



Timely Access Report

Measurement Year 2015

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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. Based on the widespread inaccuracy of the timely access compliance data health plans submitted to the Department of Managed Health Care (DMHC), the DMHC is unable to determine whether health plans met this responsibility during 2015.

To demonstrate compliance, health plans submit annual reports to the DMHC and attest to the completeness and accuracy of the information submitted under penalty of perjury.¹ The DMHC reviews the compliance reports, issues findings regarding the data and makes recommendations for changes that will better protect California consumers.

Ninety percent of 2015 Timely Access Compliance Reports submitted to the DMHC contained one or more significant data inaccuracies, making it virtually impossible for the DMHC to measure individual health plan compliance and compare plans across the industry. The data errors and inaccuracies uncovered by the DMHC are discussed in this report. While some data errors can be attributed to a lack of attention to detail or a failure to accurately perform basic mathematical calculations, several of the issues involve failure by health plans to follow the mandatory DMHC methodology, which is required by law. Other significant data errors appear to have been caused by work performed by a single vendor hired by numerous health plans to gather data and prepare compliance reports. Twenty-two health plans that used this vendor submitted deficient compliance reports, several of which included information concerning thousands of primary care physicians and specialists who were not under contract with the health plan and who did not participate in the plan's network.

The DMHC will take immediate steps to correct these deficiencies and ensure that health plans submit accurate data in all future compliance reports. In February 2017, the DMHC will hold an all-stakeholder meeting to discuss steps that must be taken by health plans to ensure that 2016 compliance data submitted to the DMHC in March 2017 is validated and accurate.

Health plans that failed to follow the mandatory DMHC methodology or submitted inaccurate or erroneous data in connection with 2015 compliance reports violated California's health plan law, known as the Knox-Keene Act. The DMHC's Office of Enforcement will be investigating these plans for possible disciplinary action.

The DMHC remains committed to taking regulatory action to ensure that California's health plan industry fully complies with the Timely Access laws and regulations.

Introduction and Background

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

Under California law, health plans are required to make sure that consumers have ready access to all services covered under their health plan contract. For this to occur, consumers must be able to see their health plan doctor and other plan providers within a timeframe that is appropriate, based on the consumer's clinical condition. To ensure access to care, health plans must maintain networks with providers who have enough appointment availability to meet the needs of all plan members. The DMHC monitors health plans to ensure that all networks have:

- The right types of doctors, specialists and other providers;
- Enough providers to serve the overall plan population;
- Providers located within reasonable distances from where consumers live and work; and
- Providers who have enough appointment availability to meet the requirements of California's Timely Access laws and regulations.

Timely Access Regulations

The Timely Access regulations² became effective seven years ago in January 2010. They require health plans to maintain provider networks sufficient to ensure that consumers can get appointments within appropriate timeframes, based on each individual's specific clinical condition, and no later than:

Appointment Type	Timeframe
Urgent Care (prior authorization <u>not</u> required by health plan)	48 hours from request
Urgent Care (prior authorization required by health plan)	96 hours from request
Non-Urgent Doctor Appointment (primary care physician)	10 business days
Non-Urgent Doctor Appointment (specialty physician)	15 business days
Non-Urgent Mental Health Appointment (non-physician [^])	10 business days
Non-Urgent Appointment (ancillary provider ^{^^})	15 business days

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

^{^^} Examples of a non-urgent appointment for ancillary services include lab work or diagnostic testing, such as a mammogram or MRI, or treatment of an illness or injury such as physical therapy.

To ensure that these appointment timeframes are met on a consistent basis, each health plan must monitor its own network, measure appointment availability and submit compliance reports to the DMHC each year by March 31.

The DMHC has provided considerable assistance to California health plans with regard to implementation of the Timely Access laws and regulations. After developing the Timely Access regulations, the DMHC devoted significant time and resources so that California's health plan industry could grow and develop in this new area, and allow plans to develop provider networks that maintain appointment availability required under the law. Among other things, DMHC efforts have included:

- Reviewing and providing feedback regarding health plan policies and procedures;
- Creating standardized methodologies and forms for use by health plans;
- Holding annual stakeholder meetings to gather feedback from plans, providers and consumers;
- Conducting hundreds of webinars, both industry-wide and for individual health plans;
- Reviewing annual Timely Access Compliance Reports; and
- Taking enforcement action against health plans that failed to comply with the law.

Timely Access Compliance Reports submitted by California health plans during the first four years of the process (2011-2014) were not useful in determining individual health plan compliance or comparing plans across the industry, due to variation in the techniques or methods used by different health plans when gathering data and measuring compliance. In 2015, following a change to the law, the DMHC created a mandatory methodology that all health plans are required to follow when gathering data, measuring compliance and submitting annual reports.³

The Timely Access regulations also require health plans to ensure that enrollees have access to timely services through the following additional protections:



Health plans are required to provide (or arrange for the provision of) telephone triage or screening services on a 24/7 basis, through which patients can obtain timely assistance in determining the urgency of their condition, including a return call within a reasonable timeframe, not to exceed 30 minutes.



During normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed 10 minutes.



Interpreter services shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment.

Timely Access Compliance Reports

As noted above, California law requires health plans to submit Timely Access Compliance Reports no later than March 31 each year. The DMHC reviews the compliance information, makes recommendations for changes that further protect enrollees, and posts its final findings on the DMHC website.⁴

Annual compliance reports submitted by health plans include two primary categories of information:

- The plan's Compliance Report, which reports performance under the six time-elapsed appointment availability standards; and
- The plan's Provider Roster, which lists all providers who were in the plan's network as of December 31 of the prior calendar year.⁵

The Health Industry Collaboration Effort, Inc. ("ICE")⁶ played a significant role in 2015 health plan Compliance Reports, as it facilitated services from an external vendor ("the ICE Vendor") that 24 health plans utilized to gather data and prepare Compliance Reports.

The DMHC reviewed and assessed Timely Access Compliance Reports submitted by 40 health plans for Measurement Year 2015.⁷ In addition, data for the reporting plans was compiled and analyzed.

As part of its review of the Compliance Reports, the DMHC issued nearly 150 comments to health plans regarding inaccurate data and other data issues that were identified. The DMHC also contacted ICE with questions regarding data for primary care and specialist physicians for health plans that utilized the ICE Vendor. Despite the DMHC's significant efforts, health plans did not correct many of these data-related issues.

Findings for Measurement Year 2015

Timely Access Compliance Reports submitted by health plans for 2015 contained extensive and unacceptable data inaccuracies regarding network providers and voluminous data errors regarding rates of compliance. In addition, the reports illustrated numerous instances in which health plans failed to follow the mandatory methodology published by the DMHC.

The DMHC is frustrated by the lack of commitment by California's health plan industry to comply with the Timely Access laws and regulations through the submission of accurate annual compliance data. As noted above, prior to issuing its findings as set forth in this report, the DMHC issued nearly 150 comments to health plans regarding data errors and allowed plans to correct data issues whenever possible.

Figures A and B (shown on the next two pages) identify the DMHC's findings regarding the data issues, broken down by category and by individual health plan. Only four health plans submitted data without identifiable errors: Community Health Group (full service), Inland Empire Health Plan (full service), Human Affairs International of California (specialized behavioral health) and Managed Health Network (specialized behavioral health).

Figure A: Data Errors for MY 2015 – Full Service Health Plans

(Health plans that utilized ICE are noted in blue.)

	Health Plan Name	Failure to Use DMHC Template	Did Not Separate Data by Line of Business	Completed Some Survey Questions in Wrong Year	Omitted a Significant Number of Providers from the Survey Sample	Failed to Submit Data for One or More Provider Types	Erroneous Compliance Calculations	Significant Inflation in Number of Specialists	Submitted Data for Specialists Not in Plan (>20% Variance)	Submitted Data for PCPs Not in Plan (>20% Variance)	Totals
1	Aetna Health of California, Inc.		X				X	X	X	X	5
2	Alameda Alliance for Health	X	X						X		3
3	Blue Cross of California (Anthem Blue Cross)								X	X	2
4	Blue Cross of CA Partnership Plan					X					1
5	California Physicians' Service (Blue Shield of California)		X							X	2
6	California Health and Wellness Plan (CA Health & Wellness)								X	X	2
7	Care 1st Health Plan				X				X	X	3
8	Chinese Community Health Plan					X					1
9	Cigna HealthCare of California, Inc.					X			X	X	3
10	Community Care Health Plan, Inc.		X			X			X		3
11	Community Health Group										0
12	Contra Costa County Medical Services (Contra Costa Health Plan)					X			X	X	3
13	County of Ventura (Ventura County Health Care Plan)					X				X	2
14	Fresno-Kings-Madera Regional Health Authority (CalViva Health)									X	1
15	Health Net Community Solutions, Inc.		X				X		X	X	4
16	Health Net of California, Inc.		X				X				2
17	Inland Empire Health Plan (IEHP)										0
18	Kaiser Foundation Health Plan, Inc. (Kaiser Permanente)		X								1
19	Kern Health Systems					X	X		X	X	4
20	Local Initiative Health Authority For L.A. County (L.A. Care Health Plan)				X	X					2
21	Molina Healthcare of CA Partner Plan, Inc.		X				X				2
22	Partnership HealthPlan of California					X	X				2
23	San Francisco Community Health Authority						X		X	X	3
24	San Joaquin County Health Commission (The Health Plan of San Joaquin)			X		X			X		3
25	San Mateo Health Commission (Health Plan of San Mateo)	X		X							2
26	Santa Barbara San Luis Obispo Regional Health Auth (CenCal Health)	X									1
27	Santa Clara County (Valley Health Plan)	X					X				2
28	Santa Clara County Health Authority (Santa Clara Family Health Plan)	X					X				2
29	Santa Cruz-Monterey-Merced Managed Med. Care Comm. (Central California Alliance for Health)					X					1
30	Seaside Health Plan					X	X				2
31	Sharp Health Plan		X								1
32	Sutter Health Plan (Sutter Health Plus)					X					1
33	UHC of California (UnitedHealthcare of California)					X			X	X	3
34	Western Health Advantage	X									1
Totals		6	9	2	2	14	10	1	13	13	70

Figure B: Data Errors for MY 2015 – Behavioral Health Plans

Health Plan Name		Failed to Submit Data for One or More Provider Types	Erroneous Compliance Calculations	Totals
1	Avante Behavioral Health Plan		X	1
2	Cigna Behavioral Health of California, Inc.	X	X	2
3	Holman Professional Counseling Centers		X	1
4	Human Affairs International of California (HAI-CA)			0
5	Managed Health Network			0
6	U.S. Behavioral Health Plan, California (OptumHealth Behavioral Solutions of California)		X	1
Totals		1	4	5

Despite the DMHC's significant efforts during the past seven years to assist health plans in complying with California's Timely Access laws and regulations, 90 percent of reporting health plans (36 out of 40) failed to submit accurate Timely Access compliance data for 2015 or failed to follow the mandatory methodology. The DMHC cannot determine (or report to the public) how many health plans did (or did not) comply with the appointment availability requirements, due to the failure by nearly every plan within the industry to submit accurate compliance data. This undermines the purpose of the Timely Access laws and regulations, which require an annual review of health plan networks for the express purpose of determining whether consumers can see their doctors to obtain medically necessary services on a timely basis.

The Office of Enforcement will investigate all health plans that violated the law by failing to submit accurate compliance data for 2015 as required under the Knox-Keene Act and/or in accordance with the requirements of the standardized DMHC methodology.

Additional details regarding the DMHC's findings for 2015 are set forth below.

1. Ninety Percent of Health Plans Submitted Inaccurate Data

As noted above, 90 percent of reporting health plans submitted inaccurate data and/or failed to follow the mandatory DMHC methodology. The DMHC finds the apparent lack of commitment by health plans in this critical area of consumer protection to be gravely disconcerting. The data submitted by health plans for 2015 contains so many errors that it is virtually impossible to draw conclusions regarding individual health plan compliance and performance across the industry.

The voluminous data issues, set forth in Findings 5-13 below, significantly impaired the DMHC's ability to make substantive compliance determinations regarding individual health plan performance, compare plans across the industry and complete accurate outlier analysis.

2. The ICE Vendor Contributed to Data Inaccuracies Concerning Providers

In response to inquiries from the DMHC, ICE indicated that its vendor may be responsible for some of the significant data inaccuracies related to primary care physicians ("PCPs" - see discussion concerning this data, below.) In its message, ICE stated:

"ICE worked with the vendor to prepare separate PPO-only compliance reports for CDI, but did not think to remove the PPO-only provider results from the HMO results for the DMHC TAR filing. Therefore, there may have been PCP results listed in the raw survey data that were not a part of the plan's DMHC HMO network as confirmed by United and [Blue Shield of California]."⁸

This comment also suggests that some health plans did not review and validate data contained in Timely Access Compliance Reports prepared for the plan by the ICE vendor prior to attestation and submission of those reports to the DMHC. It would appear that these plans do not have adequate processes in place to assure quality and accuracy of Timely Access Compliance data. This point is reinforced by the following response to a DMHC inquiry concerning PCP data that was issued by a representative of Aetna Health of California, Inc.:

"... [I] was advised that both documents in question here (both the raw data and the rolled up Survey Results) were provided to all Health Plans by the ICE vendor. Aetna did not create these documents; we received them from the vendor a few days prior to the DMHC due date. We have contacted the vendor to advise them of the errors..."⁹

3. Data Issues Identified by the DMHC Were Not Rectified

During the process of reviewing Timely Access Compliance Reports submitted for 2015, the DMHC issued nearly 150 comments to health plans regarding data inaccuracies. However, despite significant efforts to get the plans to correct the data, a number of the data-related issues were not corrected. In some cases, the errors were not correctable, as they resulted from non-compliant methods utilized by health plans or their vendors when gathering data and measuring compliance. Making matters worse, a significant number of the provider-related data errors involved situations where health plans reported appointment availability and compliance data for providers who were not part of the health plan's own network.

4. Health Plans Submitted Compliance Data for PCPs Not in Their Network

Timely Access Compliance Reports submitted by 13 health plans list a significant number of PCPs who were not in the health plan's provider network, according to information contained in Provider Rosters submitted by the same health plans on the same date.

Compliance Reports identify providers within the plan's network and list results from the plan's appointment availability survey. Provider Rosters list all providers (including all PCPs) who were part of the plan's network, as of December 31 of the prior year. Both reports are filed with the DMHC on March 31. The reports should be consistent with one another, with small variances accounting for providers who either joined the network or left the network during the period of time between when the data for the two reports is assembled by the health plan.

As part of its review process, the DMHC compared the identity of PCPs in Compliance Reports and Provider Rosters by first name, last name and National Provider Identifier. The DMHC concluded that Compliance Reports submitted by 13 plans listed a significant percentage of PCPs who were not actually part of the health plan's own network of providers, based on the information provided by the plan through its Provider Roster.

Figures C and D provide details regarding the submission of compliance data for PCPs who were not part of the health plan's network, broken down by number and percentage.

Figure C

Number of PCPs in Compliance Report Not Listed Within the Plan's Provider Roster

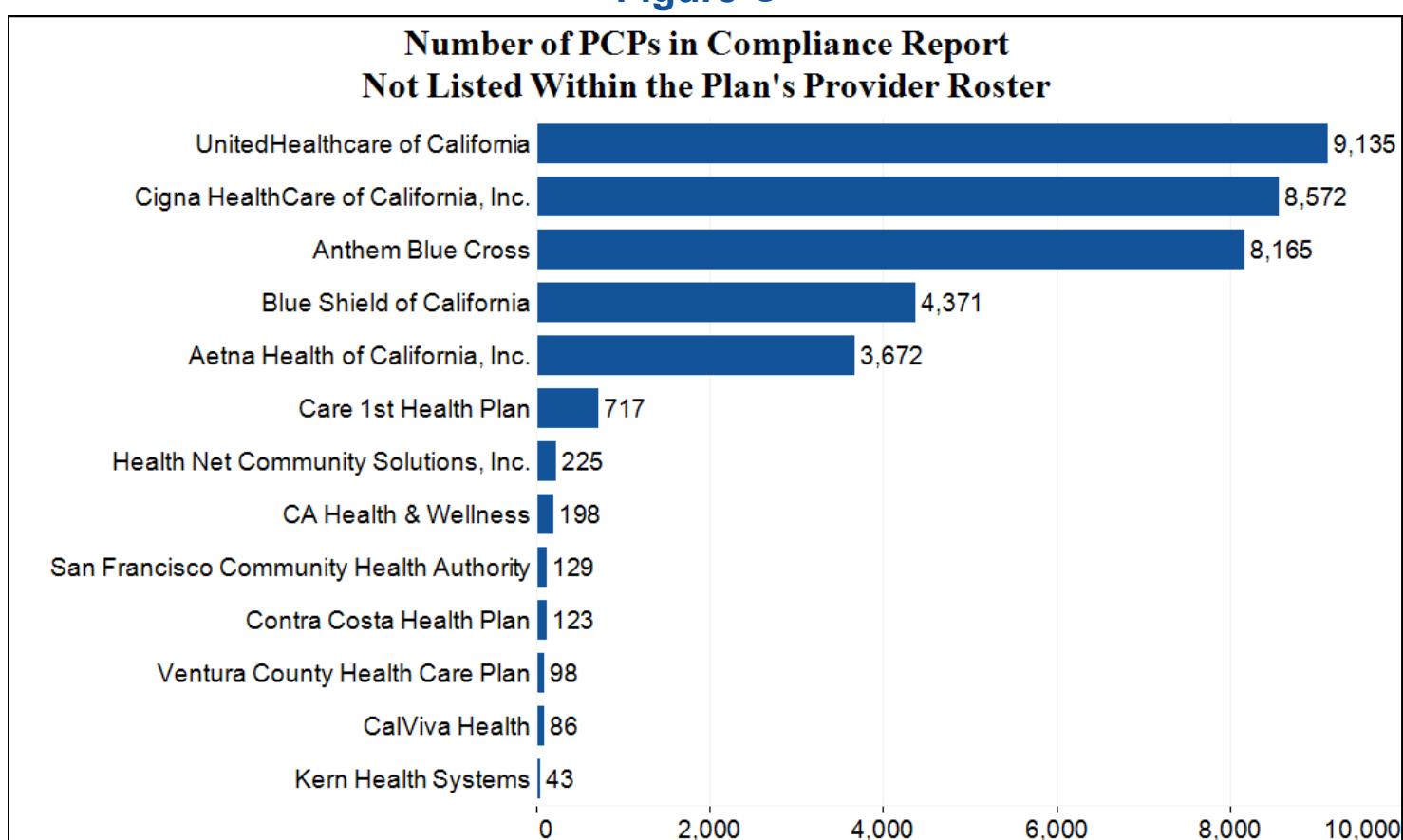
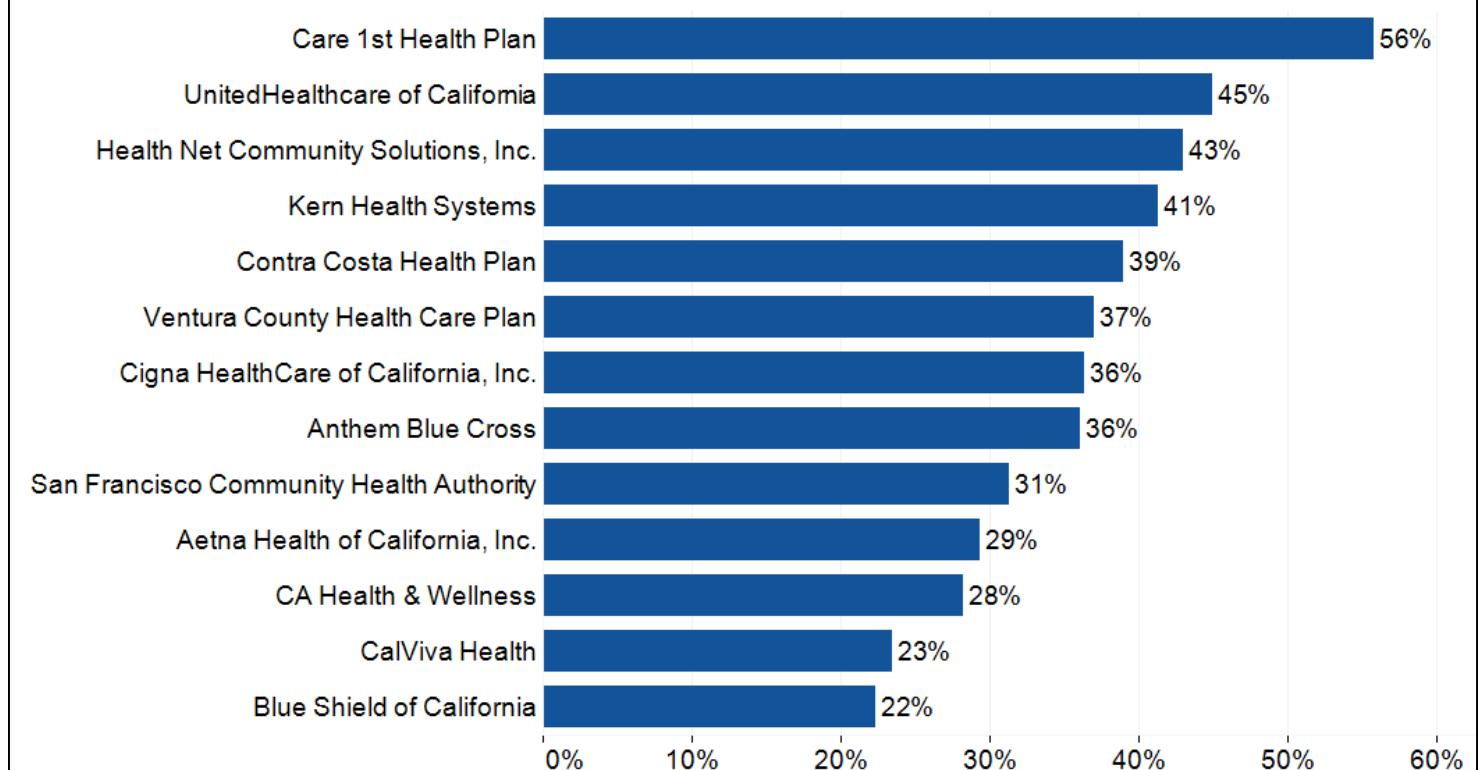


Figure D

Percentage of PCPs in Compliance Report Not Listed Within the Plan's Provider Roster



5. Health Plans Submitted Compliance Data for Specialists Not in Their Network

Similar to the issue with PCPs, Timely Access Compliance Reports submitted by 13 health plans list a significant number of specialty physicians who were not in the health plan's provider network, according to information contained in Provider Rosters submitted by the same health plans on the same date.

As part of its review process, the DMHC compared the identity of specialty physicians in Compliance Reports and Provider Rosters by first name, last name and National Provider Identifier. The DMHC concluded that Compliance Reports submitted by 13 plans listed a significant percentage of specialty physicians who were not actually a part of the health plan's own network of providers, based on the information provided by the plan with its Provider Roster.

Figures E and F provide details on the compliance data for specialty physicians who were not part of the health plan's network, broken down by number and percentage.

Figure E

Number of Specialists in Compliance Report Not Listed Within the Plan's Provider Roster

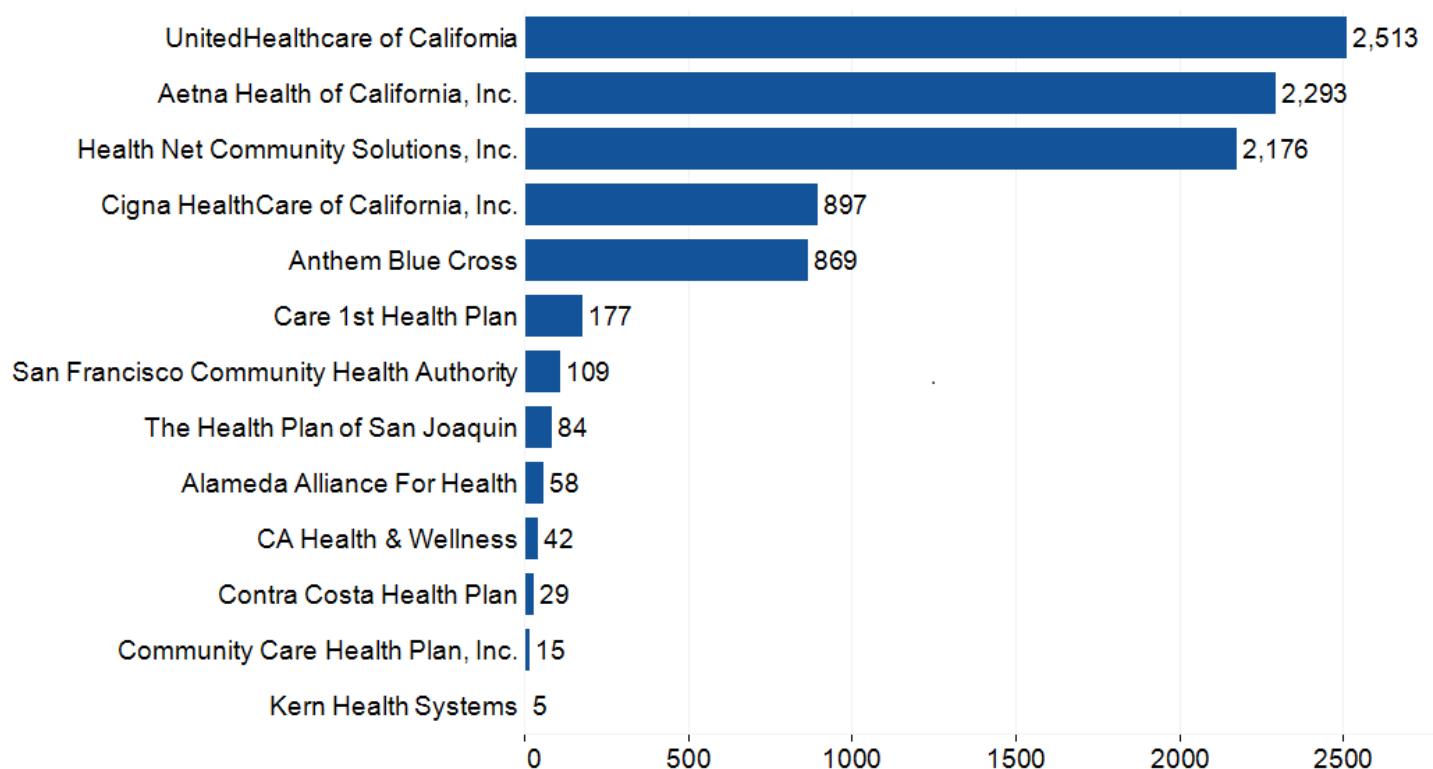
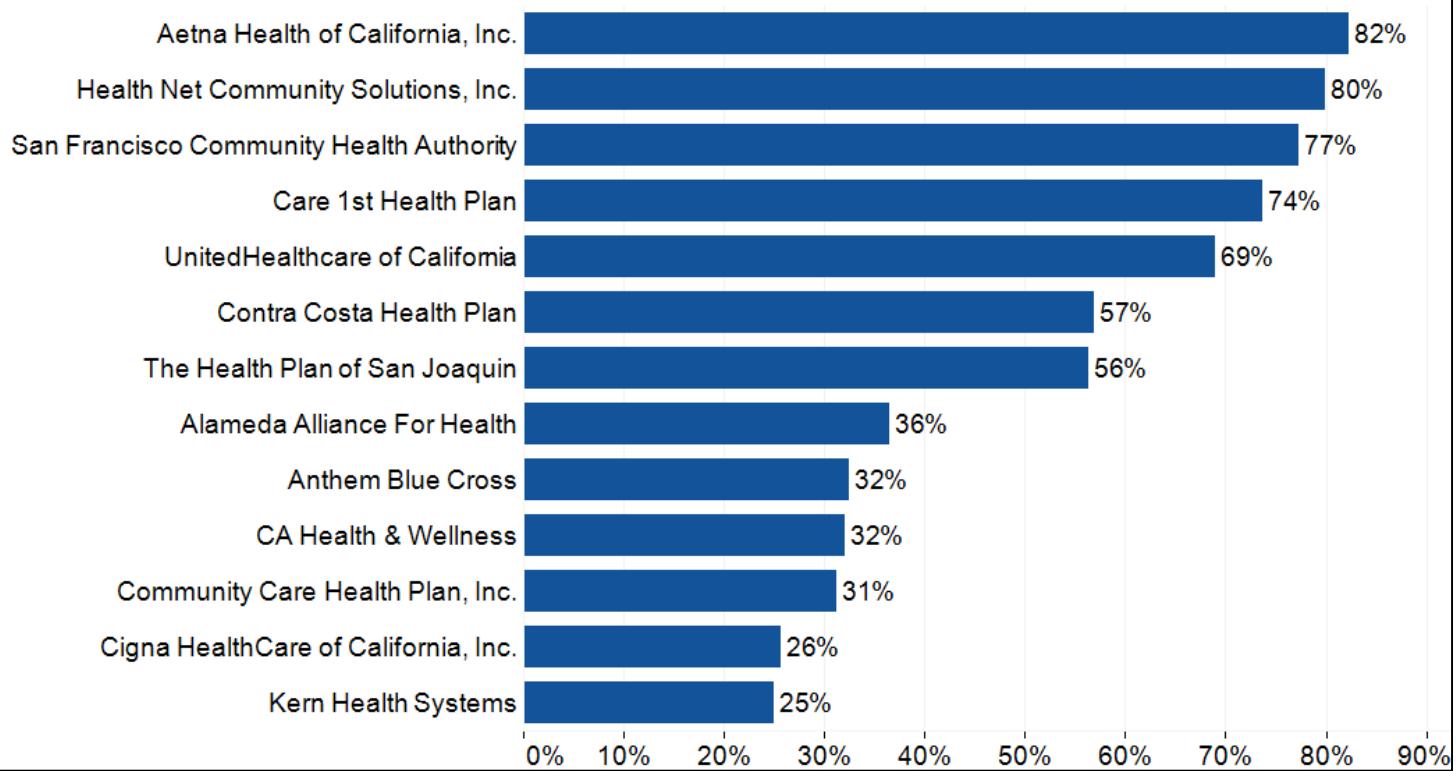


Figure F

Percentage of Specialists in Compliance Report Not Listed Within the Plan's Provider Roster



6. One Health Plan Significantly Overinflated Data for Network Specialists

For 2015, health plans were required to report appointment availability for contracted cardiologists, dermatologists and allergists.

The 2015 compliance report submitted by Aetna Health of California, Inc. indicated that its provider network contained more than 30,000 contracted cardiologists, dermatologists and allergists. The figures reported by Aetna Health of California, Inc. were more than three times higher than the number of specialists reported by any other health plan for those three provider types.

Although the plan's report indicated that it followed approved sampling methods set forth in the mandatory methodology, the DMHC's review indicates that, with respect to cardiologists, Aetna Health of California, Inc. reported the same groups in the same county in the same line of business more than 160 times. Adding to the confusion, the number of providers identified for the medical groups changed within and among the duplicate instances of reporting, suggesting that the information may have been obtained or accessed through different sources.

As a result, Aetna Health of California, Inc. greatly overinflated its reported specialist network. The magnitude of the error was large enough to distort all health plan data and, until discovered by the DMHC, resulted in inaccurate analysis regarding health plan outliers. Therefore, this error by Aetna Health of California, Inc. alone affected the DMHC's overall ability to evaluate and compare plans.

7. Fourteen Plans Made Errors When Calculating Compliance Rates

Fourteen health plans submitted Timely Access Compliance Reports containing compliance rate calculation errors. Health plans that failed to comply with this mandatory reporting requirement for 2015 are listed in Figures A and B on pages 7 and 8 of this report.

More than 40 of the comments the DMHC issued to plans during the review process related to compliance rate calculation errors. These errors typically involved basic mathematical issues such as:

- Compliance rates not mathematically possible (e.g., a compliance rate of 50 percent in a situation where a total of three providers were surveyed);
- Compliance rates in excess of 100 percent (not theoretically possible);
- Compliance rates with incorrect decimal placements (e.g., 0.94 percent, rather than 94 percent);
- Failures to accurately transfer the proper number of provider responses onto the compliance template (e.g., underlying plan worksheet indicates that 26 providers were surveyed, but the compliance template reports that 21 out of 24 providers rather than 21 out of 26 providers were in compliance with the time-elapsed standard); and
- Compliance rates in error because data was placed in the wrong column on the template.

These errors required the DMHC to spend significant time and resources to audit and correct data, essentially redoing the health plan's work, and thereby slowing the DMHC's review. Errors of this type strongly suggest that health plans did not allocate the resources necessary to ensure appropriate report review and submission of accurate data, data for which they are required to attest accuracy under penalty of perjury.

8. Health Plans Failed to Submit Compliance Data for Required Provider Types

The DMHC's mandatory methodology for Timely Access Compliance Reports requires health plans to submit compliance data for primary care physicians, five types of specialty physicians¹⁰ and three types of ancillary providers.¹¹ Fifteen health plans failed to submit compliance data for one or more provider types.

For example, L.A. Care Health Plan used a provider roster that did not include all providers in its network to select the sample of providers to survey. Upon inquiry L.A. Care Health Plan provided the following response:

“[The plan’s vendor change, plus its] change in the internal process for providing the provider data, along with a change in the experienced staff that was assigned to the project, caused L.A. Care to provide incorrect and incomplete data to ICE for use in the MY 2015 Data A-F and the surveys.”¹²

L.A. Care Health Plan also confirmed that it did not provide data regarding compliance in the areas of child psychiatry, physical therapy, and mammography, due to the plan’s failure to provide a complete provider roster to its vendor. This prevented the DMHC from analyzing the plan’s compliance with the Timely Access laws and/or comparing the plan’s performance across the industry.

Other health plans that failed to comply with this mandatory reporting requirement for 2015 are listed in Figures A and B on pages 7 and 8 of this report.

9. Two Health Plans Omitted a Significant Number of Providers from the Survey Sample

The DMHC's mandatory methodology for Timely Access Compliance Reports requires health plans to follow specific instructions with regard to appointment availability surveys conducted to gather Timely Access compliance data. The DMHC found that two health plans – Care 1st Health Plan and L.A. Care Health Plan – omitted a significant number of providers from the contact lists prior to conducting the appointment availability survey. As a result, the sample size of providers selected to take the survey was inadequate and did not reflect the entire network.

10. Health Plans Did Not Complete the Survey in the 2015 Calendar Year

The DMHC's mandatory methodology for Timely Access Compliance Reports requires health plans to follow specific instructions with regard to the timing of phone calls made to providers in connection with appointment availability surveys. These telephone calls must be conducted during the calendar year for which compliance results are reported.

The DMHC found that two health plans – The Health Plan of San Joaquin and Health Plan of San Mateo – submitted Timely Access Compliance Reports for 2015 in which some portion of the health plan’s appointment availability surveys were conducted during 2016, rather than during 2015. As a result, this data could not be analyzed for compliance and compared across the industry.

11. Health Plans Failed to Submit Compliance Data Separated by Line of Business

Nine health plans submitted Timely Access Compliance Reports that failed to separate compliance data by individual/family, commercial and Medi-Cal lines of business, as required by the Timely Access statute and the mandatory DMHC methodology.

Health plans that failed to correctly report data by line of business are listed in Figure A on page 7 of this report.

12. Six Health Plans Failed to Report Results Using the DMHC Template

The DMHC's mandatory methodology for Timely Access Compliance Reports requires health plans to utilize a DMHC-created standardized template for reporting rates of compliance.

Six health plans – Alameda Alliance for Health, Health Plan of San Mateo, CenCal Health, Valley Health Plan, Santa Clara Family Health Plan and Western Health Advantage – failed to use the DMHC-created template. Failure by these plans to follow the required methodology slowed the DMHC's review process, because plans had to resubmit the data using the required template.

13. Enrollee Satisfaction and Provider Perspective and Concerns Surveys Need Improvement

In addition to determining compliance rates, Timely Access Compliance Reports must include results of annual enrollee satisfaction surveys and provider perspective and concerns surveys conducted by health plans.¹³ These feedback surveys (separate from appointment availability surveys conducted to determine Timely Access compliance) must be administered using a valid and reliable survey methodology to elicit useful information regarding the plan's compliance with Timely Access standards.

The DMHC reviewed information regarding these surveys submitted in the plans' 2015 Compliance Reports.

Response rates to provider surveys varied greatly among plans, with some so low that the results are unlikely to be statistically significant. Plans that engaged in follow-up with non-responding providers tended to have better response rates. Some health plans failed to submit all information required in connection with provider perspectives surveys. In particular, several health plans failed to compare the survey results against results from the prior year.

Many plans used standardized enrollee satisfaction surveys (usually created by accreditation agencies for different purposes), which allowed comparison of plan performance against certain national benchmarks but included few questions regarding access, limiting their usefulness in assessing Timely Access concerns.

In order to provide meaningful feedback regarding appointment availability, future enrollee satisfaction and provider perspective and concerns surveys need to be standardized among health plans and administered in a more consistent manner.

Next Steps

1. If a consumer is having trouble obtaining a timely appointment with a physician or other health care provider, the DMHC strongly encourages they contact their health plan for assistance (at the toll-free number listed on the consumer's health plan ID card). If the health plan does not resolve the issue in accordance with timely access to care standards, or they are dissatisfied with the health plan's response, they should contact the DMHC Help Center for assistance at 1-888-466-2219 or www.HealthHelp.ca.gov. Additionally, if they are experiencing an imminent or serious threat to their health they can immediately contact the DMHC Help Center.
2. All health plans that violated the Knox-Keene Act by failing to submit accurate or useable 2015 compliance data or by failing to follow the mandatory DMHC methodology will be investigated by the DMHC Office of Enforcement.
3. The DMHC will require all health plans that submit annual Timely Access Compliance Reports to immediately take all steps necessary to ensure that the plan has the administrative capacity to gather compliance data in accordance with the mandatory methodology, validate compliance data and identify and rectify compliance data errors so that all future compliance reports submitted to the DMHC are accurate.
4. In February 2017, the DMHC will hold an all-stakeholder meeting to discuss the following:
 - The immediate steps the health plans will take to validate compliance data and ensure the accuracy of Timely Access Compliance Reports for 2016 that must be filed with the DMHC no later than March 31, 2017;
 - Future process changes that health plans will make to ensure compliance with the mandatory DMHC methodology;
 - The need for a DMHC-approved monitor or data validator that would oversee health plan compliance prior to the submission of 2016 data to the DMHC;
 - Increased health plan oversight of the vendors utilized to gather data, conduct surveys and prepare Timely Access Compliance Reports;
 - Recommendations for changes to the existing appointment availability survey methodology or other steps that will enable more accurate gathering and reporting of compliance data; and
 - Additional issues related to appointment availability surveys or validation of compliance data for 2016 and 2017.
5. For 2017, the DMHC will direct the plans to use a DMHC approved vendor to conduct surveys of providers to determine appointment availability.

Next Steps (continued)

6. The DMHC will require all health plans that contract with an external vendor for Timely Access data gathering, report preparation or other compliance activity to file a copy of the vendor agreement with the DMHC no later than March 31, 2017. With this filing, each health plan will be required to provide details regarding the functions that are delegated to the vendor, the process by which the plan oversees the vendor and identify the specific plan representative(s) responsible for overseeing the vendor.
7. Given the significant data errors and issues in 2015 Timely Access Compliance Reports submitted by health plans that utilized the ICE vendor, the DMHC will not allow the health plans to use the ICE vendor.
8. The DMHC has determined that moving to a mandatory audit-style methodology for Timely Access Compliance Reports is not feasible for 2018, because the information needed for that type of methodology is not currently collected by health plans or medical groups, and it would be too resource intensive to change systems and processes to collect audit-style data by that time. The DMHC has significant concerns regarding the ability of California's health plan industry to collect Timely Access compliance data through a system-wide audit-style methodology when so many health plans have been unable to submit accurate compliance data for the currently established survey-style methodology.

Therefore, the DMHC will require health plans to employ much more stringent oversight of the survey data gathering and data reporting process with the goal of obtaining complete, accurate data on plans' compliance with timely access requirements.

Conclusion

The serious and significant failure by California's health plan industry to ensure gathering and submission of accurate Timely Access compliance data has forced the DMHC to take steps to protect California consumers and ensure access to care as required under the law.

California's health plan industry must immediately secure all resources necessary to gather data in accordance with the mandatory DMHC methodology and accurately report compliance in all future reports. Plans that do not comply will be subject to enforcement action.

Providing timely access to health care services is a fundamental responsibility of health plans. The DMHC remains committed to taking regulatory action to ensure that California's health plan industry fully complies with the Timely Access laws and regulations.

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 more than 1.7 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.

Endnotes

Note: The Knox-Keene Act is codified at California Health and Safety Code (HSC) § 1340 et seq. The regulations promulgated from the Knox-Keene Act are codified at Title 28 of the California Code of Regulations (CCR) § 1000 et seq.

¹ HSC § 1396

² 28 CCR § 1300.67.2.2

³ Under the DMHC's mandatory methodology for 2015, health plans made a choice to use either the "survey" approach (providers contacted regarding future appointment availability) or the "audit" approach (review of past appointments to determine timeframe compliance.) All health plans other than Kaiser Permanente chose the "survey" approach. Kaiser Permanente chose to use the "audit" approach for its large number of integrated system providers and the "survey" approach for its smaller number of external providers.

⁴ HSC § 1367.03(i)

⁵ The Provider Roster (also referred to by the DMHC as the "Timely Access Provider Network Report") submitted by each health plan is used by the DMHC in its annual review of health plan networks conducted pursuant to HSC § 1367.035(d).

⁶ On its website, ICE describes itself as "a volunteer, multi-disciplinary team of providers, health plans, associations, state and federal agencies and accrediting bodies working collaboratively to improve health care regulatory compliance through education of the public. (www.iceforhealth.org)

⁷ The DMHC's Timely Access methodology uses the term "Measurement Year" because compliance during the previous calendar year is reported no later than March 31 of the subsequent year. To avoid confusion, this report simply refers to calendar years when discussing health plan compliance.

⁸ October 28, 2016 email message to the DMHC from ICE Administrator.

⁹ September 23, 2016 email message to the DMHC from Compliance Lead, Aetna Health of California, Inc.

¹⁰ The five types of specialist included for 2015 were Cardiologist, Dermatologist, Allergist, Psychiatrist and Child Psychiatrist.

¹¹ The three types of ancillary included for 2015 were MRI, Mammography and Physical Therapy.

¹² July 26, 2016 Timely Access Web Portal communication to the DMHC from Staff Counsel I, L.A. Care Health Plan.

¹³ 28 CCR § 1300.67.2.2(d)(2)

