DEPARTMENT OF
Managed
Health Care

Timely Access Report

Measurement Year 2020

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) 2020 provider appointment availability survey data (timely access data) submitted by health plans licensed under the Knox-Keene Act to the California Department of Managed Health Care (DMHC). This includes all Medi-Cal managed care plans licensed by the DMHC.[1] 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 2020, the DMHC required full service and behavioral health plans to utilize external vendors to validate the health plans' timely access data and conduct a quality assurance review of their Timely Access Compliance Reports (compliance reports).

Health plans and health care providers had to rapidly make many transitions during 2020 to continue to safely provide health care services to enrollees during the COVID-19 pandemic. Many health plans noted concerns about the impacts COVID-19 had on appointment availability in their timely access data submissions. These concerns ranged from providers taking time off for illness to challenges associated with scheduling appointments with COVID-19 health protocols in place. However, most health plans that noted concerns showed an increase in appointment availability compared to MY 2019 timely access data. Additionally, health plans had the flexibility to record the next available appointment offered by a provider, regardless of whether the appointment was an in-person or a telehealth appointment. This change was first incorporated into the standardized methodology in MY 2019.[2]

The standardized methodology health plans had to follow in collecting appointment availability data and submitting compliance reports to the DMHC remained the same in MY 2020 as MY 2019. This makes MY 2020 the first year data can be similarly compared across multiple years using the same methodology. However, as noted above, MY 2020 is a unique year due to the COVID-19 pandemic.

Due to DMHC's oversight and monitoring activities, health plans have continued to make improvements in the quality of data collection and reporting over the last five years. However, two health plans (Positive Healthcare and Valley Health Plan) had MY 2020 results excluded from multiple charts due to data quality issues which are further explained in Appendix A of this report. Positive Healthcare began accepting enrollment under its full service Knox-Keene Act license in 2019 and began reporting survey data to the DMHC in MY 2020. Valley Health Plan has had data excluded from at least one chart for three consecutive years because of concerns related to data quality and reporting. Valley Health Plan has been cited by the Office of Enforcement for previous violations and the DMHC will evaluate the health plan's compliance

[1] The DMHC regulates health plans licensed under the Knox-Keene Act. While California law exempts County Organized Health Systems (COHS) plans from Knox-Keene licensure for Medi-Cal, COHS plans must have a Knox-Keene license for other lines of business. Health Plan of San Mateo is the only COHS plan that voluntarily included their Medi-Cal line of business in their Knox-Keene license.
[2] The DMHC expanded the timely access survey methodology to include telehealth providers in MY 2019 and continued this update in the methodology used for MY 2020 through 2022.

for ongoing enforcement action. To address reliability concerns, the DMHC will request both health plans submit corrective actions to improve the reliability of the data for future reporting years and monitor the effectiveness of corrective action plans previously submitted.

Key Survey Findings for Full Service Health Plans:

- For non-urgent and urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 98% to a low of 53% (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 98% to a low of 69% (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 97% to a low of 35% (Chart 9).

Key Survey Findings for Behavioral Health Plans:

- For non-urgent and urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 79% to a low of 75% (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 88% to a low of 83% (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% to a low of 64% (Chart 21).

Know Your Health Care Rights: Timely Access to Care

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 at **1-866-466-2219** or www.HealthHelp.ca.gov

DMHC Help Center:

The DMHC Help Center has provided assistance to over 2.5 million consumers to resolve problems with their health plans. As part of this assistance, the DMHC Help Center has assisted many people who 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 27.7 million Californians by regulating health plans, assisting consumers through the DMHC 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 to each enrollee consistent with good professional practice and within the timely access standards.

The Timely Access Regulation requires 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 wait time 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.

To strengthen the DMHC's ability to oversee health plan compliance, Health and Safety Code section 1367.03 was amended by Senate Bill (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 the timely access standards. The goal of using a standardized methodology for all health plans is that it would result in comparable data across 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 stakeholders including 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 compliance reports to the DMHC. SB 964 provided an Administrative Procedures Act (APA) waiver which allowed the DMHC to refine the survey methodology year-over-year.

On June 12, 2020, the DMHC submitted to the Office of Administrative Law (OAL) the notice of proposed rulemaking action to amend the timely access regulation, which included a standardized methodology and a requirement that no less than 70% of the health plan's providers in each network have an urgent appointment and non-urgent appointment available with the applicable time-elapsed standard (rates of compliance). After three public comment periods, the final amended package was submitted to the OAL for review on August 2, 2021. OAL approved

the amendments on January 12, 2022, and the regulation was effective April 1, 2022. Health plans will begin monitoring their networks under the new requirements set forth in the amended regulation for MY 2023 and report the results to the DMHC on May 1, 2024. Beginning in MY 2023, the DMHC will have a rate of compliance to which health plans will be held accountable. The updated regulation will help the DMHC hold health plans accountable for meeting a minimum rate of compliance.[3]

Additional requirements in the amended timely access regulations include:

• Requiring health plans to continue using an external vendor to validate their timely access data prior to submitting the date 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.

Health plans will be required to demonstrate each of the plans' networks meet a specified rate of compliance under the amended timely access regulation. This will allow the DMHC to review each individual health plan network's ability to deliver timely appointments, ascertain whether each health plan network met the established rate of compliance, and compare performance across all health plans.

Once health plans begin reporting data under the amended regulation in 2024, the DMHC will begin displaying timely access data by health plan network rather than aggregated by health plan.[4] This approach will be more consistent with the way enrollees access health care services from their health plan and will allow for better coordination of timely access and network adequacy reviews, which in turn will lead to better health plan accountability.

Additionally, SB 221 (Wiener, Chapter 724, Statutes of 2021) was recently signed by the Governor and further amended Health and Safety Code section 1367.03. SB 221 codifies the existing definitions and wait time standards in the Timely Access Regulation and introduces new requirements for follow-up behavioral health appointments. The DMHC is working with stakeholders to implement the new law.

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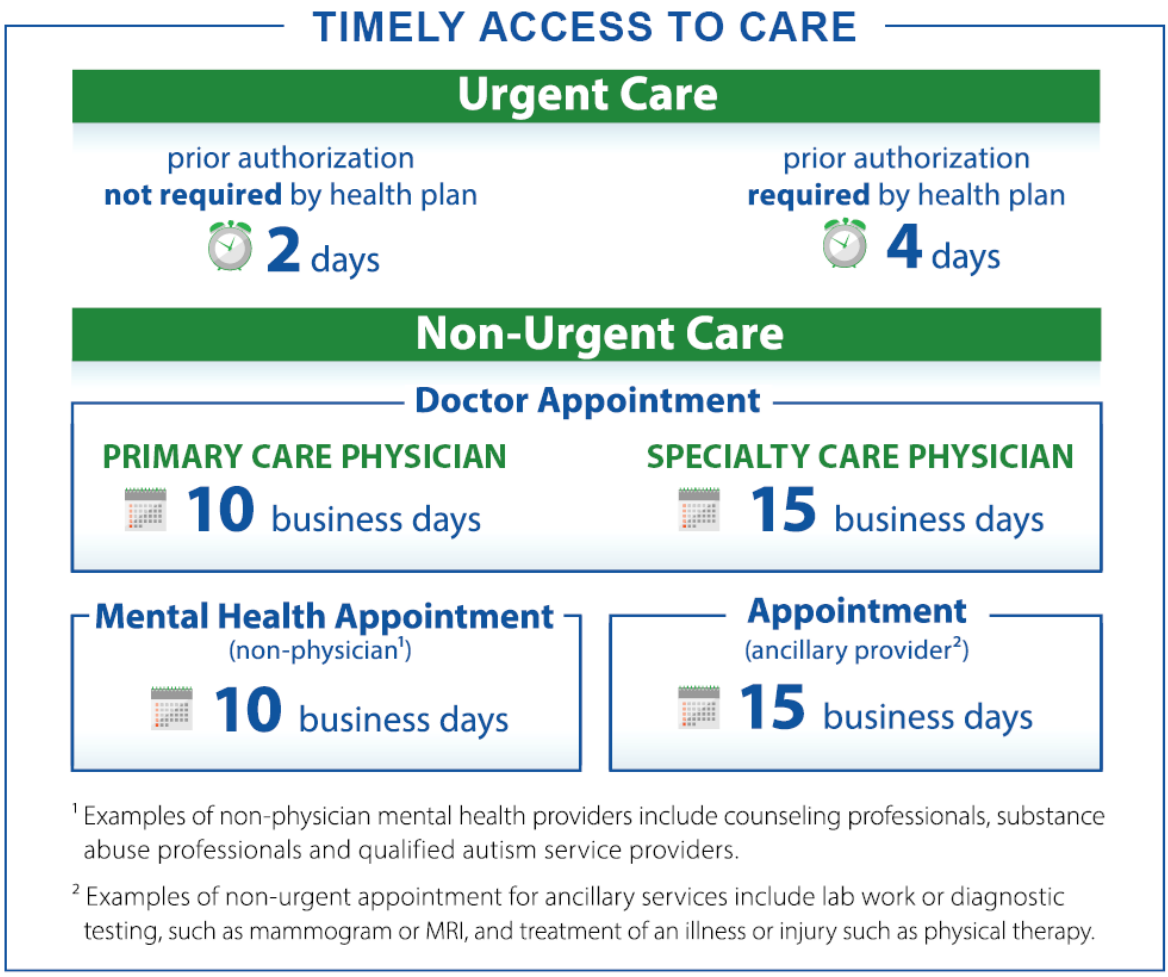
[3] The amended regulation is available on the DMHC's website.
[4] A network is a discrete set of providers the health plan has designated to deliver all covered services to enrollees covered by a health plan in a specific service area.

It is worth noting that health plans are in the process of collecting data for MY 2022, using the same methodology used for MY 2019, 2020, and 2021. For MY 2022, the DMHC is taking steps to gather information regarding how health plans will implement the new SB 221 monitoring and reporting requirements, including the new follow-up appointment standard for non-physician mental health care or substance use disorder providers which will become effective July 1, 2022. The DMHC will incorporate the new reporting requirements included in the amended timely access regulation and SB 221 as soon as possible and anticipates these requirements will be included in the standardized data collection methodology starting as soon as MY 2023.

Timely Access Standards

The specific wait time standards in the Timely Access Regulation are provided in the chart below.[5] 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.



[5] The appointment wait time standards set forth in this report are current as of 2021. Pursuant to SB 221, these standards will include a follow-up appointment standard for non-physician mental health and substance use disorder providers beginning July 1, 2022.

Health plans are required to ensure that each of its provider networks has the capacity to offer enrollees appointments within the 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 Regulation allows the wait time for an appointment to be extended if the referring or treating licensed health care provider, acting within the scope of the provider's 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, preventive 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 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. Other methods of meeting urgent care needs that are not delivered via appointments cannot be measured by the survey.

How the DMHC Monitors Timely Access

In addition to the review of health plan timely access compliance reports, the DMHC utilizes a variety of regulatory oversight tools 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.
- Evaluating health plan networks annually and when there is a contract termination between a health plan and provider group that impacts 2,000 or more enrollees to ensure health plans have an adequate number of providers to offer timely access to care to their enrollees.
- Performing network adequacy reviews, on an as needed basis, when a health plan seeks to make a significant change to its license, including changes to its service area, or a significant change in its roster of providers.
- Auditing of health plan operations through routine medical surveys. One component of the medical surveys is the assessment of health 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 health 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 892 access to care complaints in 2020, making up 6.9% of all complaint issues resolved 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.

Between January 1, 2017, and October 31, 2021, the DMHC has issued 49 access-related deficiencies to health plans through the medical survey process. Of these 49 deficiencies:

- Twenty-two deficiencies were corrected by the health plans at the issuance of the Final Report or Follow-Up Report or were resolved through a settlement agreement.
- Seven deficiencies were not corrected at the issuance of the Follow-Up Report and have been referred (or are pending referral) to the DMHC's Office of Enforcement.
- Seventeen deficiencies are pending the completion of the Follow-Up Survey.
- Three deficiencies remained uncorrected as the health plan surrendered their Knox-Keene License prior to the Follow-Up Survey completion.

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 Provider Appointment Availability Survey Methodology sets forth the process for 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 timely access 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 Methodology 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. Health plans compare the providers' responses to these surveys against the appointment wait time standards to ascertain the percentage of providers with an appointment available within the urgent and non-urgent wait time standards. Health plans then report the results of the survey 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. By meeting the target sample size defined by the survey methodology, health plans should produce results sufficiently reliable with sampling errors of approximately five percent for each provider type by appointment type.[6] The charts combine data for more than one provider type or appointment type, which increases the sample size and results in lower sampling errors. Each chart includes the range of the sampling errors across all health plans included in the chart. 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. Sampling errors over five percent raise concerns that the sample may not be representative of the population of health plan providers. Appendix A contains a detailed explanation of the data discrepancies.

Aggregate Rate of Compliance

The charts show provider responses to appointment availability requests for MY 2020. The charts present the provider responses by: 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), Medi-Cal Products, and all products combined. It is important to understand the health plan survey results reflect only the

[6] A sampling error is the statistical error associated with estimates drawn from a sample of a population. Since a sample may not be representative of the population as a whole, the sampling error represents possible difference between the sample estimate and the population parameter. The sampling errors for this report are calculated at an 80% confidence level, which means that a rate of compliance estimate of 75% with a sampling error of +-5% indicates that there is an 80% certainty that the true rate of compliance is between 70% and 80%.

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% aggregate rate of compliance with a two-percentage point sampling error, this means 75% 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 health plan providers is between 73% and 77%.

Full Service Health Plans Survey Data

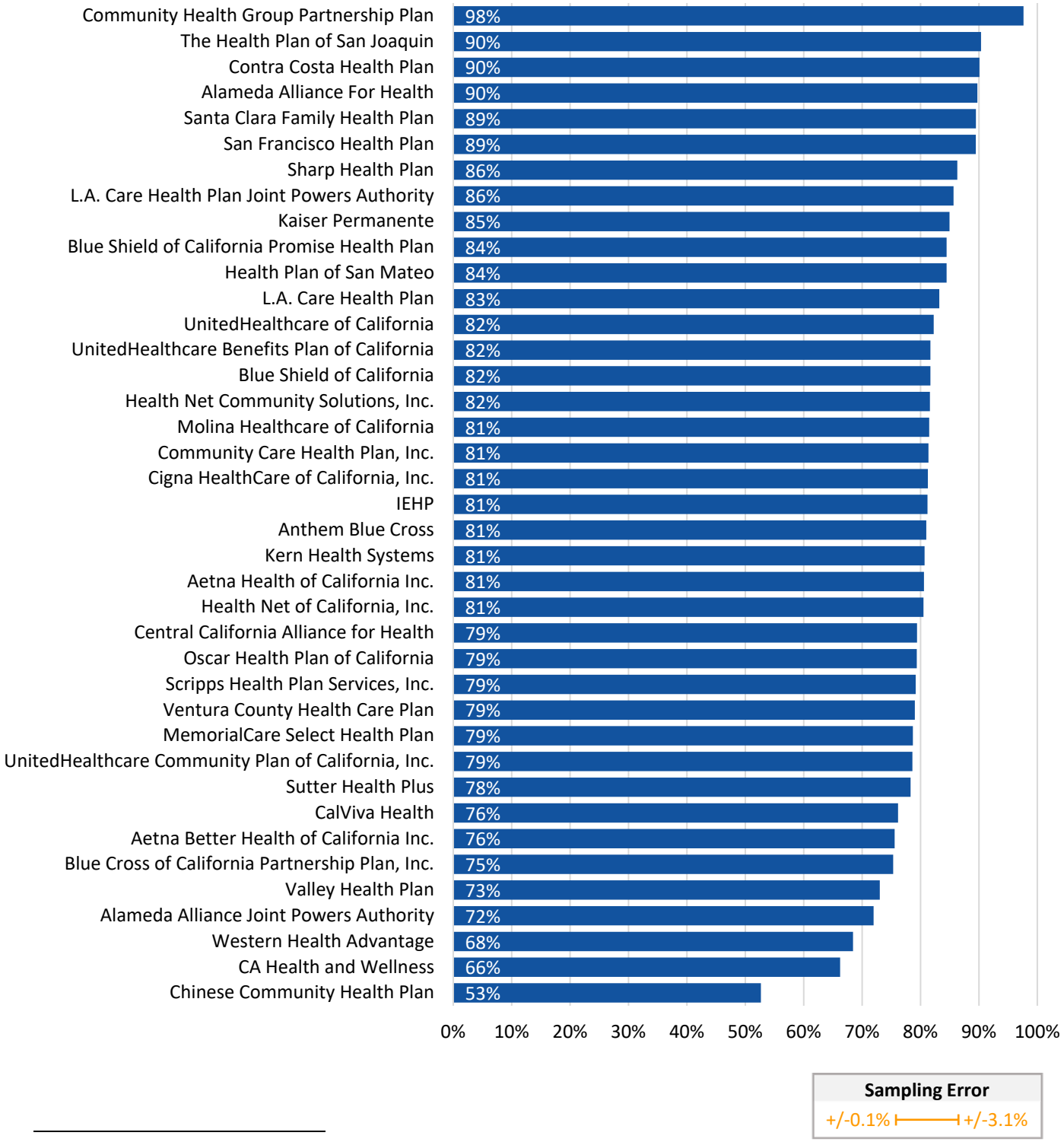
URGENT AND NON-URGENT APPOINTMENTS

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.[7]



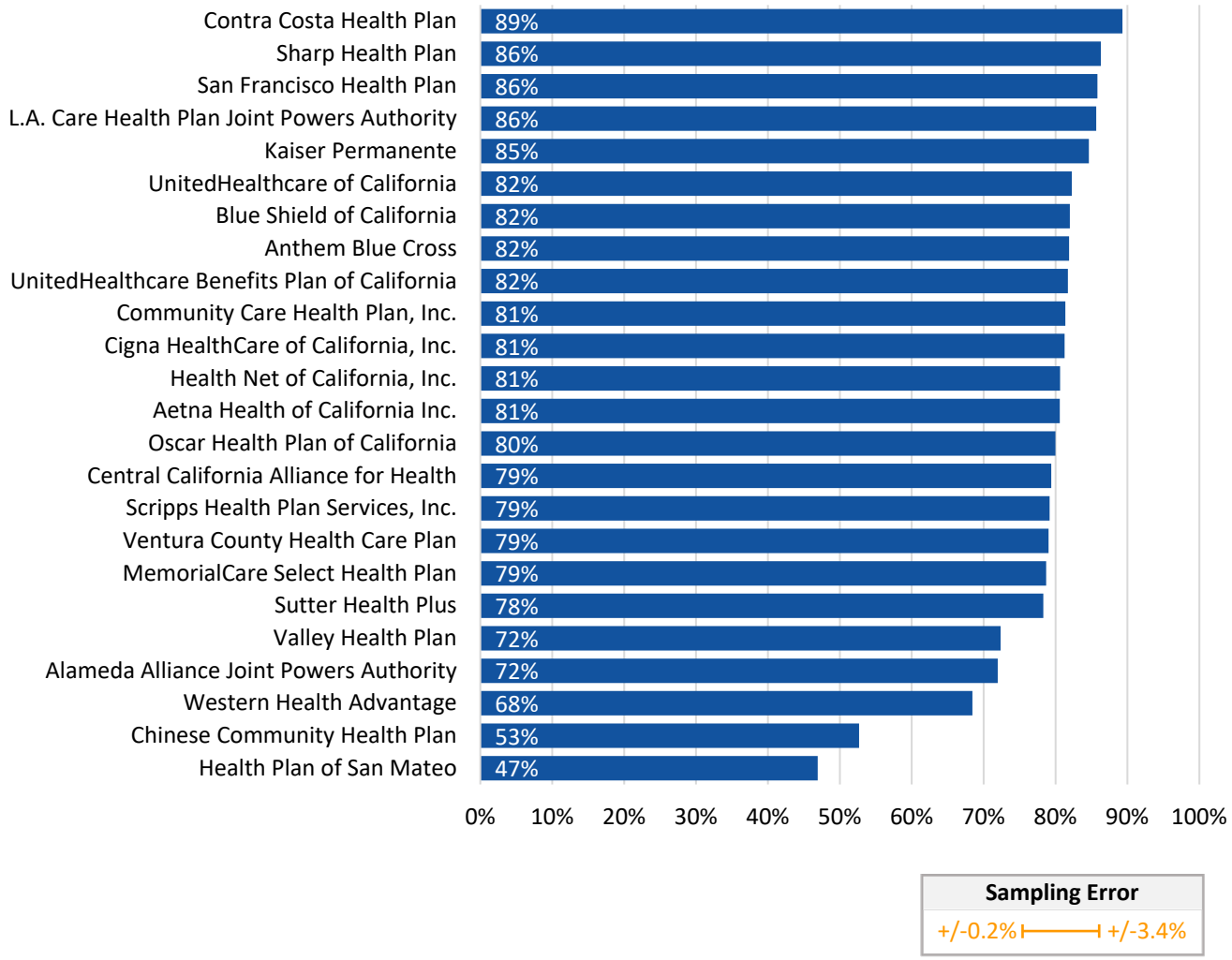
[7] One health plan (Positive Healthcare) is not displayed. See Appendix A.

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.

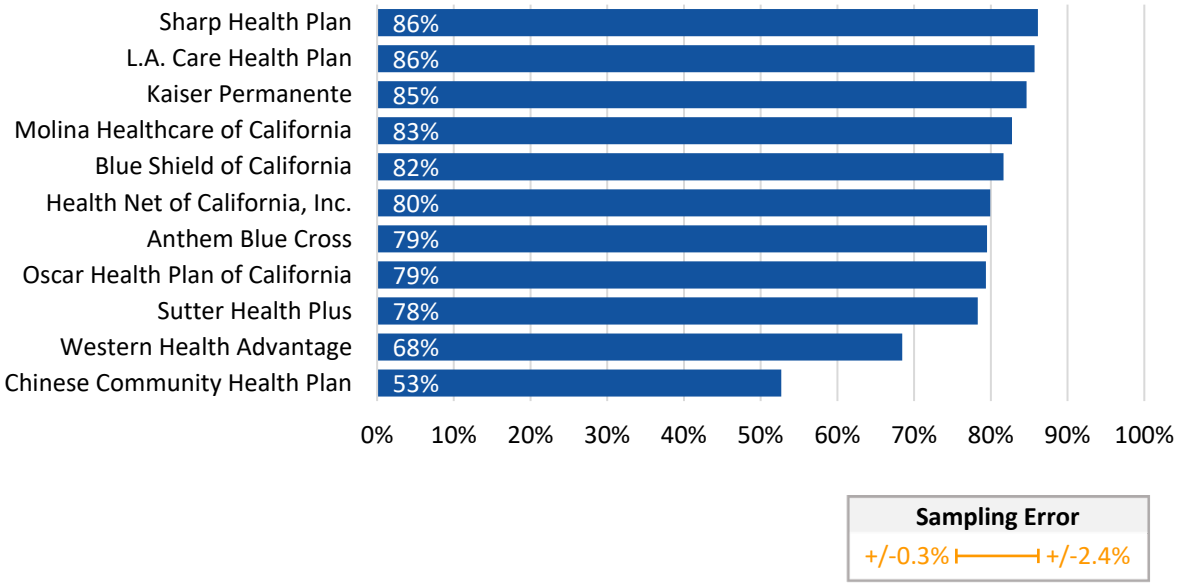


Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

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.[8]



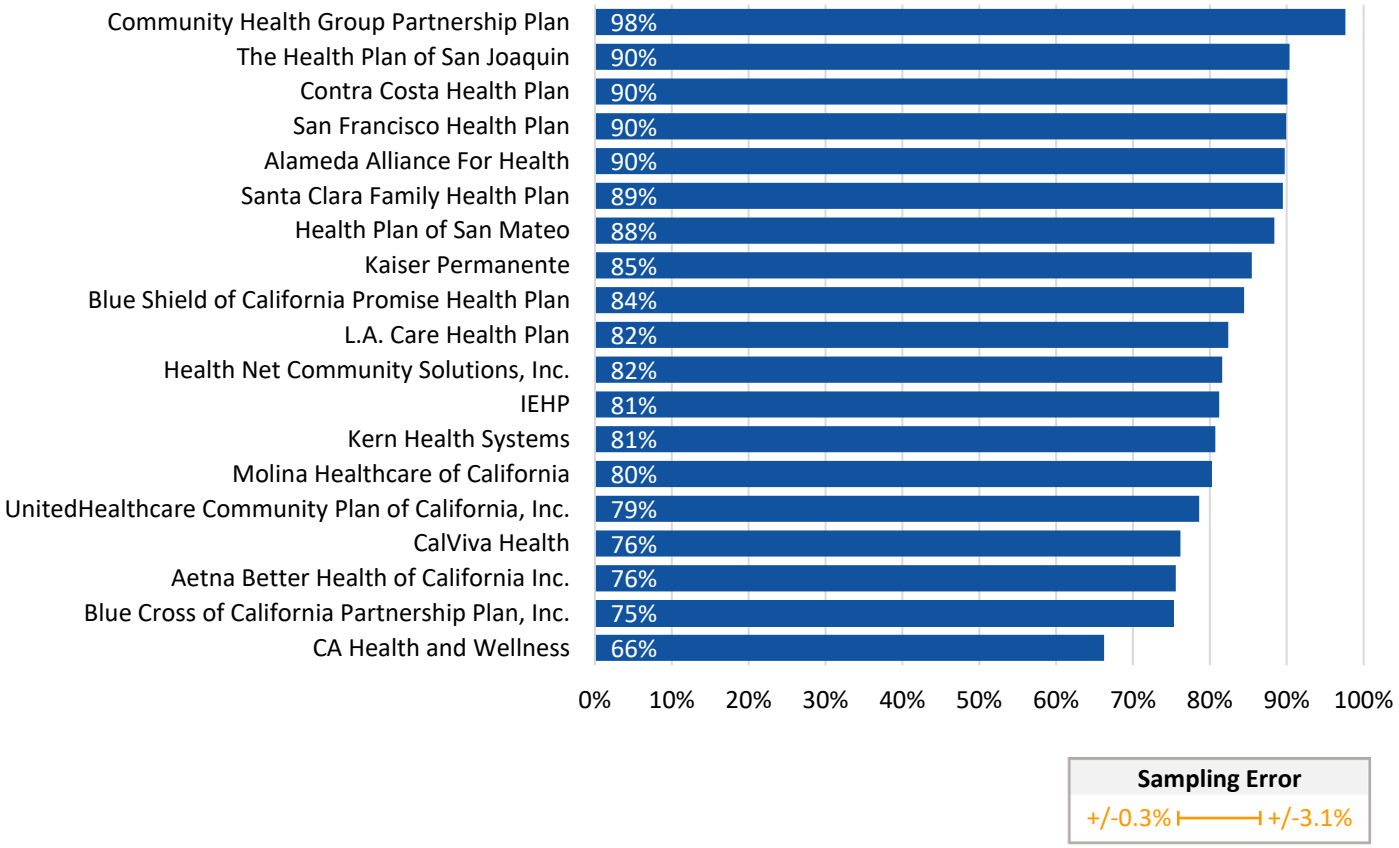
[8] One health plan (Valley Health Plan) is not displayed. See Appendix A.

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.[9]



[9] Two health plans (Positive Healthcare and Valley Health Plan) are not displayed. See Appendix A.

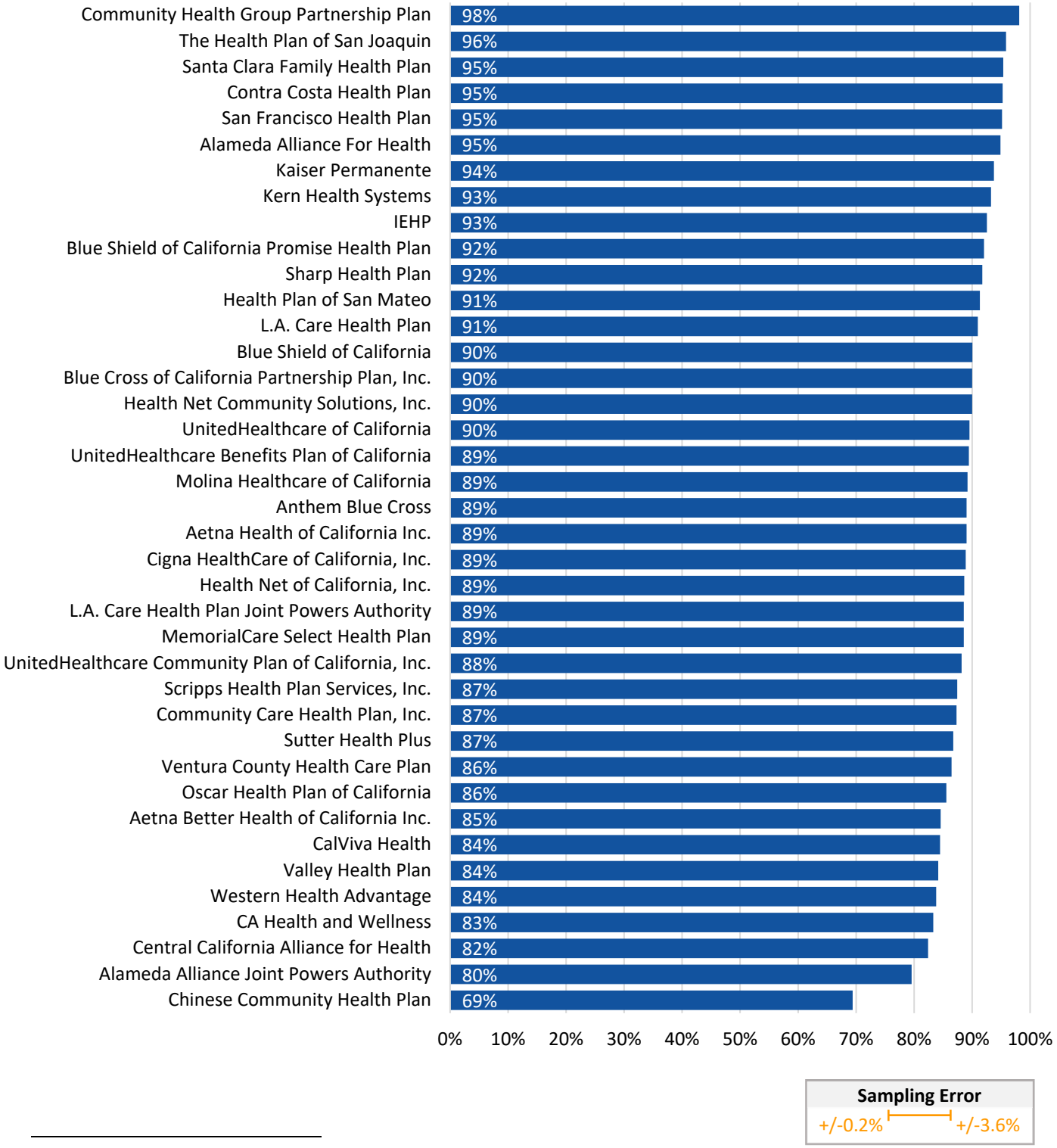
NON-URGENT APPOINTMENTS

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.[10]



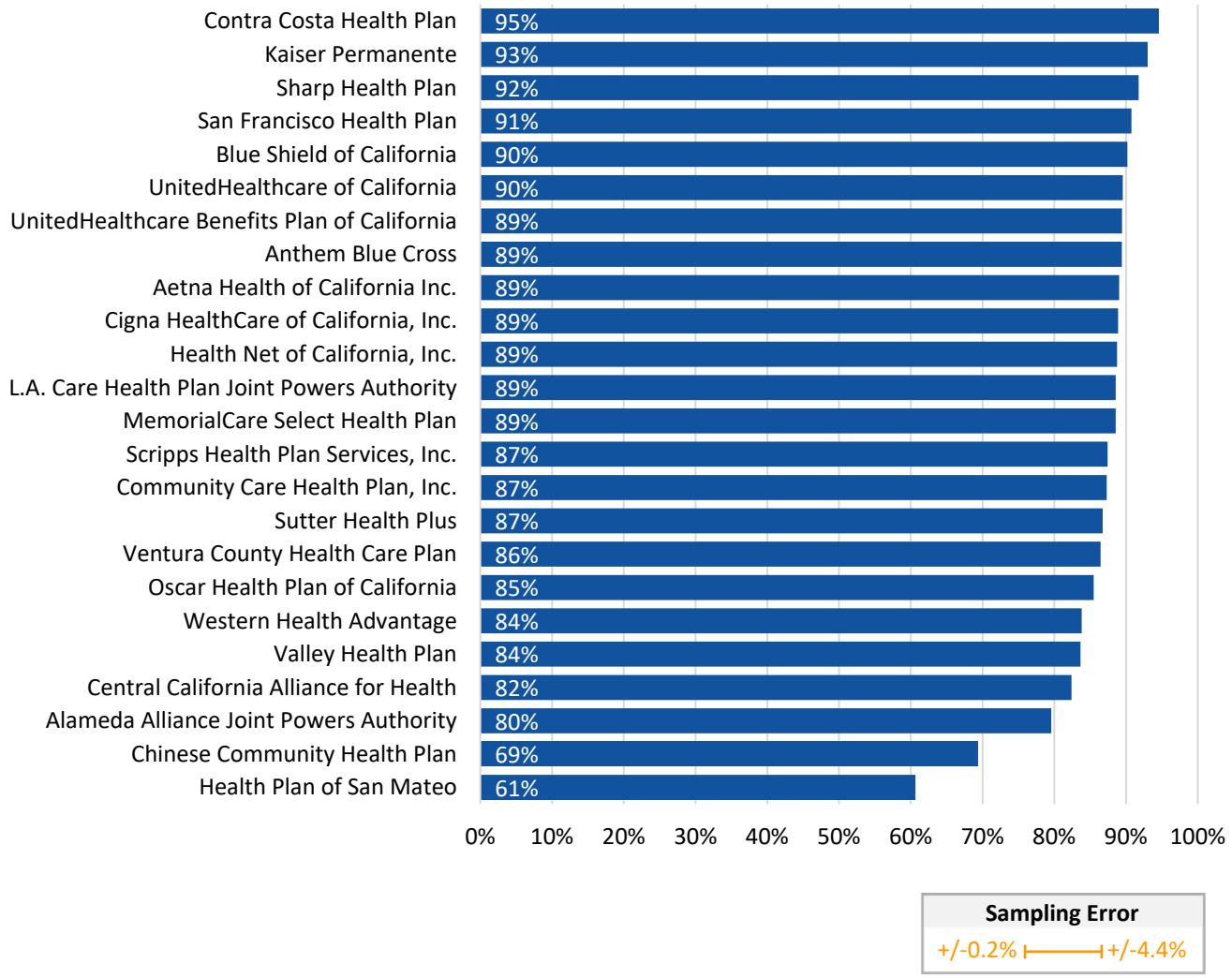
[10] One health (Positive Healthcare) is not displayed. See Appendix A.

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.

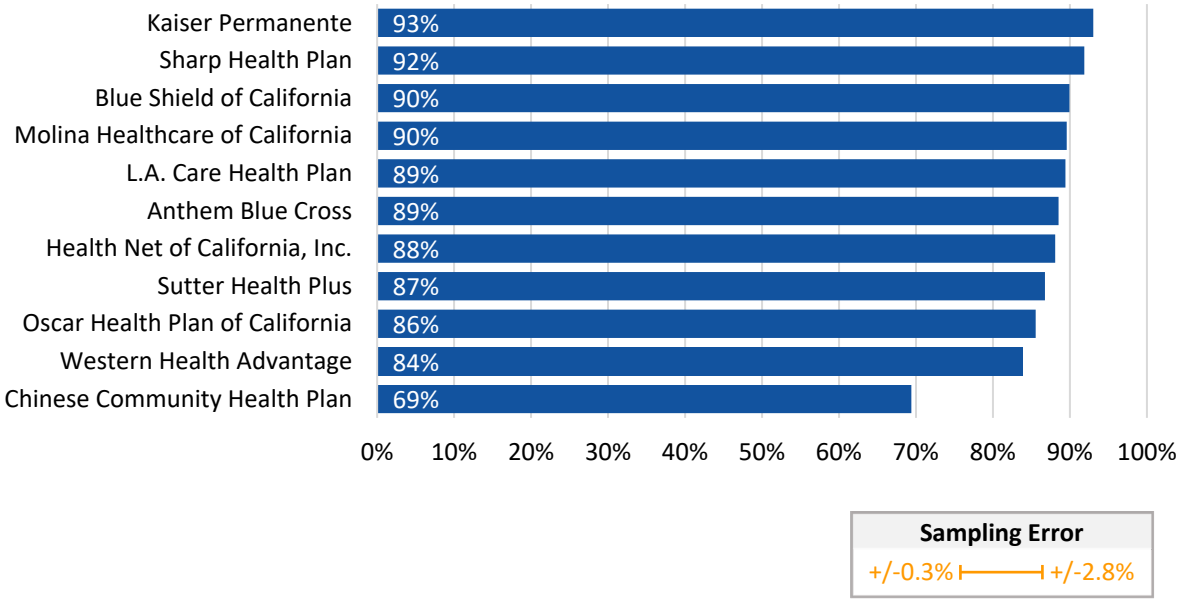


Percentage of Surveyed Providers Meeting Non-Urgent Appointment Wait Time Standards

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.[11]



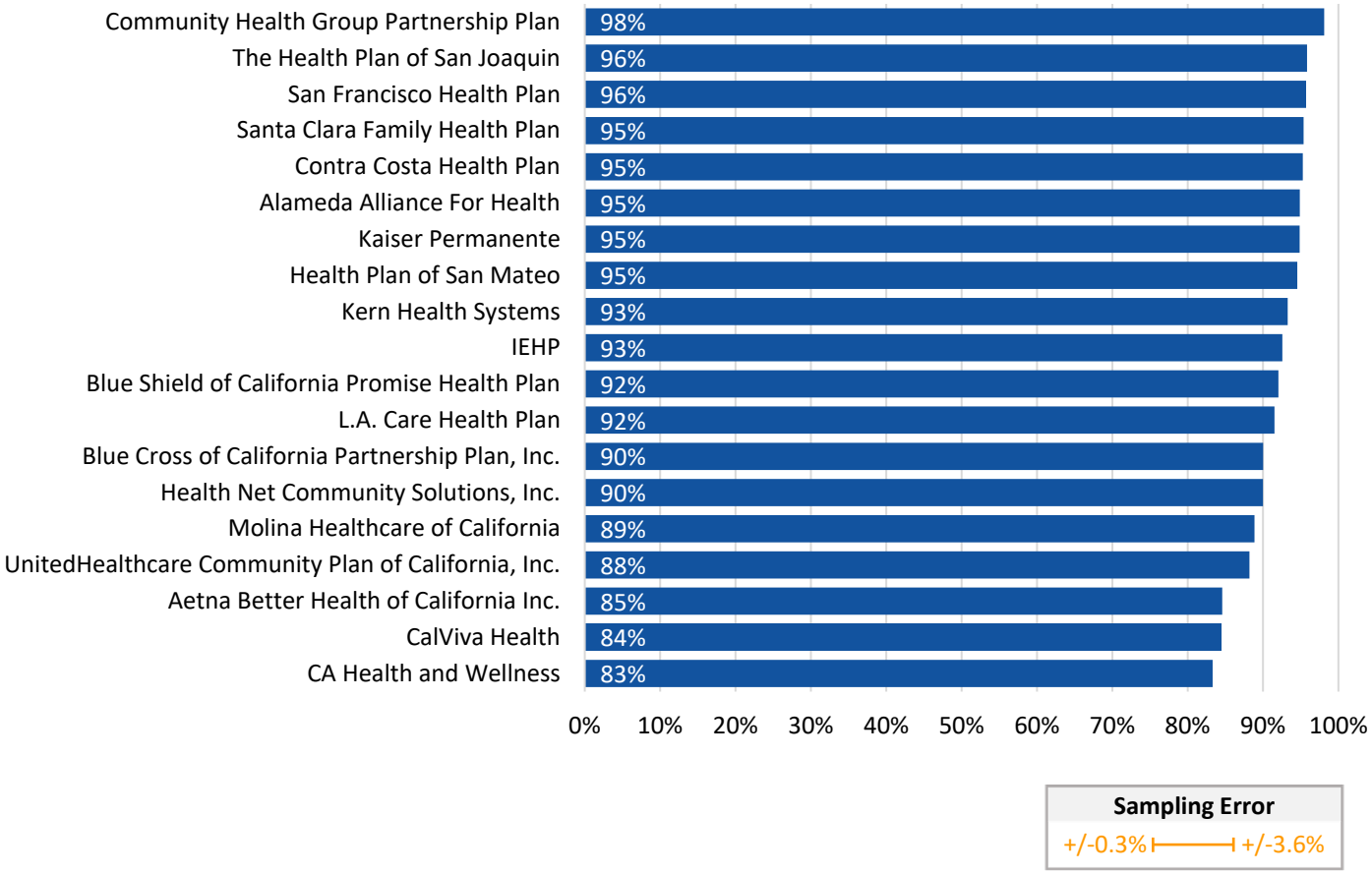
[11] One health plan (Valley Health Plan) is not displayed. See Appendix A.

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.[12]



[12] Two health plans (Positive Healthcare and Valley Health Plan) are not displayed. See Appendix A.

URGENT APPOINTMENTS

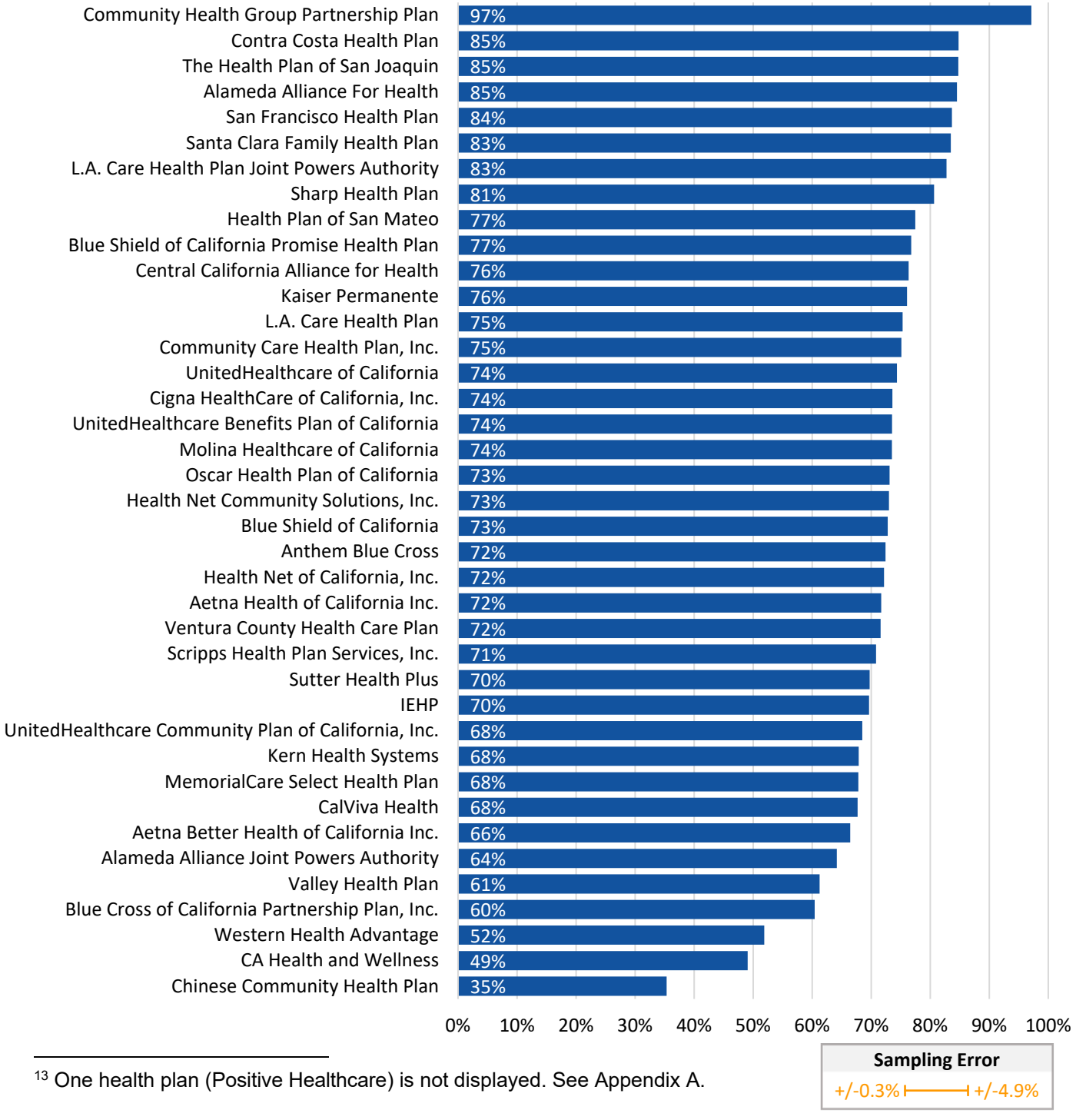
Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards

As noted earlier in the report, 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.[13]



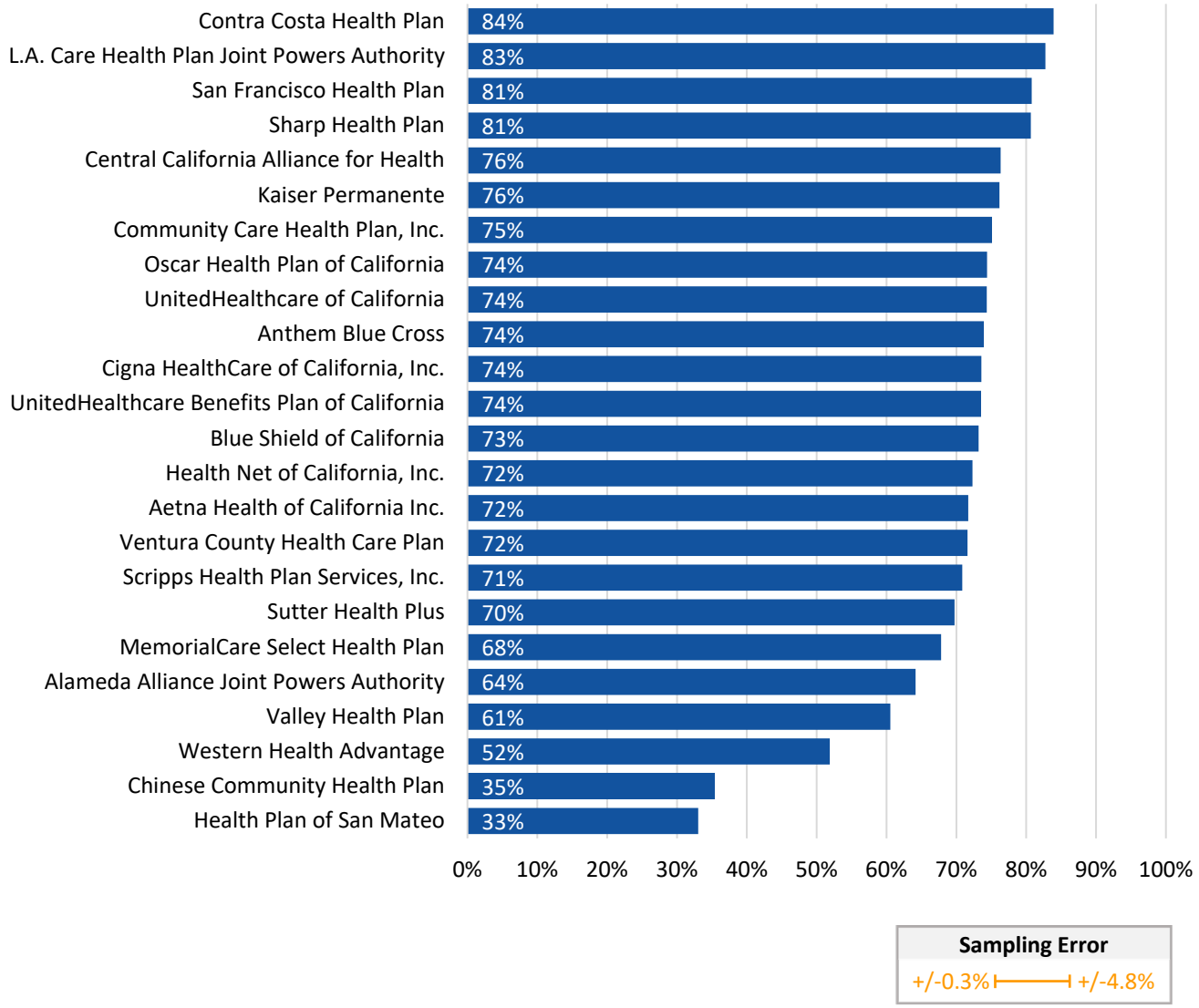
[13] One health plan (Positive Healthcare) is not displayed. See Appendix A.

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.

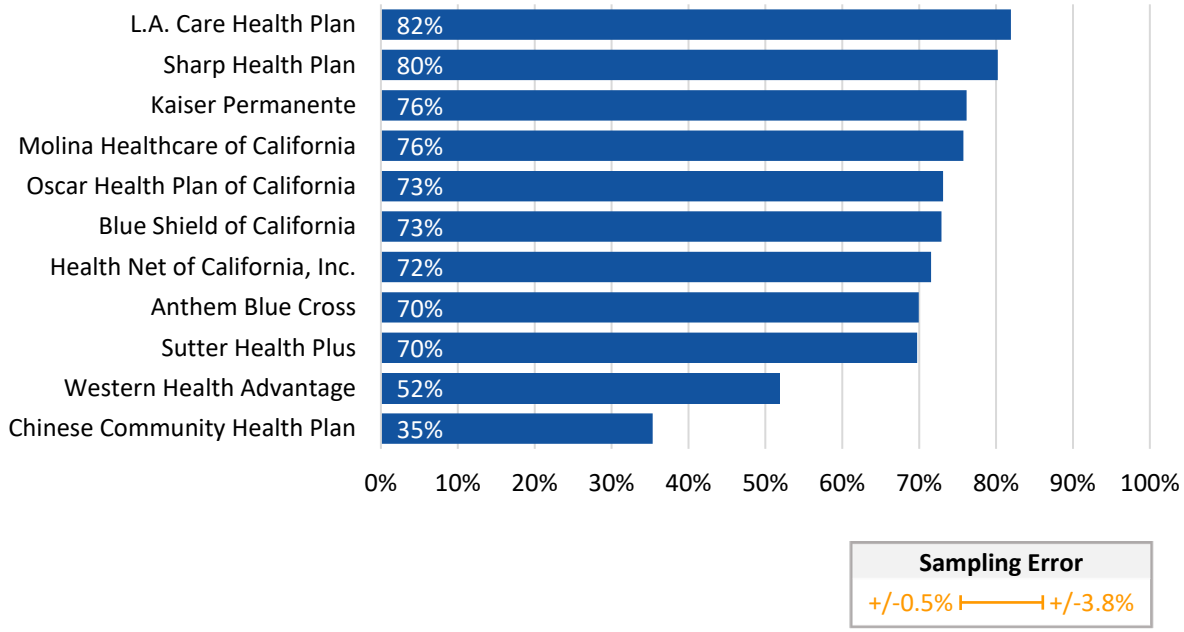


Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards

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.[14]



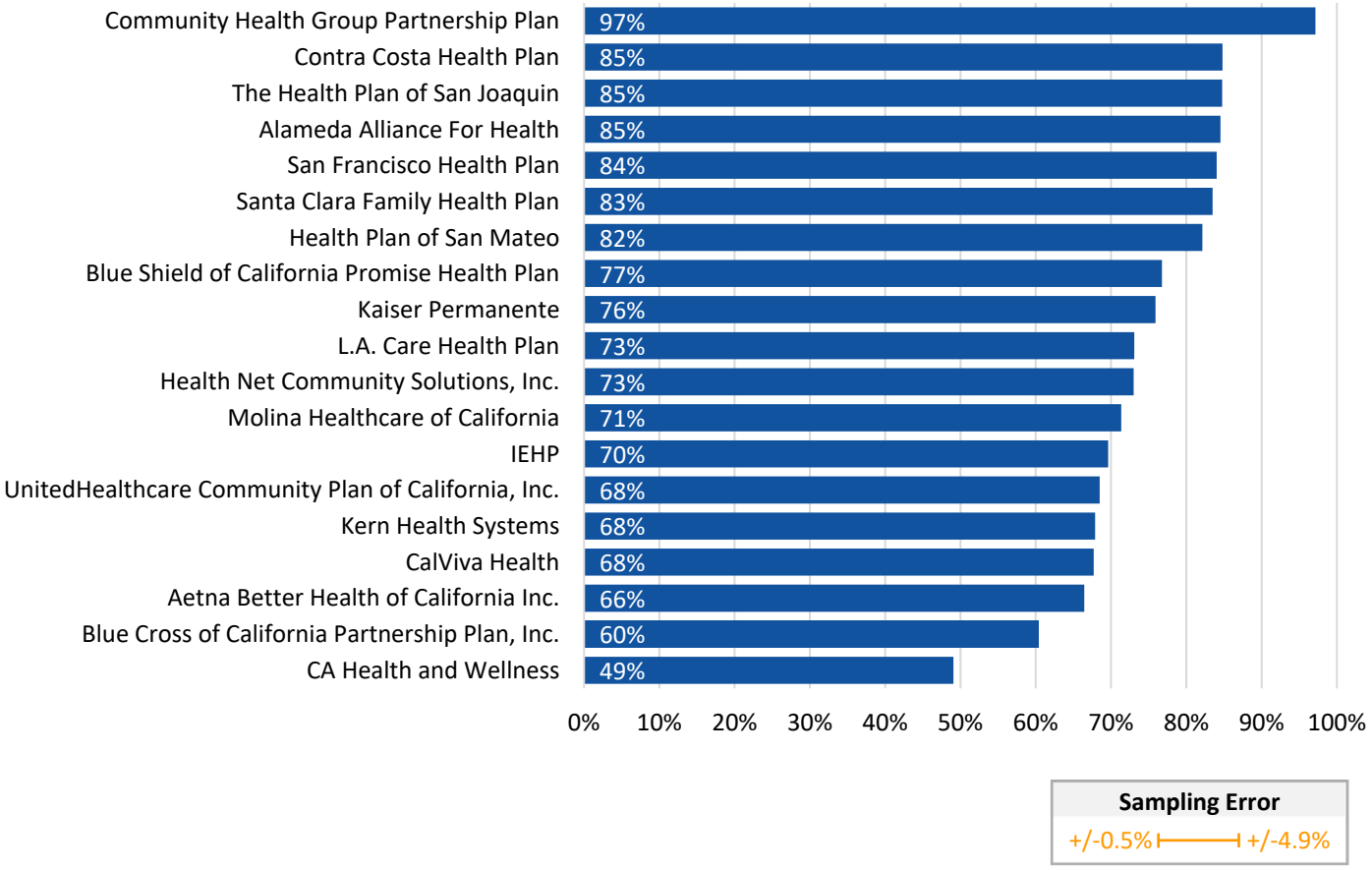
[14] One health plan (Valley Health Plan) is not displayed. See Appendix A.

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.[15]



[15] Two health plans (Positive Healthcare and Valley Health Plan) are not displayed. See Appendix A.

Behavioral Health Plans Survey Data

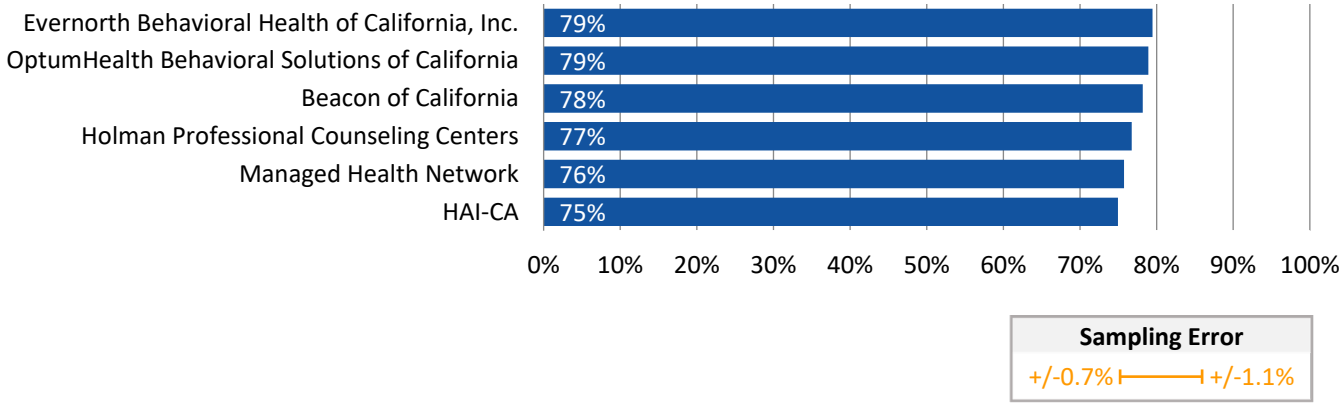
URGENT AND NON-URGENT APPOINTMENTS

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.

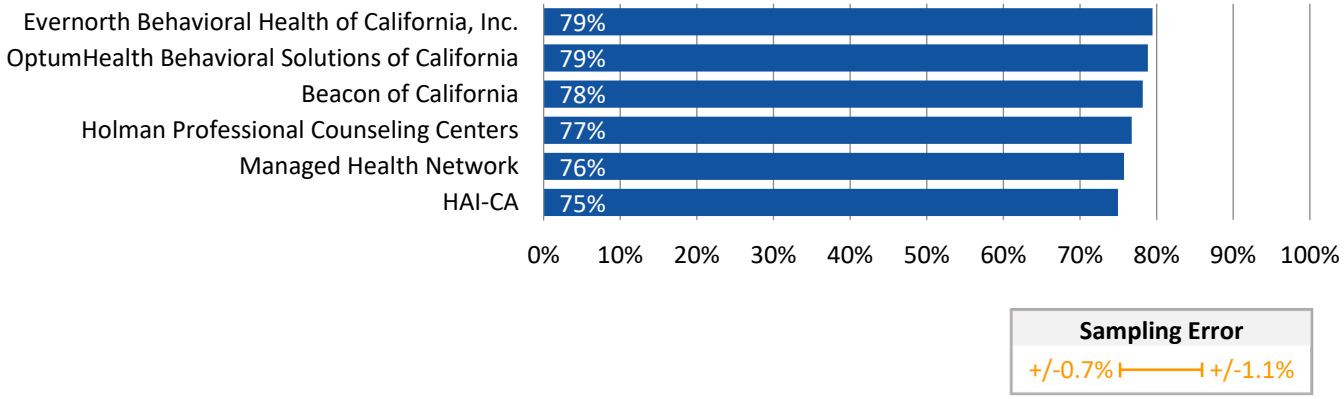


Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

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.

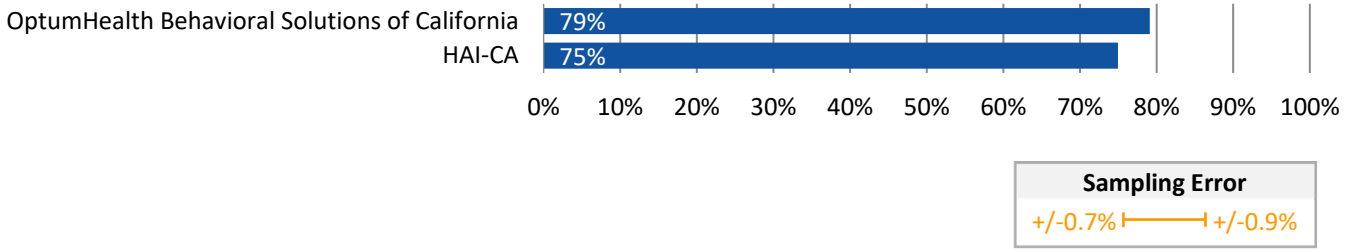


Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

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.

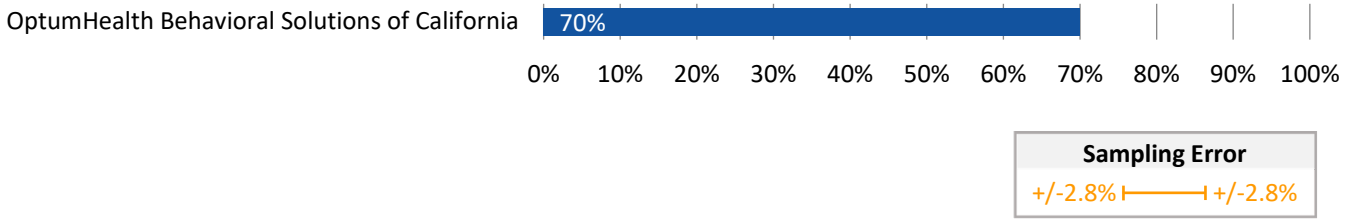


Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

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.



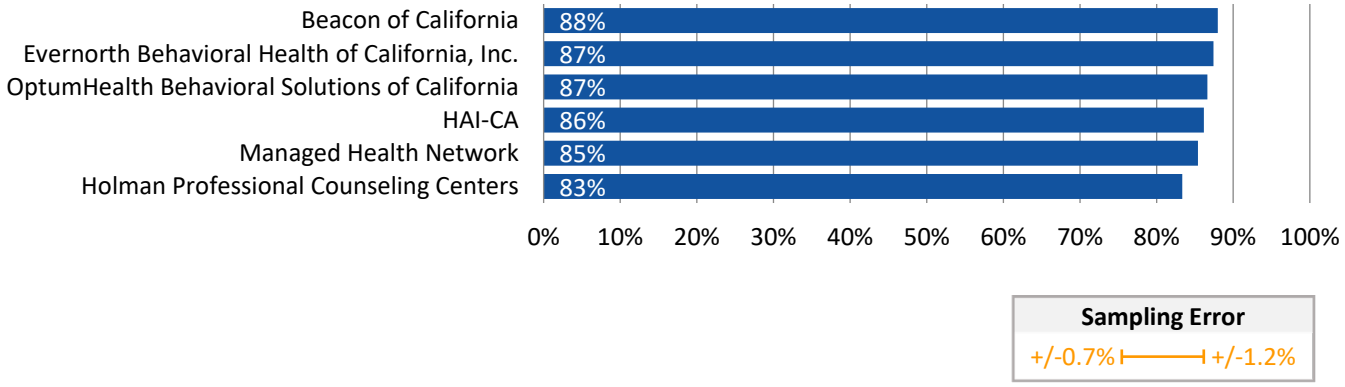
NON-URGENT APPOINTMENTS

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.

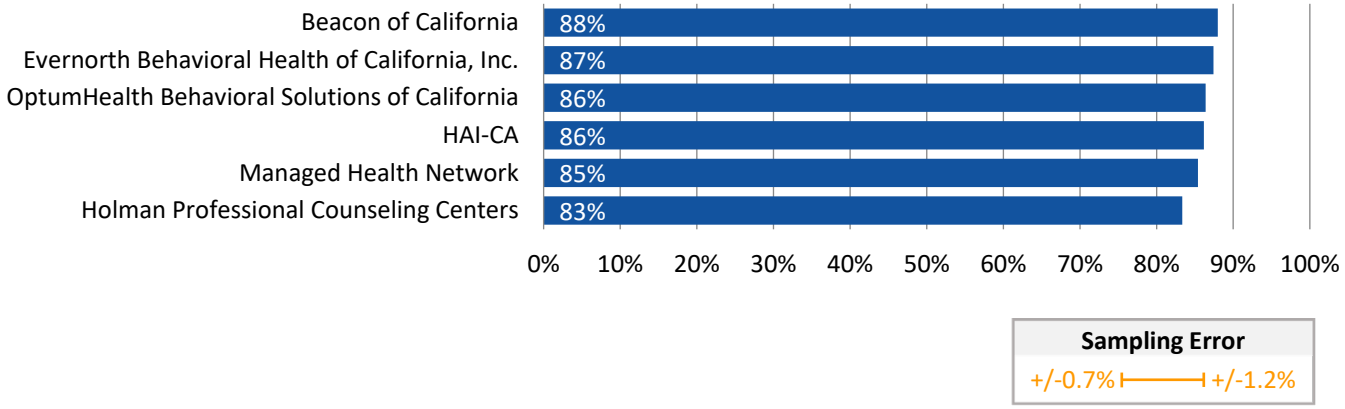


Percentage of Surveyed Providers Meeting Non-Urgent Appointment Wait Time Standards

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.

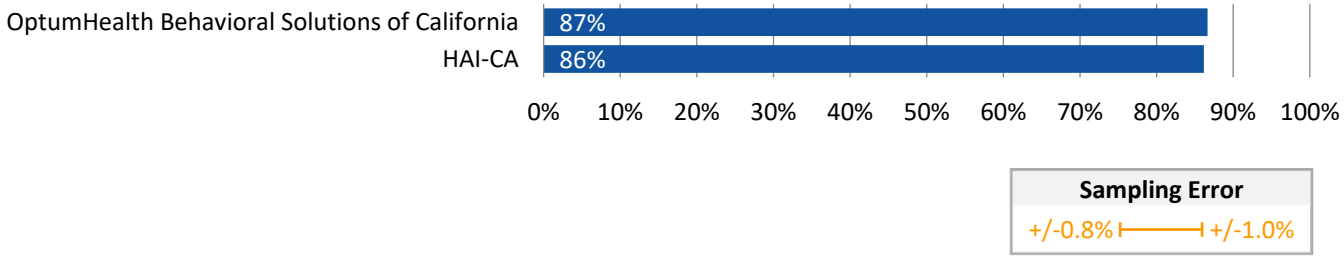


Percentage of Surveyed Providers Meeting Non-Urgent Appointment Wait Time Standards

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.

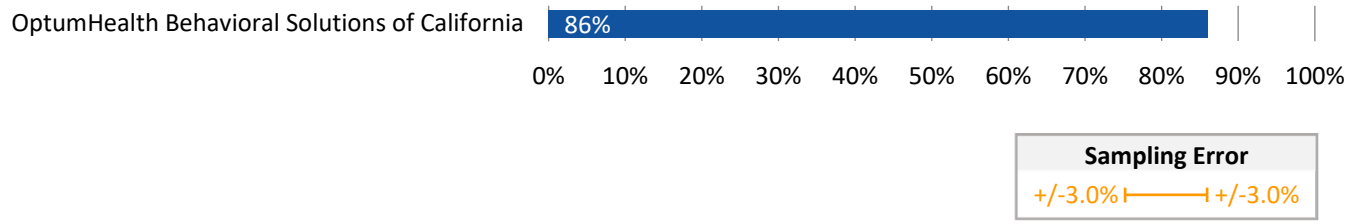


Percentage of Surveyed Providers Meeting Non-Urgent Appointment Wait Time Standards

Chart 20

Behavioral Health Plans – Medi-Cal

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



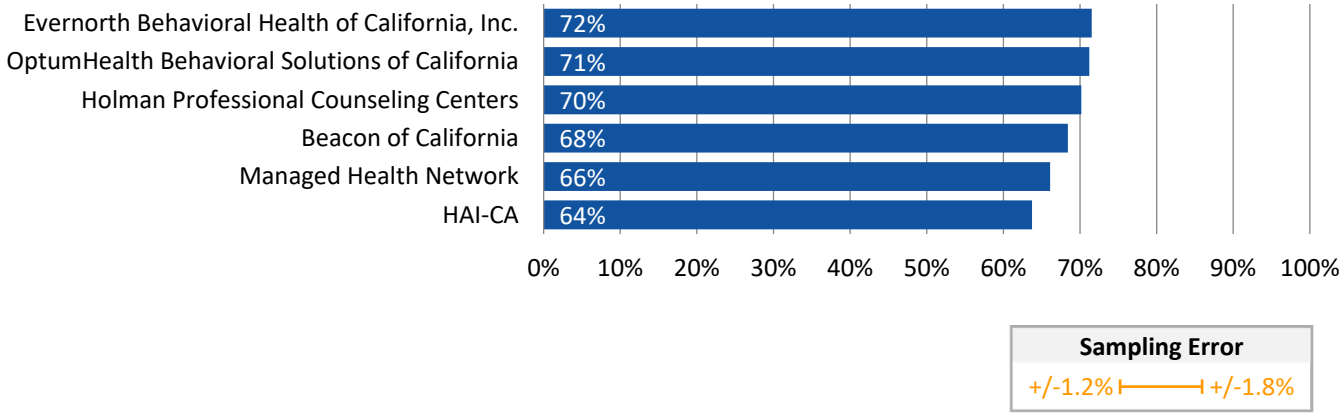
URGENT APPOINTMENTS

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.

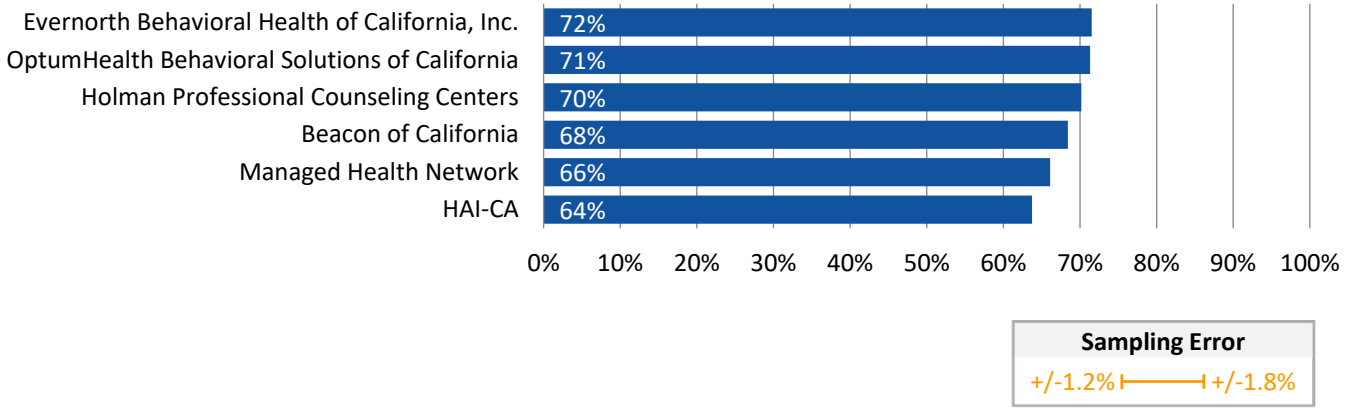


Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards

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.

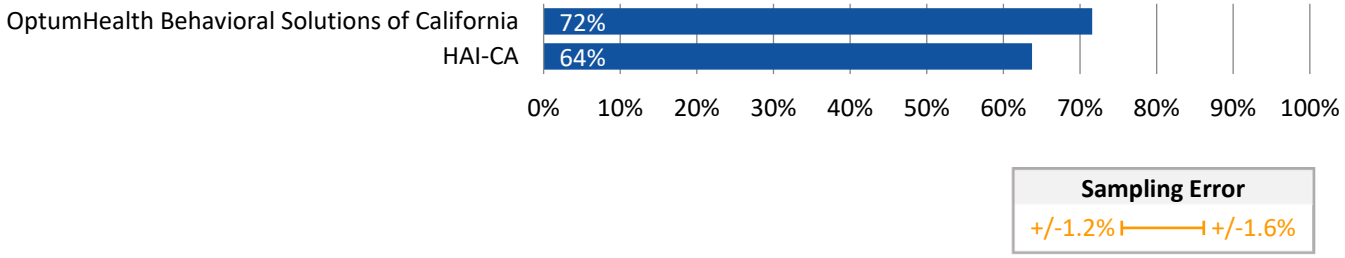


Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards

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.

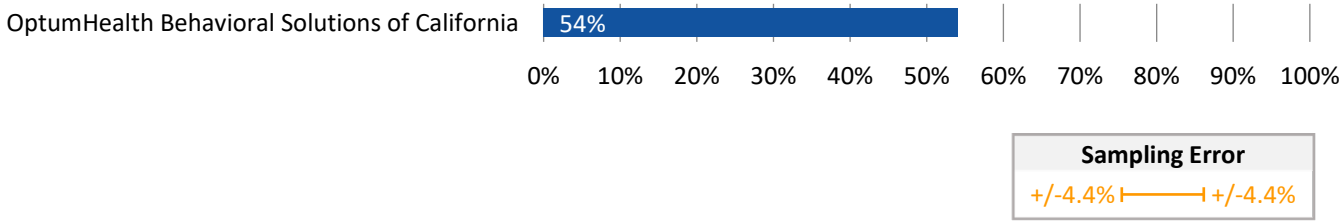


Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards

Chart 24

Behavioral Health Plans – Medi-Cal

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

As we look forward, the DMHC remains focused on ensuring health plan enrollees can access appropriate health care services within the timely access standards. Health plans have already started collecting data for MY 2022, using the same methodology used for MY 2019, 2020 and 2021.

The DMHC worked closely with stakeholders, including consumer advocates, health plans, and provider organizations to develop the timely access standardized methodology and rate of compliance included in the amended timely access regulation. The amended regulation will help the DMHC hold health plans accountable for meeting a minimum rate of compliance.

The DMHC will be working to codify existing requirements and incorporate the new reporting requirements in the amended timely access regulation and begin implementing the new SB 221 requirements into the timely access standardized methodology as soon as possible. It is anticipated these requirements will begin being reported by health plans as soon as MY 2023.

Next steps will include:

- Health plans will be required to collect and report timely access provider appointment availability survey data by health plan network.
- Beginning in MY 2023, the DMHC will report timely access data by health plan network rather than aggregated by health plan.
- Beginning in MY 2023, the DMHC will require corrective actions and take appropriate enforcement action against health plans that fail to meet the timely access 70% urgent rate of compliance standard or the 70% non-urgent rate of compliance standard.
- As required by SB 221, the DMHC will incorporate a reporting requirement into the timely access standardized methodology to capture compliance data related to the new 10 business day follow-up appointment wait time standard for non-physician mental health care or substance use disorder providers, which goes into law on July 1, 2022[16].
- The DMHC will continue to require health plans to utilize an external vendor to perform a quality assurance review and include a validation report of the health plans' data prior to submission of the survey data to the DMHC.
- Annual review of health plan reported timely access survey data, which is used to provide health plans with feedback on the reported timely access data, and to request corrective action to improve reliability, comparability, and accuracy of the data where concerns are identified.
- The DMHC will continue to monitor the effectiveness of previously submitted corrective action plans, and may refer health plans that violate statutory or regulatory reporting requirements to the Department's Office of Enforcement for further action.

[16] Health plans must comply with the follow-up appointment standard for non-physician mental health and substance use disorder providers beginning July 1, 2022, as required by SB 221. The bill also included an APA waiver until July 1, 2025, to allow the DMHC to update the timely access standardized methodology to include the new follow-up appointment wait time standard for non-physician mental health care and substance use disorder providers.

- The DMHC will also continue to work with and provide timely access data to the Center for Data Insights and Innovation (CDII) (formerly the Office of the Patient Advocate (OPA)) for incorporation into the Quality of Care Report Card.[17]

[17] OPA's reporting requirements have transitioned to the Center for Data Insights and Innovation (CDII) at the California Health and Human Services Agency.

Conclusion

Timely access to care and access to behavioral health care services will continue to be a high priority for the DMHC in the years ahead. The amended timely access regulation and the implementation of the requirements under SB 221 will help the DMHC better hold health plans accountable for providing timely access to care to enrollees. The DMHC will continue collaborative efforts with stakeholders, including health plans, providers, and consumer advocates, to implement the amended regulation and SB 221.

The DMHC Help Center is a valuable resource to enrollees facing issues with their health plan, including timely access to care. If a health plan enrollee is having trouble obtaining a timely appointment, they should first contact their health plan directly to help them get an appointment within the timely access standards. If their health plan does not resolve the issue, they should contact the DMHC Help Center for assistance at 1-888-466-2219 or www.HealthHelp.ca.gov.

Appendices

Appendix A: Timely Access Data Discrepancies & Analysis

The charts in this report include timely access data for primary care physicians and non-physician medical practitioners providing primary care, specialist physicians, non-physician mental health and ancillary providers for both urgent and non-urgent appointments.[18] The charts included in this report identify the percentage of appointments in which a provider indicated appointment availability within the wait time standards.

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 non-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, rather than individual providers, within a county network. This provider weighting means that a timely access rate for a health plan's county network with 100 providers receives a weight ten times the weight of a rate for a county network with 10 providers. 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 requests within the standard applicable to the type of provider and type of appointment.

Sampling Error

Each chart includes estimate of timely access rates and provides the range in sampling errors for the presented rates. The sampling error indicates with 80% certainty the range where the actual

[18] Specialist physicians consist of cardiologists, endocrinologists, gastroenterologists, and adult and child psychiatrists. Ancillary providers consist of service centers (facilities or entities) providing mammography and physical therapy appointments. 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.

rate might fall given the sample size and estimated rate.[19] 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 size of health plan networks and the degree to which target sample sizes were achieved. For excluded charts, surveyors contacted all providers on the contact list due to a high degree of non-response/refusals or ineligible providers in the contact list. For one health plan, Positive Healthcare, its plan partner, HAI-CA, omitted timely access data for its non-physician mental health care providers and psychiatrists from the networks reported to the DMHC. This omission likely impacted Positive Healthcare's sampling error due to the large share of providers that were excluded (see below). Results are not presented for health plans where the sampling error for the rate was greater than 5%, as these results were deemed unreliable. The chart below provides details on health plan data excluded from the previous charts due to sampling errors greater than 5%.

Chart Number	Plan Type	Health Plan Name	Measurement Type	Survey Product	MY 2020 Rate of Compliance	MY 2019 Rate of Compliance	Percentage Point Difference	MY 2020 Sampling Error
Chart 1	Full Service Plan	Positive Healthcare	Urgent/Non-Urgent	Aggregate	44%	N/A	N/A	6%
Chart 3	Full Service Plan	Valley Health Plan	Urgent/Non-Urgent	Individual/Family	75%	73%	2%	6%
Chart 4	Full Service Plan	Positive Healthcare	Urgent/Non-Urgent	Medi-Cal	44%	N/A	N/A	6%
Chart 4	Full Service Plan	Valley Health Plan	Urgent/Non-Urgent	Medi-Cal	73%	72%	1%	8%
Chart 5	Full Service Plan	Positive Healthcare	Non-Urgent	Aggregate	57%	N/A	N/A	8%
Chart 7	Full Service Plan	Valley Health Plan	Non-Urgent	Individual/Family	85%	79%	5%	7%
Chart 8	Full Service Plan	Positive Healthcare	Non-Urgent	Medi-Cal	57%	N/A	N/A	8%
Chart 8	Full Service Plan	Valley Health Plan	Non-Urgent	Medi-Cal	87%	79%	7%	9%
Chart 9	Full Service Plan	Positive Healthcare	Urgent	Aggregate	31%	N/A	N/A	10%
Chart 11	Full Service Plan	Valley Health Plan	Urgent	Individual/Family	65%	66%	-1%	10%
Chart 12	Full Service Plan	Positive Healthcare	Urgent	Medi-Cal	31%	N/A	N/A	10%
Chart 12	Full Service Plan	Valley Health Plan	Urgent	Medi-Cal	57%	64%	-8%	14%

Survey and Data Issues

The validation process the DMHC requires of health plans identified numerous data issues and potential discrepancies. In addition, the DMHC conducts other data validation checks that may be addressed with the health plan to ensure the reliability and accuracy of the data. Though issues with the data were common, the examination of the issues set forth below revealed that they only substantively impacted the statistical results for one health plan, Positive Healthcare, whose rates were omitted and deemed unreliable due to large sampling errors. The DMHC conducts further investigation into the issues or potential discrepancies identified during its review by requesting health plans provide an explanation for the discrepancy or engage in corrective action, where appropriate, to ensure that any discrepancies are corrected in future reporting years.

Erroneous compliance calculations: Compliance calculation errors include:

- Calculations from raw data did not exactly match rates calculated by the health plan for a county or provider type. Some health plans reported raw data that did not match calculated rates, but the compliance calculation errors did not show a specific bias and were determined to be non-substantive. This error led to a four-percentage point difference in the reported urgent appointment rate for one health plan, Positive Healthcare. This rate, however, was also impacted by the omission of plan partner providers from HAI-CA in Positive Healthcare's

[19] 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.

results (see below), and the impact of the error would have been smaller with the inclusion of HAI-CA providers.

- Omitting a holiday from the health plan's determination of whether an appointment fell within the 10 or 15 business day appointment wait time standard. The holiday omission error led to health plans identifying some appointments as non-compliant when the appointment was compliant with the wait time standard. Though health plans had this error, it accounted for a negligible share of appointments. Thus, this error was deemed to have little impact on rates.

<u>De-duplication errors</u>:

- De-duplication errors occurred as a result of health plans not properly de-duplicating providers to a single location in a county when providers had multiple locations, when duplicated records in the raw data were not properly accounted for in the results, or by the inclusion of individual-level identifiers for facility-level provider types. 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. Health Net Community Solutions and its plan partner, Molina Healthcare of California, reported duplicate results for the Molina-LA network. Inclusion of the duplicate results would have given the Molina-LA network disproportionate weight in the calculation of health plan-level rates, so duplicate records were removed prior to calculation of rates of compliance for Health Net Community Solutions.

<u>Survey timing</u>:

- Some health plans erred in the timing of the survey by failing to conduct two distinct surveys with at least a three-week separation. For health plans that did not allow a three-week separation between surveys, it was determined that the timeframe for the survey provided a sufficient representation of appointments over time.

<u>Omission of results for certain networks</u>:

- In some cases, health plans failed to report results for certain provider networks which may result in the rates of compliance not accurately reflecting the composition of providers available to the health plan's enrollees. HAI-CA failed to report results for psychiatrists and non-physician mental health care providers for two out of its three networks subject to the timely access survey. As a result, the rates for two of HAI-CA's contracting plan-partners, Positive Healthcare and Western Advantage Health, do not reflect the accurate composition of providers available to their enrollees. To the extent that the rates for the omitted networks differ from the one network (301) submitted by HAI-CA, the rates presented for HAI-CA may not accurately reflect their overall health plan rate. Using the rates for the HAI-CA's 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 Western Advantage Health; however, the omission likely had a substantive impact on rates and sampling errors calculated for Positive Healthcare.

- Some subcontracted plans[20] reported results for a network on behalf of its plan partner(s), but the subcontracted plan did not have enrollment for this network and did not submit this same network on its own behalf. The networks reported by the subcontracted plan on behalf of the plan partners are identified in the accompanying timely access data with an asterisk in the Health Plan ID field.

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 the 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.

[20] A subcontracted plan is a Knox Keene Act licensed health plan that is contracted with another a Knox Keene Act licensed health plan (primary health plan). The contract allows the primary plan's enrollees access to the subcontracted plan's network providers.

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.	
AIDS Healthcare Foundation	Positive Healthcare
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	
California Health and Wellness Plan	CA Health and Wellness
California Physicians' Service	Blue Shield of California
CHG Foundation	Community Health Group Partnership Plan
Chinese Community Health Plan	
Cigna HealthCare of California, Inc.	
Community Care Health Plan, Inc.	
Contra Costa County Medical Services	Contra Costa Health Plan
County of Ventura	Ventura County Health Care 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 Benefits Plan of California	
UnitedHealthcare Community Plan of California, Inc.	
Western Health Advantage	
Behavioral Health	
Beacon Health Options of California, Inc.	Beacon of California
Evernorth 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	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.	76%	85%	66%	*	*	*	*	*	*	76%	85%	66%
Aetna Health of California Inc.	81%	89%	72%	81%	89%	72%	*	*	*	*	*	*
Alameda Alliance For Health	90%	95%	85%	*	*	*	*	*	*	90%	95%	85%
Alameda Alliance Joint Powers Authority	72%	80%	64%	72%	80%	64%	*	*	*	*	*	*
Anthem Blue Cross	81%	89%	72%	82%	89%	74%	79%	89%	70%	*	*	*
Blue Cross of California Partnership Plan, Inc.	75%	90%	60%	*	*	*	*	*	*	75%	90%	60%
Blue Shield of California	82%	90%	73%	82%	90%	73%	82%	90%	73%	*	*	*
Blue Shield of California Promise Health Plan	84%	92%	77%	*	*	*	*	*	*	84%	92%	77%
CA Health and Wellness	66%	83%	49%	*	*	*	*	*	*	66%	83%	49%
CalViva Health	76%	84%	68%	*	*	*	*	*	*	76%	84%	68%
Central California Alliance for Health	79%	82%	76%	79%	82%	76%	*	*	*	*	*	*
Chinese Community Health Plan	53%	69%	35%	53%	69%	35%	53%	69%	35%	*	*	*
Cigna HealthCare of California, Inc.	81%	89%	74%	81%	89%	74%	*	*	*	*	*	*
Community Care Health Plan, Inc.	81%	87%	75%	81%	87%	75%	*	*	*	*	*	*
Community Health Group Partnership Plan	98%	98%	97%	*	*	*	*	*	*	98%	98%	97%
Contra Costa Health Plan	90%	95%	85%	89%	95%	84%	*	*	*	90%	95%	85%
Health Net Community Solutions, Inc.	82%	90%	73%	*	*	*	*	*	*	82%	90%	73%
Health Net of California, Inc.	81%	89%	72%	81%	89%	72%	80%	88%	72%	*	*	*
Health Plan of San Mateo	84%	91%	77%	47%	61%	33%	*	*	*	88%	95%	82%
IEHP	81%	93%	70%	*	*	*	*	*	*	81%	93%	70%
Kaiser Permanente	85%	94%	76%	85%	93%	76%	85%	93%	76%	85%	95%	76%
Kern Health Systems	81%	93%	68%	*	*	*	*	*	*	81%	93%	68%
L.A. Care Health Plan	83%	91%	75%	*	*	*	86%	89%	82%	82%	92%	73%
L.A. Care Health Plan Joint Powers Authority	86%	89%	83%	86%	89%	83%	*	*	*	*	*	*
MemorialCare Select Health Plan	79%	89%	68%	79%	89%	68%	*	*	*	*	*	*
Molina Healthcare of California	81%	89%	74%	*	*	*	83%	90%	76%	80%	89%	71%
Oscar Health Plan of California	79%	86%	73%	80%	85%	74%	79%	86%	73%	*	*	*
San Francisco Health Plan	89%	95%	84%	86%	91%	81%	*	*	*	90%	96%	84%
Santa Clara Family Health Plan	89%	95%	83%	*	*	*	*	*	*	89%	95%	83%
Scripps Health Plan Services, Inc.	79%	87%	71%	79%	87%	71%	*	*	*	*	*	*
Sharp Health Plan	86%	92%	81%	86%	92%	81%	86%	92%	80%	*	*	*
Sutter Health Plus	78%	87%	70%	78%	87%	70%	78%	87%	70%	*	*	*
The Health Plan of San Joaquin	90%	96%	85%	*	*	*	*	*	*	90%	96%	85%
UnitedHealthcare Benefits Plan of California	82%	89%	74%	82%	89%	74%	*	*	*	*	*	*
UnitedHealthcare Community Plan of California, Inc.	79%	88%	68%	*	*	*	*	*	*	79%	88%	68%
UnitedHealthcare of California	82%	90%	74%	82%	90%	74%	*	*	*	*	*	*
Valley Health Plan	73%	84%	61%	72%	84%	61%	*	*	*	*	*	*
Ventura County Health Care Plan	79%	86%	72%	79%	86%	72%	*	*	*	*	*	*
Western Health Advantage	68%	84%	52%	68%	84%	52%	68%	84%	52%	*	*	*

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
Beacon of California	78%	88%	68%	78%	88%	68%	*	*	*	*	*	*
Evernorth Behavioral Health of California, Inc.	79%	87%	72%	79%	87%	72%	*	*	*	*	*	*
HAI-CA	75%	86%	64%	75%	86%	64%	75%	86%	64%	*	*	*
Holman Professional Counseling Centers	77%	83%	70%	77%	83%	70%	*	*	*	*	*	*
Managed Health Network	76%	85%	66%	76%	85%	66%	*	*	*	*	*	*
OptumHealth Behavioral Solutions of California	79%	87%	71%	79%	86%	71%	79%	87%	72%	70%	86%	54%

* The 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.