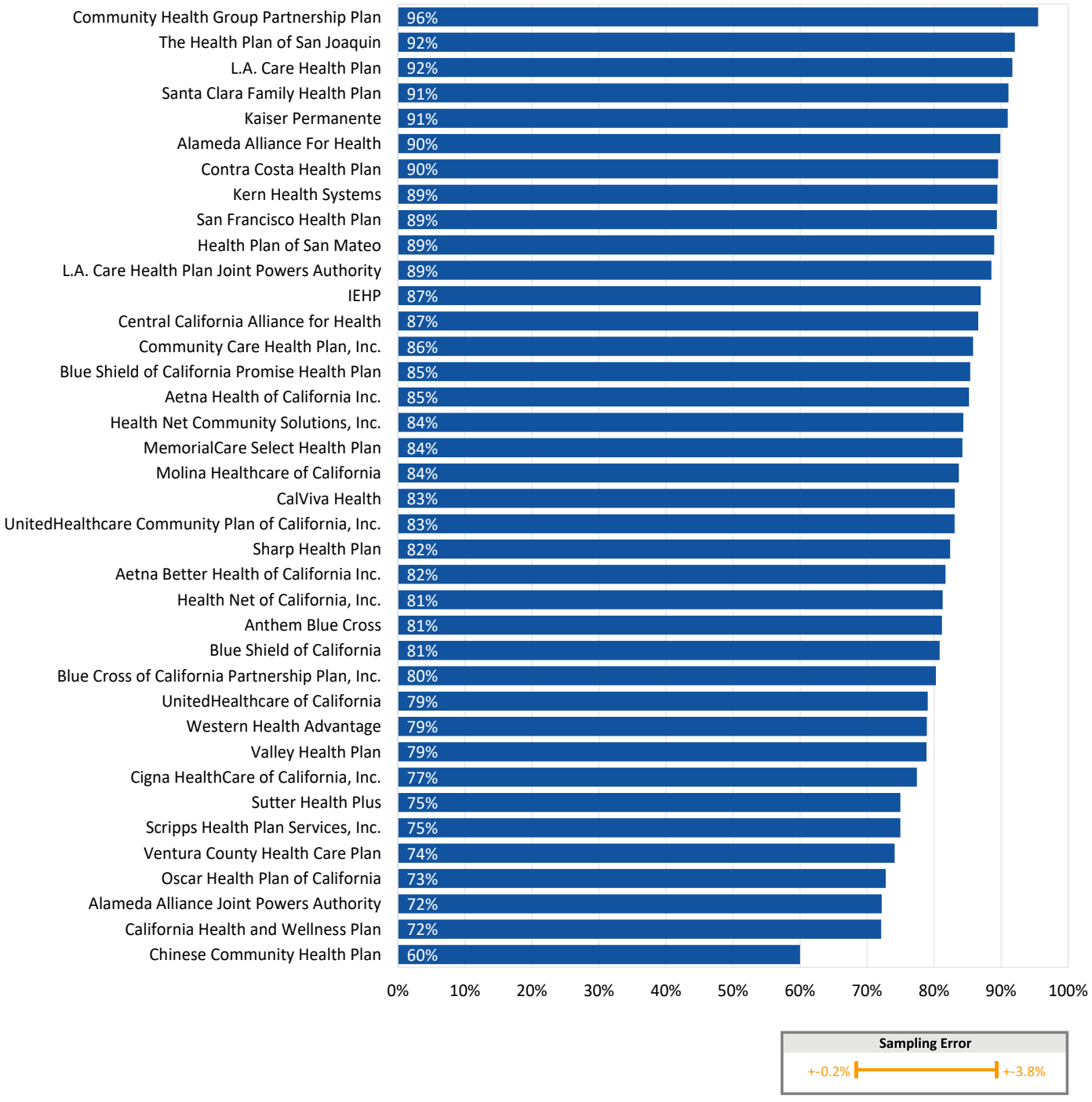
NON-URGENT APPOINTMENTS

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.

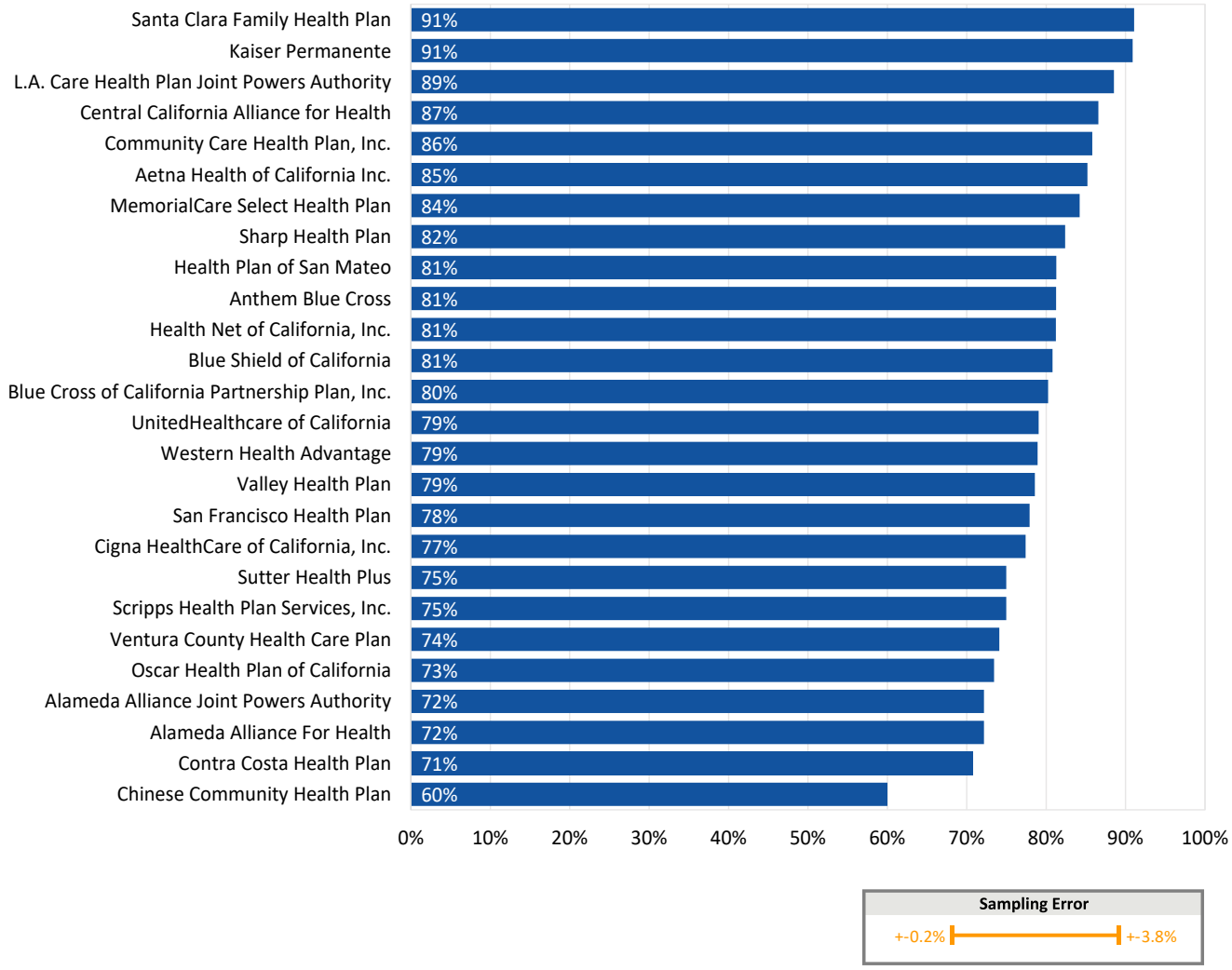


Percentage of Surveyed Providers Meeting Non-Urgent Appointment Wait Time Standards

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.

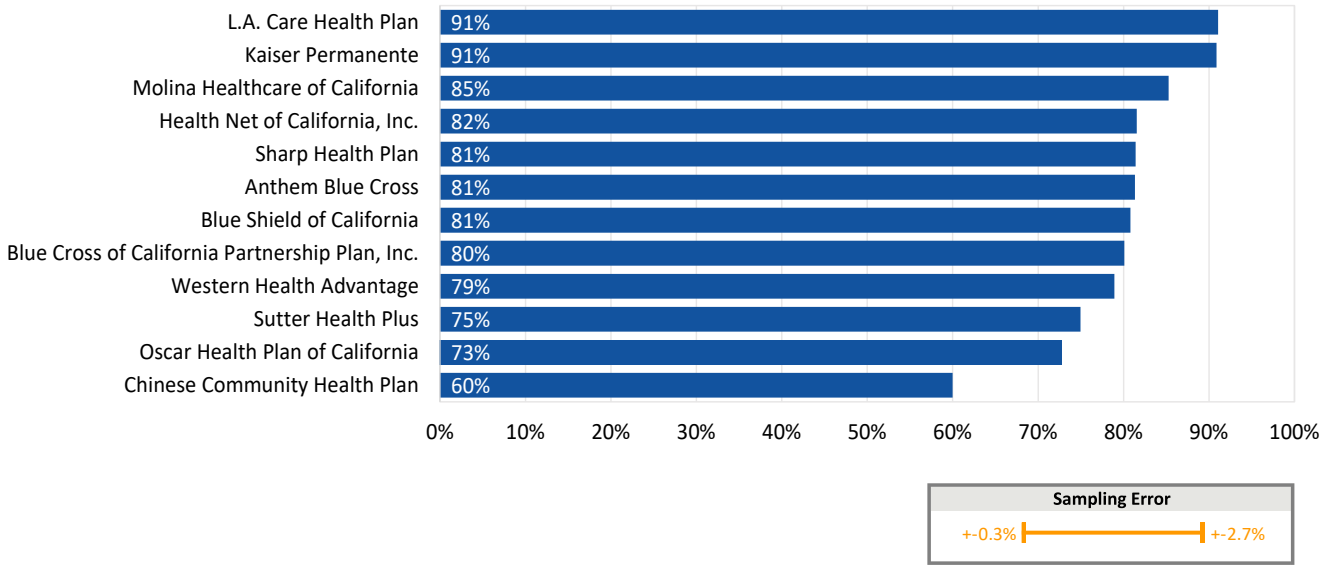


Percentage of Surveyed Providers Meeting Non-Urgent Appointment Wait Time Standards

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[5].



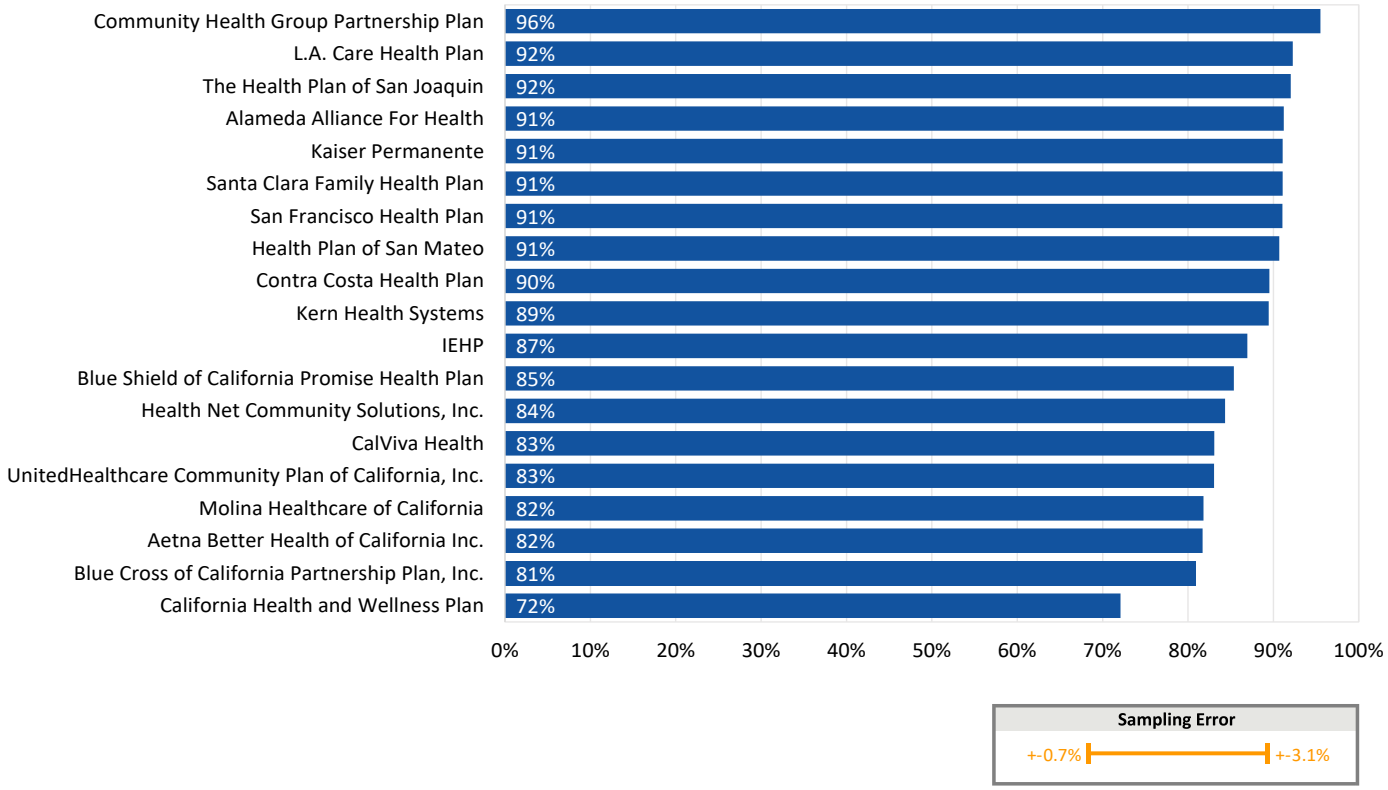
[5] One health plan (Valley Health Plan) is not displayed. See Appendix A.

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[6].



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

URGENT APPOINTMENTS

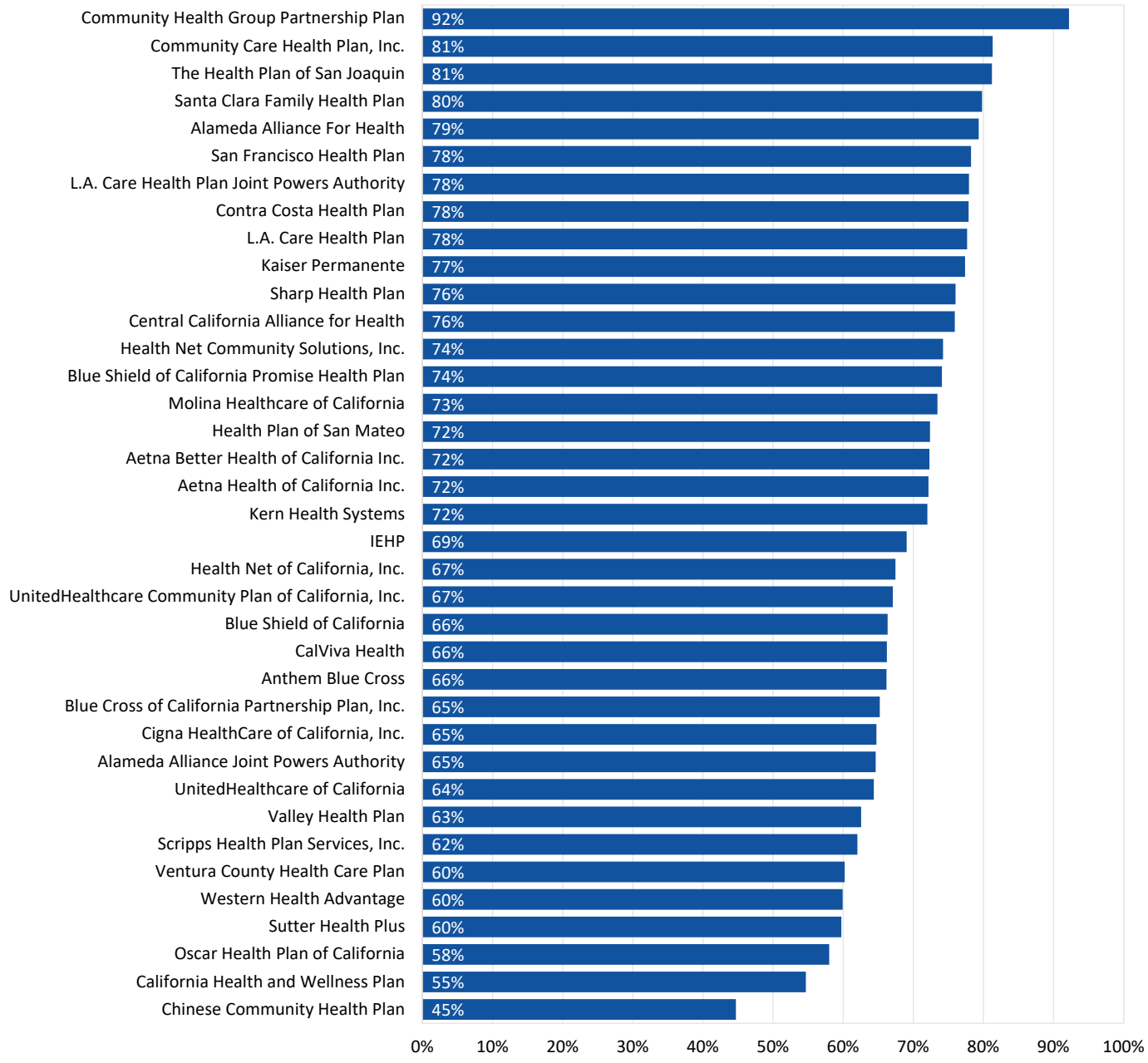
Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards

As noted above, 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. These differing methods of meeting enrollee urgent care needs are not measured in the timely access provider appointment availability survey and are not displayed in this report.

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[7].



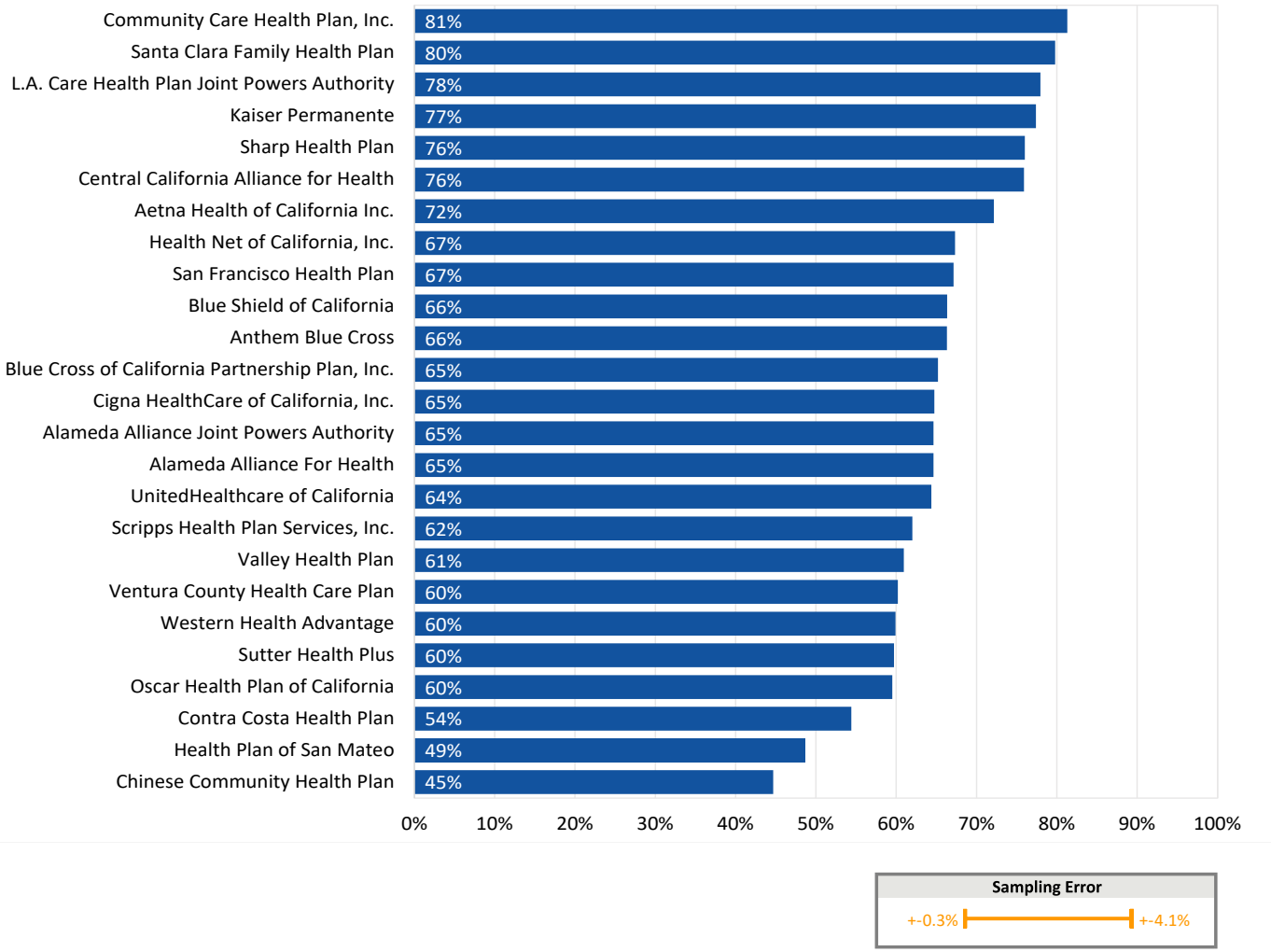
[7] One health plan (MemorialCare Select Health Plan) is not displayed. See Appendix A.

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[8].



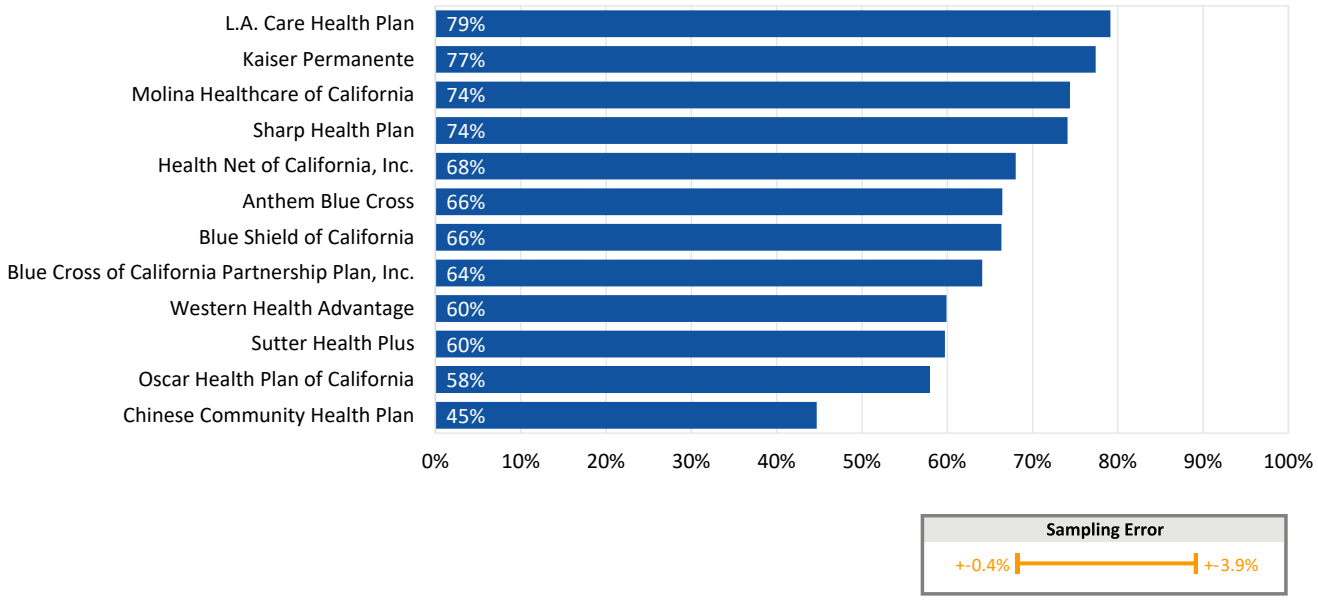
[8] One health plan (MemorialCare Select Health Plan) is not displayed. See Appendix A.

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[9].



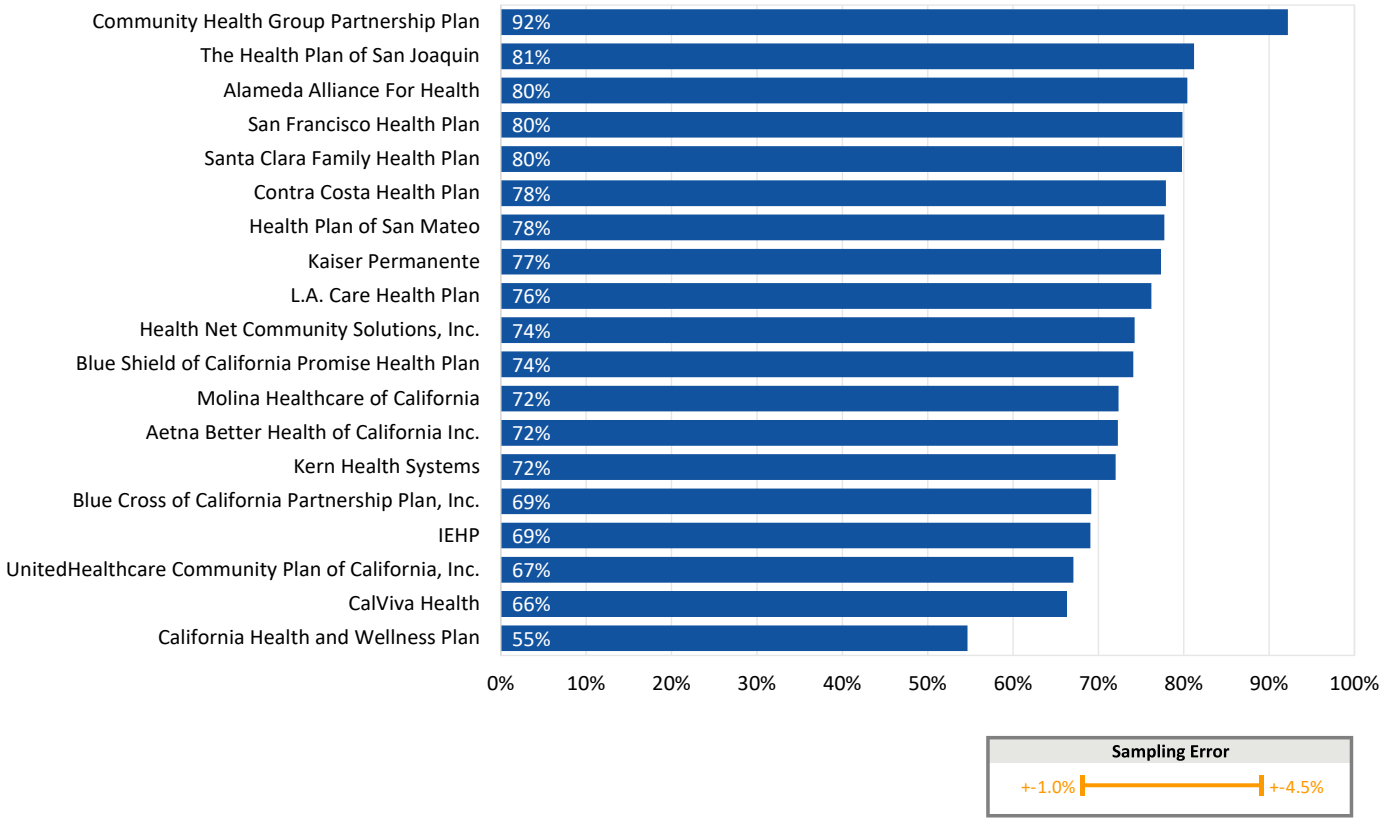
[9] One health plan (Valley Health Plan) is not displayed. See Appendix A.

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[10].



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

Behavioral Health Plan Survey Data

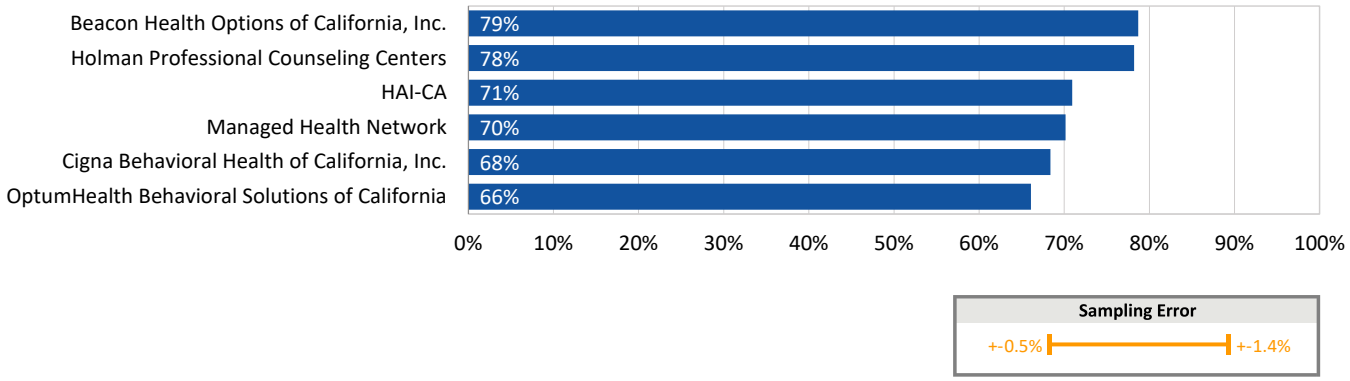
URGENT AND NON-URGENT APPOINTMENTS

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.

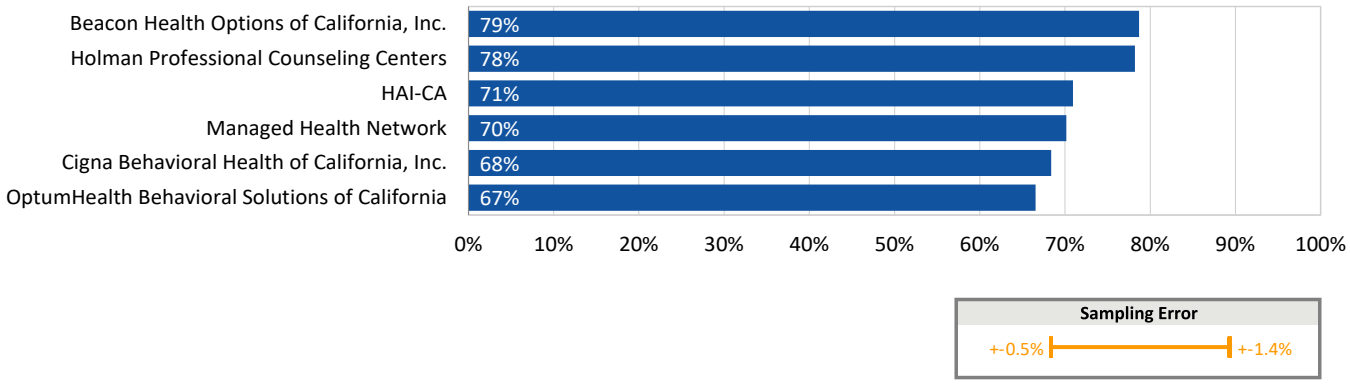


Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

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.

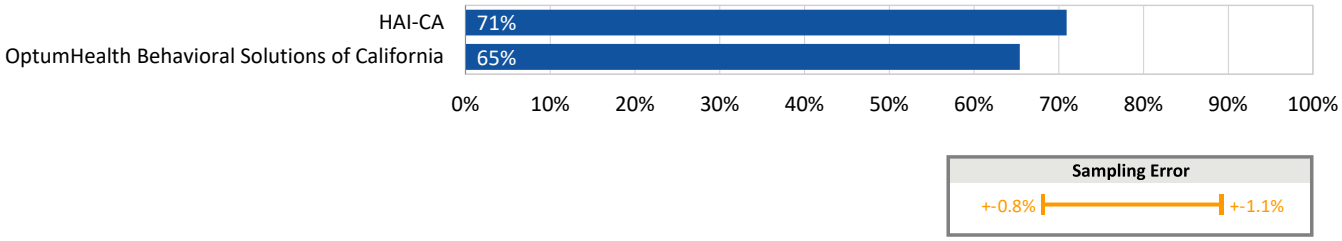


Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

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.

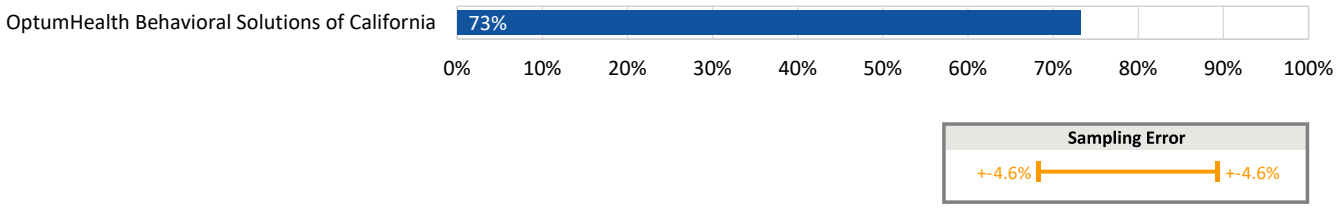


Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

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.



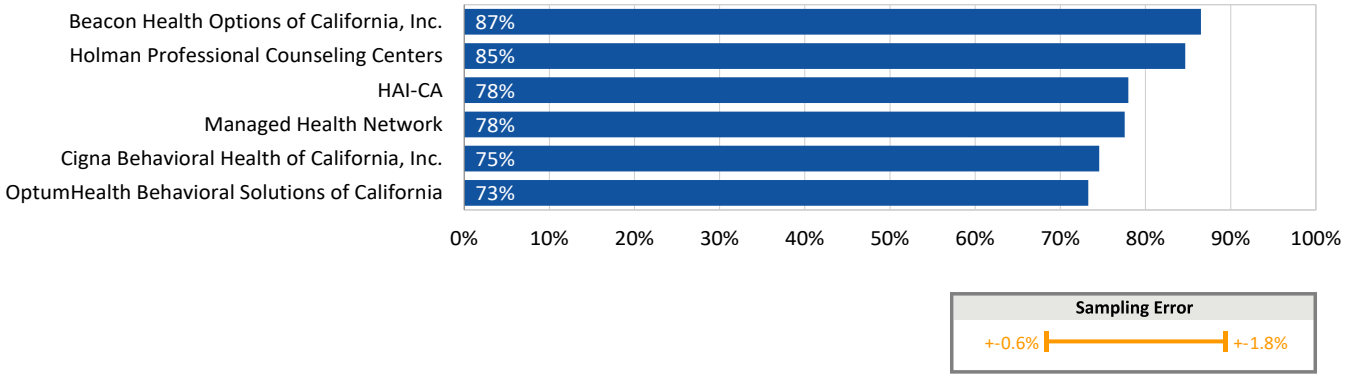
NON-URGENT APPOINTMENTS

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.

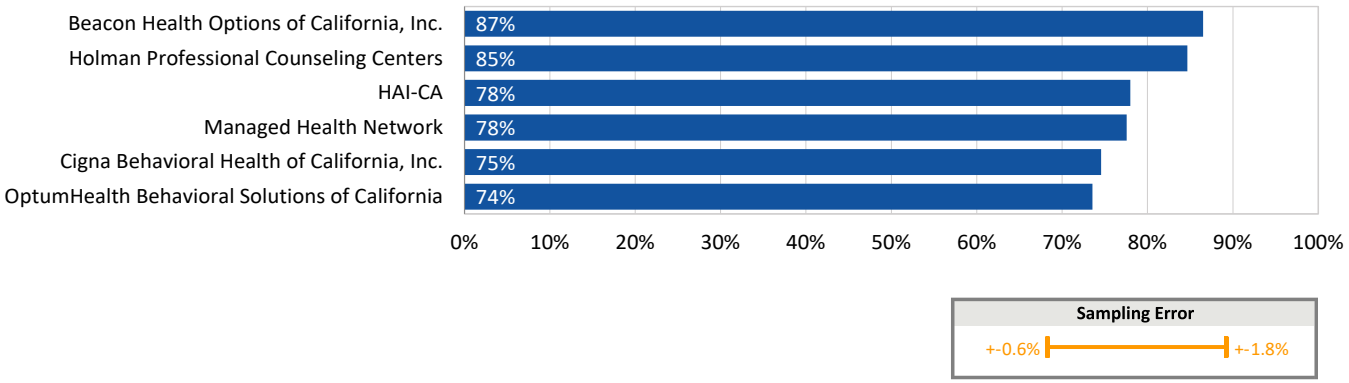


Percentage of Surveyed Providers Meeting Non-Urgent Appointment Wait Time Standards

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.

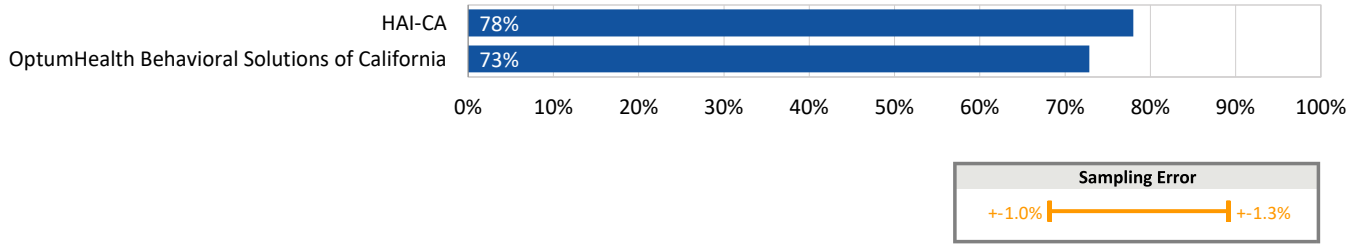


Percentage of Surveyed Providers Meeting Non-Urgent Appointment Wait Time Standards

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.

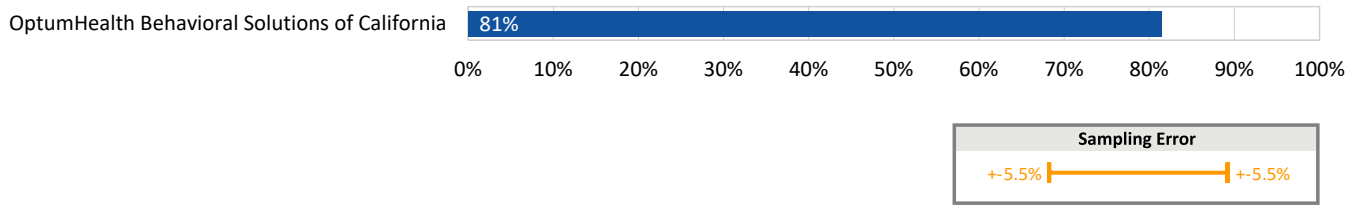


Percentage of Surveyed Providers Meeting Non-Urgent Appointment Wait Time Standards

Chart 20

Behavioral Health Plans – Medi-Cal

One Medi-Cal behavioral health plan, OptumHealth Behavioral Solutions of California, submitted data for MY 2019. While the sampling error exceeded five percentage points, the results are provided for comparison purposes. This chart combines survey results across mental health provider types (non-physician mental health, psychiatrist, and child and adolescent psychiatrist) for non-urgent appointments.



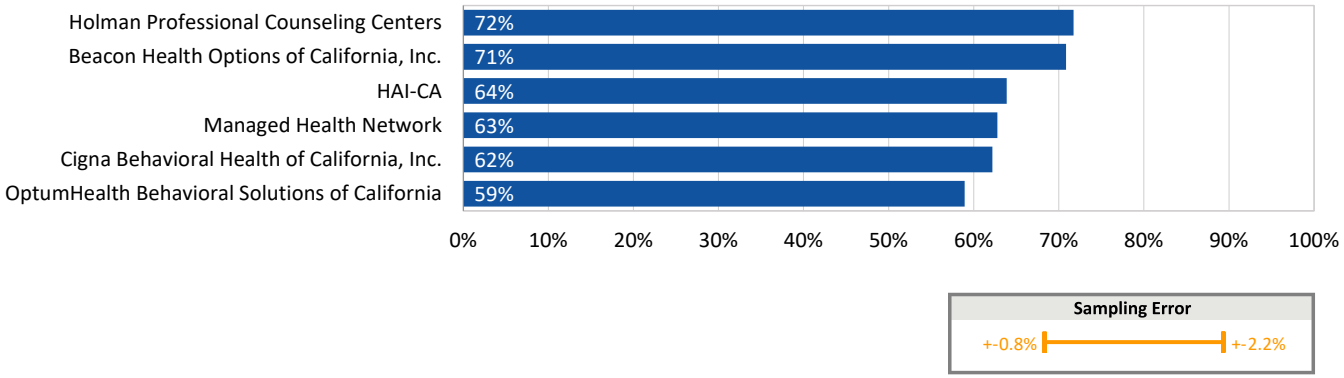
URGENT APPOINTMENTS

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.

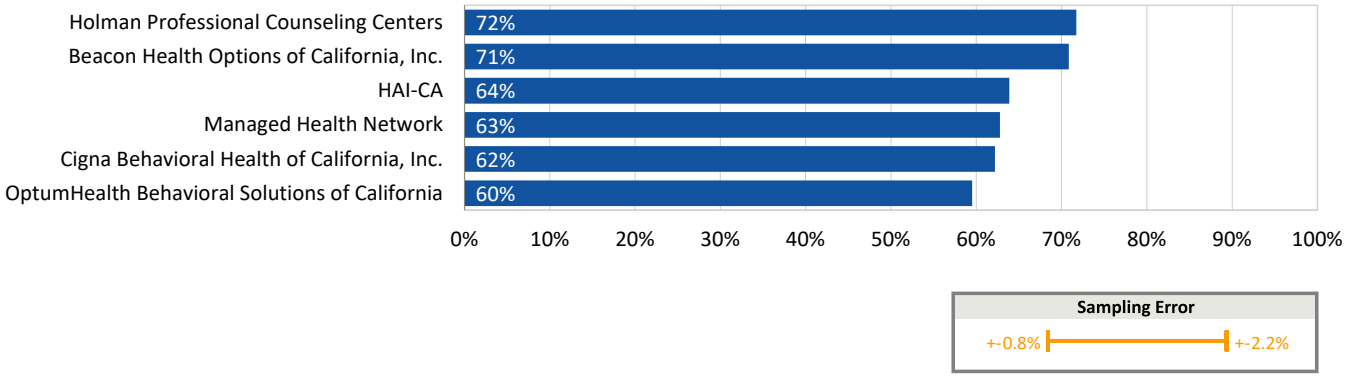


Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards

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.

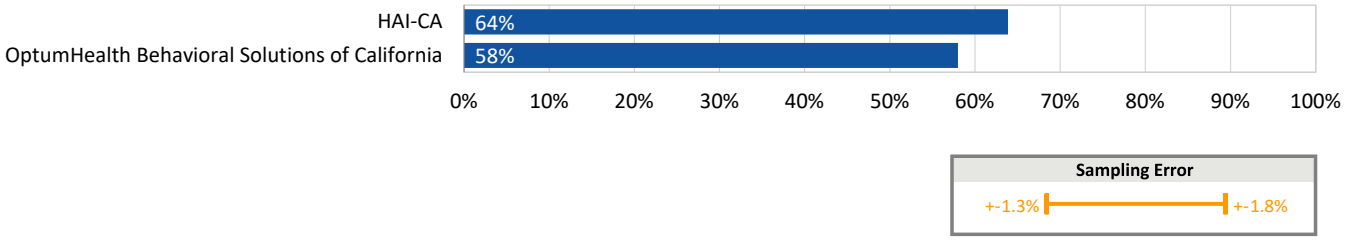


Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards

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.

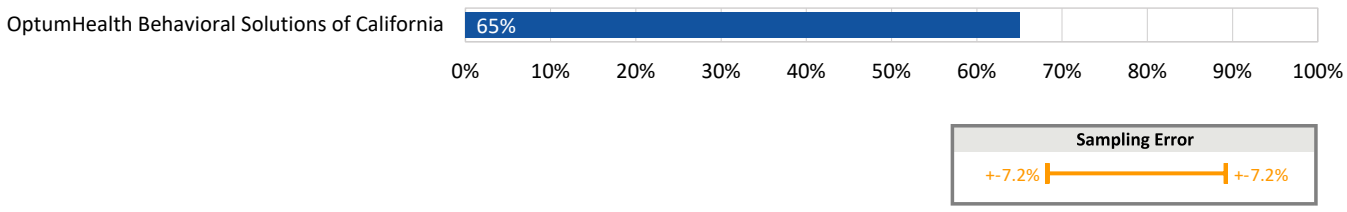


Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards

Chart 24

Behavioral Health Plans – Medi-Cal

One Medi-Cal behavioral health plan, OptumHealth Behavioral Solutions of California, submitted data for MY 2019. While the sampling error exceeded five percentage points, the results are provided for comparison purposes. This chart combines survey results across mental health provider types (non-physician behavioral health, psychiatrist, and child and adolescent psychiatrist) for urgent appointments.



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 2019 data. This feedback will include information on how the plans may improve the accuracy of their surveys and data in subsequent years.
- Finalize updates to the timely access regulation including a rate of compliance standard for both urgent and non-urgent appointments to which health plans will be held accountable.
- Report timely access data by health plan network once the updated regulation is adopted.
- 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

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 providing comparable timely access data to the public and other interested parties.

Health plans must continue their efforts to improve the accuracy and completeness of their timely access compliance data. Health plans that fail to comply with the mandatory methodology will be referred to the DMHC Office of Enforcement.

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[11] for both urgent and non-urgent appointments. The charts included in this report identify the percentage of appointments in which a provider indicated appointment availability within the wait-time standards set forth in the Knox-Keene Act and as required in the MY 2019 Provider Appointment Availability Survey Methodology.

A number of data discrepancies were identified in health plan compliance reports for MY 2019. Descriptions as to whether the analysis excluded or noted results in connection with the analysis are discussed in this Appendix.

Data – Survey Methodology

The timely access rates were calculated by health plans through survey responses from providers that were contracted with health plans. The surveys identified whether the first available appointment with a provider fell within the timely access standards. Survey responses for a provider may be applied across multiple health plan networks or across health plans when applicable. A provider may have been surveyed multiple times where the provider is contracted with more than one health plan, the provider practiced in multiple counties, or due to health plan survey errors.

Overall Rate

The overall timely access rate is first computed by the DMHC-contracted statistician at the county network-level. The numerator for overall rate is the sum 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 for the rate 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 urgent care appointments. The calculated county network overall rate is then used to calculate a weighted mean at the health plan-level, which is described below.

All Health Plan-Level Rates

For overall, urgent, and non-urgent care appointments, the DMHC-contracted statistician's 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 (service center) weighting means that a timely access rate for a health plan's county network with 100 providers (service centers) receives a weight ten times the weight of a rate for a county network with 10 providers (service centers). This weighting ensures that the overall rates are not biased by rates in counties with smaller numbers of providers or service centers. The resulting rates show the expected percentage of successful appointment.

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[11] Specialists consist of cardiologists, endocrinologists, gastroenterologists, and adult and child psychiatrists. Ancillary providers consist of mammography and physical therapist providers. Non-physician mental health care providers consist of licensed professional clinical counselor, psychologists (Ph.D.-level), marriage and family therapists/licensed marriage and family therapists, and master of social work/licensed clinical social workers.

Sampling Error

Each chart includes the timely access rates and provides the range in sampling errors for the presented rates. The sampling error indicates an 80 percent certainty where actual rate falls between given the sample size and estimated rate[12]. Sampling errors were calculated by the DMHC-contracted statistician 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 or ineligible providers in the contact list. In other cases, though, it appears that health plans failed to exhaust all potential respondents, suggesting that they did not adequately prepare to replace non-responders. With the exception of OptumHealth Behavioral Solutions of California, which results are included in charts 20 and 24 for comparison purposes, results are not presented for health plans where the sampling error for the rate was greater than five 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 five percent.

Chart Number	Plan Type	Health Plan Name	Measurement Type	Product	MY 2019 Rate of Compliance	MY 2018 Rate of Compliance	Percentage Point Difference	MY 2019 Sampling Error
Chart 4	Full Service Plan	Valley Health Plan	Urgent/Non-Urgent	Medi-Cal	72%	56%	16%	6.1%
Chart 7	Full Service Plan	Valley Health Plan	Non-Urgent	Individual/Family	79%	78%	1%	5.9%
Chart 8	Full Service Plan	Valley Health Plan	Non-Urgent	Medi-Cal	79%	70%	10%	7.2%
Chart 9	Full Service Plan	MemorialCare Select Health Plan	Urgent	Aggregate	72%	70%	2%	6.2%
Chart 10	Full Service Plan	MemorialCare Select Health Plan	Urgent	Commercial	72%	70%	2%	6.2%
Chart 11	Full Service Plan	Valley Health Plan	Urgent	Individual/Family	66%	53%	13%	8.2%
Chart 12	Full Service Plan	Valley Health Plan	Urgent	Medi-Cal	64%	41%	23%	9.9%

OptumHealth Behavioral Solutions of California was included in charts 20 and 24 for comparison purposes. However, the health plan produced results that resulted in a sampling error greater than five percent.

Chart Number	Plan Type	Health Plan Name	Measurement Type	Product	MY 2019 Rate of Compliance	MY 2018 Rate of Compliance	Percentage Point Difference	MY 2019 Sampling Error
Chart 20	Behavioral Health Only	OptumHealth Behavioral Solutions of California	Non-Urgent	Medi-Cal	81%	93%	-12%	5.5%
Chart 24	Behavioral Health Only	OptumHealth Behavioral Solutions of California	Urgent	Medi-Cal	65%	76%	-11%	7.2%

Survey and Data Issues

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

<u>Erroneous compliance calculations:</u>

- These errors include miscellaneous calculation errors where calculations from raw data did not exactly match rates calculated for some county survey types. These errors did not show a specific bias and were determined to be non-substantive. For all but three reported rates of

[12] The timely access survey is administered to a sample of health plan providers within each county network, 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 analysis asked every provider in a health plan if they were able to provide an appointment within the appropriate time frame.

compliance, the errors led to less than a percentage point difference in the reported rate. Santa Clara County showed three rates where the difference was between 1 and 3 percentage points for urgent care rates for its Individual/Family networks, commercial networks, and its overall plan.

De-duplication errors:

- These errors did not show a specific bias and were determined to be non-substantive. For all but three reported rates of compliance, the errors led to less than a percentage point difference in the reported rate. Santa Clara County showed three rates where the difference was between 1 and 3 percentage points for urgent care rates for its Individual/Family networks, commercial networks, and its overall plan.

Survey timing:

- Health plans failed to conduct two distinct surveys with at least a six-week separation. For health plans that did not allow a six-week separation between surveys, it was determined that the timeframe for the survey provided a sufficient representation of appointments over time.

Survey of unapproved provider types:

- Health plans surveyed provider types that were not among the specified list of provider types. This issue was predominantly for non-physician mental health care providers, where the health plan surveyed mental health professionals outside of the four approved types were surveyed. This issue impacts the comparability of results across networks, as unapproved provider types may, on average, show different rates of compliance relative to the approved provider types. Additionally, the weighting of non-physician mental health care providers for the calculation of compliance rates will be inflated for health plans with these errors.

Omission of results for certain provider types:

- Human Affairs International of California (HAI) failed to report results for psychiatrists and non-physician mental health care providers for two out of its three networks. As a result, the rates for two of HAI's contracting plan- partners, San Mateo Health Commission and Western Advantage Health, may not reflect the accurate composition of providers available to their enrollees. And to the extent that the rates for the omitted networks differ from the one network (301) submitted by HAI, the rates presented for HAI may not accurately reflect their overall plan rate. Using the rates for the HAI 301 network, the DMHC-contracted statistician estimated the impact of the omission and determined that the omission likely had a non-substantive impact on the reported rates for the contracting plan-partners, with the assumption that the omitted rates for HAI's networks are similar to the rates of HAI's 301 network.

Target Sample Size:

- Target sample sizes established at the health plan network county-level were often not met due to ineligible providers being included in the survey contact list or because providers failed to respond to the survey. Failure to achieve target sample size occurred mainly in counties with small numbers of providers which necessitated a survey of all or nearly all providers 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.

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	
Alameda Alliance Joint Powers Authority	
Blue Cross of California	Anthem Blue Cross
Blue Cross of California Partnership Plan, Inc.	
Blue Shield of California Promise Health Plan	
CHG Foundation	Community Health Group Partnership Plan
California Health and Wellness Plan	
California Physicians' Service	Blue Shield of California
Chinese Community Health Plan	
Cigna HealthCare of California, Inc.	
Community Care Health Plan, Inc.	
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	
L.A. Care Health Plan Joint Powers Authority	
Local Initiative Health Authority for Los Angeles County	L.A. Care Health Plan
MemorialCare Select Health Plan	
Molina Healthcare of California	
Oscar Health Plan of California	
San Francisco Health Authority	San Francisco Health Plan
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.	
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	
Beacon Health Options of California, Inc.	
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

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	Urgent	Non-Urgent	Urgent/Non-Urgent	Urgent	Non-Urgent	Urgent/Non-Urgent	Urgent	Non-Urgent	Urgent/Non-Urgent	Urgent	Non-Urgent
Aetna Better Health of California Inc.	77%	72%	82%	*	*	*	*	*	*	77%	72%	82%
Aetna Health of California Inc.	79%	72%	85%	79%	72%	85%	*	*	*	*	*	*
Alameda Alliance For Health	85%	79%	90%	68%	65%	72%	*	*	*	86%	80%	91%
Alameda Alliance Joint Powers Authority	68%	65%	72%	68%	65%	72%	*	*	*	*	*	*
Anthem Blue Cross	74%	66%	81%	74%	66%	81%	74%	66%	81%	*	*	*
Blue Cross of California Partnership Plan, Inc.	73%	65%	80%	73%	65%	80%	72%	64%	80%	75%	69%	81%
Blue Shield of California Promise Health Plan	80%	74%	85%	*	*	*	*	*	*	80%	74%	85%
California Health and Wellness Plan	63%	55%	72%	*	*	*	*	*	*	63%	55%	72%
Blue Shield of California	74%	66%	81%	74%	66%	81%	74%	66%	81%	*	*	*
Chinese Community Health Plan	52%	45%	60%	52%	45%	60%	52%	45%	60%	*	*	*
Cigna HealthCare of California, Inc.	71%	65%	77%	71%	65%	77%	*	*	*	*	*	*
Community Care Health Plan, Inc.	84%	81%	86%	84%	81%	86%	*	*	*	*	*	*
Community Health Group Partnership Plan	94%	92%	96%	*	*	*	*	*	*	94%	92%	96%
Contra Costa Health Plan	84%	78%	90%	63%	54%	71%	*	*	*	84%	78%	90%
CalViVa Health	75%	66%	83%	*	*	*	*	*	*	75%	66%	83%
Health Net Community Solutions, Inc.	79%	74%	84%	*	*	*	*	*	*	79%	74%	84%
Health Net of California, Inc.	74%	67%	81%	74%	67%	81%	75%	68%	82%	*	*	*
IEHP	78%	69%	87%	*	*	*	*	*	*	78%	69%	87%
Kaiser Permanente	84%	77%	91%	84%	77%	91%	84%	77%	91%	84%	77%	91%
Kern Health Systems	81%	72%	89%	*	*	*	*	*	*	81%	72%	89%
L.A. Care Health Plan Joint Powers Authority	83%	78%	89%	83%	78%	89%	*	*	*	*	*	*
L.A. Care Health Plan	85%	78%	92%	*	*	*	85%	79%	91%	84%	76%	92%
MemorialCare Select Health Plan	78%	72%	84%	78%	72%	84%	*	*	*	*	*	*
Molina Healthcare of California	79%	73%	84%	*	*	*	80%	74%	85%	77%	72%	82%
Oscar Health Plan of California	65%	58%	73%	67%	60%	73%	65%	58%	73%	*	*	*
San Francisco Health Plan	84%	78%	89%	73%	67%	78%	*	*	*	85%	80%	91%
The Health Plan of San Joaquin	87%	81%	92%	*	*	*	*	*	*	87%	81%	92%
Health Plan of San Mateo	81%	72%	89%	65%	49%	81%	*	*	*	84%	78%	91%
Valley Health Plan	71%	63%	79%	70%	61%	79%	73%	*	*	*	*	*
Santa Clara Family Health Plan	85%	80%	91%	85%	80%	91%	*	*	*	85%	80%	91%
Central California Alliance for Health	81%	76%	87%	81%	76%	87%	*	*	*	*	*	*
Scripps Health Plan Services, Inc.	69%	62%	75%	69%	62%	75%	*	*	*	*	*	*
Sharp Health Plan	79%	76%	82%	79%	76%	82%	78%	74%	81%	*	*	*
Sutter Health Plus	67%	60%	75%	67%	60%	75%	67%	60%	75%	*	*	*
UnitedHealthcare of California	72%	64%	79%	72%	64%	79%	*	*	*	*	*	*
UnitedHealthcare Community Plan of California, Inc.	75%	67%	83%	*	*	*	*	*	*	75%	67%	83%
Ventura County Health Care Plan	67%	60%	74%	67%	60%	74%	*	*	*	*	*	*
Western Health Advantage	70%	60%	79%	70%	60%	79%	70%	60%	79%	*	*	*

Behavioral Health Plans												
Health Plan Name	Aggregate			Commercial			Individual/Family			Medi-Cal		
	Urgent/Non-Urgent	Urgent	Non-Urgent	Urgent/Non-Urgent	Urgent	Non-Urgent	Urgent/Non-Urgent	Urgent	Non-Urgent	Urgent/Non-Urgent	Urgent	Non-Urgent
Beacon Health Options of California, Inc.	79%	71%	87%	79%	71%	87%	*	*	*	*	*	*
Cigna Behavioral Health of California, Inc.	68%	62%	75%	68%	62%	75%	*	*	*	*	*	*
Holman Professional Counseling Centers	78%	72%	85%	78%	72%	85%	*	*	*	*	*	*
HAI-CA	71%	64%	78%	71%	64%	78%	71%	64%	78%	*	*	*
Managed Health Network	70%	63%	78%	70%	63%	78%	*	*	*	*	*	*
OptumHealth Behavioral Solutions of California	66%	59%	73%	67%	60%	74%	65%	58%	73%	73%	*65%	*81%

* 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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