DEPARTMENT OF
Managed
HealthCare

Timely Access Report

Measurement Year 2017

1-888-466-2219

HAVE A PROBLEM WITH YOUR HEALTH PLAN? CONTACT THE DMHC

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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 among a health plan's fundamental duties to its enrollees. This report summarizes provider appointment availability data health plans submitted to the Department of Managed Health Care (DMHC) for Measurement Year (MY) 2017. The charts within this report show provider responses to appointment availability requests.

The DMHC required full service health and behavioral health plans to utilize external vendors to validate the health plans' Timely Access data and conduct a quality assurance review of their MY 2017 Timely Access Compliance Reports (compliance reports) prior to submitting them to the DMHC, a requirement that was first implemented for MY 2016. While MY 2017 data underwent this same quality assurance review to improve data quality, the DMHC found some data errors in MY 2017 data that health plans were unable to correct. Although these errors limit some of the possible data representations, the DMHC was able to compare MY 2017 data across health plans at a more granular level than for previously reported MY data. As a result, the DMHC expanded the number of charts in this MY 2017 report and displayed data by product for the first time (Commercial, Individual/ Family and Medi-Cal).

While the DMHC was able to compare MY 2017 data across health plans at a more granular level than for previously reported MY data, the DMHC will continue to require health plans to improve data quality to make timely access reporting more reliable, while also providing more detailed comparisons of the data. Health plans must still further improve the accuracy and completeness of their timely access compliance data. For MY 2017 data, some health plans continued to have issues with following the mandatory methodology, completing all of the required surveys, and achieving an acceptable statistical sample of surveyed providers.

Ensuring health plans provide timely access to health care services is one of the DMHC's highest priorities. The DMHC continues to work with stakeholders, including health plans, providers, associations and consumer advocates to refine the provider survey methodology and develop an acceptable rate of compliance for provider appointment wait times. Furthermore, the DMHC is taking the necessary steps to have mandatory methodologies for measuring compliance with the timely access standards and the acceptable rate of compliance included in regulation so that compliance results are comparable year over year.

Key Survey Findings for Full Service Health Plans:

- The percentage of all surveyed providers who had appointments available within the wait time standards (urgent and non-urgent) ranged from a high of 99 percent to a low of 63 percent (Chart 1).
- For non-urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 99 percent to a low of 70 percent (Chart 5).
- For urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 99 percent to a low of 52 percent (Chart 9).

Key Survey Findings for Behavioral Health Plans:

- The percentage of all surveyed providers who had appointments available within the wait time standards (urgent and non-urgent) ranged from a high of 83 percent to a low of 64 percent (Chart 13).
- For non-urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 87 percent to a low of 71 percent (Chart 17).
- For urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 80 percent to a low of 57 percent (Chart 21).

Key Audit Findings for Full Service Health Plan, Kaiser Permanente[1]:

- The percentage of all audited providers meeting appointment wait time standards across all provider types and appointment types (urgent and non-urgent) was 92 percent (Chart 25).
- The percentage of all audited providers meeting non-urgent appointment standards was 91 percent (Chart 29).
- The percentage of all audited providers meeting urgent appointment standards was 98 percent (Chart 33).

Introduction and Background

Created by consumer sponsored legislation in 1999, the 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 Department protects the health care rights of more than 26 million Californians by regulating health care service plans, assisting consumers through a consumer Help Center, educating consumers on their rights and responsibilities, and preserving the financial stability of the managed health care system. Within the provisions of the Knox-Keene Act, health plans are required to make all services readily available at reasonable times to each enrollee consistent with good professional practice and within the timely access standards.

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

Appointment Type	Time Frame
Urgent Care (Prior authorization not required by health plan)	48 hours
Urgent Care (prior authorization required by health plan)	96 hours
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[1])	10 business days
Non-Urgent 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.

For several years following the promulgation of the Timely Access Regulation, health plans gauge appointment wait times by utilizing a variety of methods, including provider telephone surveys, secret shoppers and practice management software audits. These non-standardized methods in the first four years (MY 2011 – MY 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 health plans to gather data and measure compliance.

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

methodologies for measuring compliance with timely access standards. The use of standardized methodologies would result in the submission of accurate and comparable data from health plans, and more improve the ability of the DMHC to compare results among health plans, and ultimately, develop an acceptable rate of compliance.

Immediately following passage of SB 964, the DMHC adopted an initial standardized methodology, which required health plans to conduct a telephone survey of providers to assess the timeframe for the next available appointment.

The DMHC has incorporated feedback from health plans, providers and consumer advocates to make changes to the mandatory methodology all health plans are required to follow when gathering data, measuring compliance and submitting compliance reports. The SB 964 Administrative Procedures Act Waiver, which was granted until January 1, 2020, has allowed the DMHC to refine the survey methodology year over year utilizing stakeholder feedback. Because the DMHC has continued to amend and improve the methodology and reporting requirements year over year, the data submitted by health plans is not comparable across measurement years. This type of comparison will be possible after the mandated methodology is included in the timely access regulation.

For MY 2015, ninety percent of Timely Access Compliance Reports submitted to the DMHC contained one or more significant data inaccuracies, making it impossible for the DMHC to measure individual health plan compliance and compare health plan data across the industry.

Following the release of the MY 2015 report, the DMHC met with stakeholders to discuss the steps health plans were required to immediately take to ensure accurate reporting of future timely access data. The DMHC required the full service health and behavioral health plans to retain data validators to review and authenticate timely access data before submitting their annual compliance reports for MY 2016 and MY 2017 to the DMHC.

The DMHC will continue to require health plans to improve reporting and will consult with health plans, providers and consumer advocates to further refine the methodology to increase the accuracy of submitted data.

How the DMHC Monitors Timely Access

Since timely access to care is a top priority for the DMHC, the Department utilizes a variety of regulatory oversight tools to ensure consumers have timely access to care. One of these tools is the Timely Access Regulation, which requires health plans to submit annual reports detailing compliance with time-elapsed standards. To ensure appointment timeframes are met on a consistent basis, each health plan must monitor its own network, measure appointment availability and submit compliance reports annually to the DMHC. These are commonly referred to as the Timely Access Reports. The DMHC makes this data public through the publication of this annual report.

Additional oversight measures that help the DMHC assess timely access to care include:

- Monitoring enrollee complaints submitted to the DMHC's Help Center to identify trends and take appropriate action, including referral to the Department's Office of Enforcement.

- Annually evaluating health plan networks to ensure health plans have an adequate number of providers to provide timely access to care for their enrollees.
- Auditing health plan operations through routine medical surveys. A component of the medical surveys is an assessment of plan compliance with 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 the health plan, an enrollee or the DMHC. Network adequacy issues also may be identified during the review of individual enrollee grievance and utilization management files that customarily occurs as a part of these on-site medical surveys. The Department also reviews the plan's quality assurance standards for timely delivery of language assistance services for routine, urgent and emergency health care services. These must include standards for coordinating interpretation services with appointment scheduling.
- Taking enforcement action against health plans that violate timely access requirements, which often includes a corrective action plan.

Evolving Methodologies Result In Non-Comparable Year Over Year Data

The DMHC has made progressive changes to the mandatory methodology over the past three measurement years in order to improve data accuracy, decrease provider burden, and more reliably measure an enrollee's ability to obtain an appointment within the timely access standards. As a result of these changes, the data submitted by a health plan is not comparable across measurement years. Once the mandatory methodology is codified in the timely access regulation, health plan data will be comparable across measurement years beginning with MY 2020.

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

Health plans are required to provide access to a primary care provider (PCP) or a hospital within 15 miles or 30 minutes from where enrollees live or work. (Alternate geographic access standards are evaluated when a health plan is unable to meet these standards).

Health plans are required to provide (or arrange for) telephone triage or screening services on a 24/7 basis. Patients can get help to determine how urgent their condition is, 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 knowledgeable and competent health plan customer service representative shall not exceed 10 minutes.

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

While the DMHC is working to establish an acceptable rate of compliance with the appointment wait time standards, health plans are required to adhere to rates of compliance established under each health plan's own quality assurance processes. While not standardized across plans, these quality assurance processes require health plans to take specific action if their survey results fall below their own standards.

The charts within this report, compiled using data reported by health plans illustrate the results and show the percentage of surveyed providers that responded with appointments available within the appointment wait time standards. The percentages reflected in the survey charts indicate the percentage of providers that had an appointment within the wait time standards.

The DMHC requires health plans to measure timely access by using the Provider Appointment Availability Survey, and then report the results in their timely access compliance reports. The survey is a randomly selected, statistically reliable sample of a health plan's network. Health plans that use the survey methodology contact a random sample of providers in their network and ask for the next available appointment. The providers' responses to these survey questions are compared against the appointment wait time standards and then submitted to the DMHC as part of the health plan's timely access compliance report.

Kaiser Permanente Survey and Audit Data

Kaiser Permanente utilized both the survey and audit methodologies to report timely access compliance data to the DMHC. Kaiser Permanente used the audit methodology for its integrated providers and the survey methodology for its external providers in the same manner other health plans surveyed providers and submitted survey data to the DMHC. Kaiser Permanente's survey results are included in the survey charts.

Kaiser Permanente applied the audit methodology for its integrated providers by auditing its scheduling records to identify the time elapsed between the date of the enrollees request for an appointment and the date the appointment occurred. The percentages included in the audit charts reflect the percentages of audited appointments that occurred within the wait time standards. Kaiser Permanente's integrated provider data is further discussed in the audit data section of this report.

Data Sampling Error Rate

This report displays data where the sampling errors were less than five percent to ensure the reliability of the data. The charts combine data for more than one provider type or appointment type to achieve a sampling error rate of five percent or less. For example, provider types were combined to allow for a high level understanding of the data. In some cases, the survey results were adjusted by the DMHC's statisticians to remove data inconsistencies and allow the DMHC to compare survey results across health plans. Please see Appendix A for a more detailed explanation of the data.

Aggregate Rate of Compliance

The survey data charts show provider responses to appointment availability requests for MY 2017. It is important to understand the health plan survey results reflect only a point in time, based on the sample size of surveyed providers who responded.

For example, if a health plan's survey result shows a 75 percent Aggregate Rate of Compliance, this denotes that 75 percent of the time a provider responded that the next available appointment fell within the appointment wait time standards. This does not mean that 75 percent of all providers within the health plan's network maintain appointment availability within the appointment wait time standards.

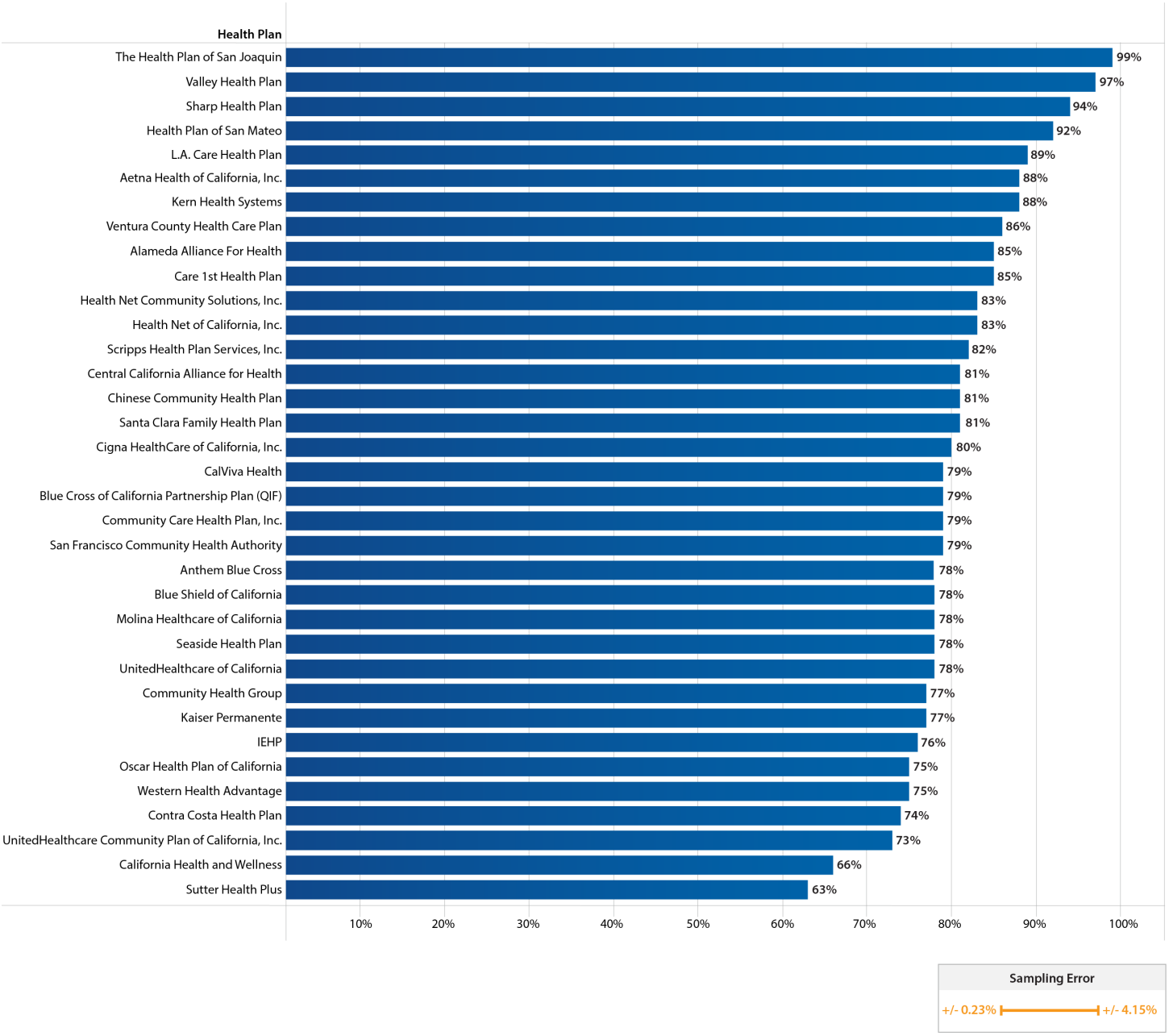
Full Service Health Plan
Survey Data

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

Chart 1

Full Service Health Plans - Aggregate

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

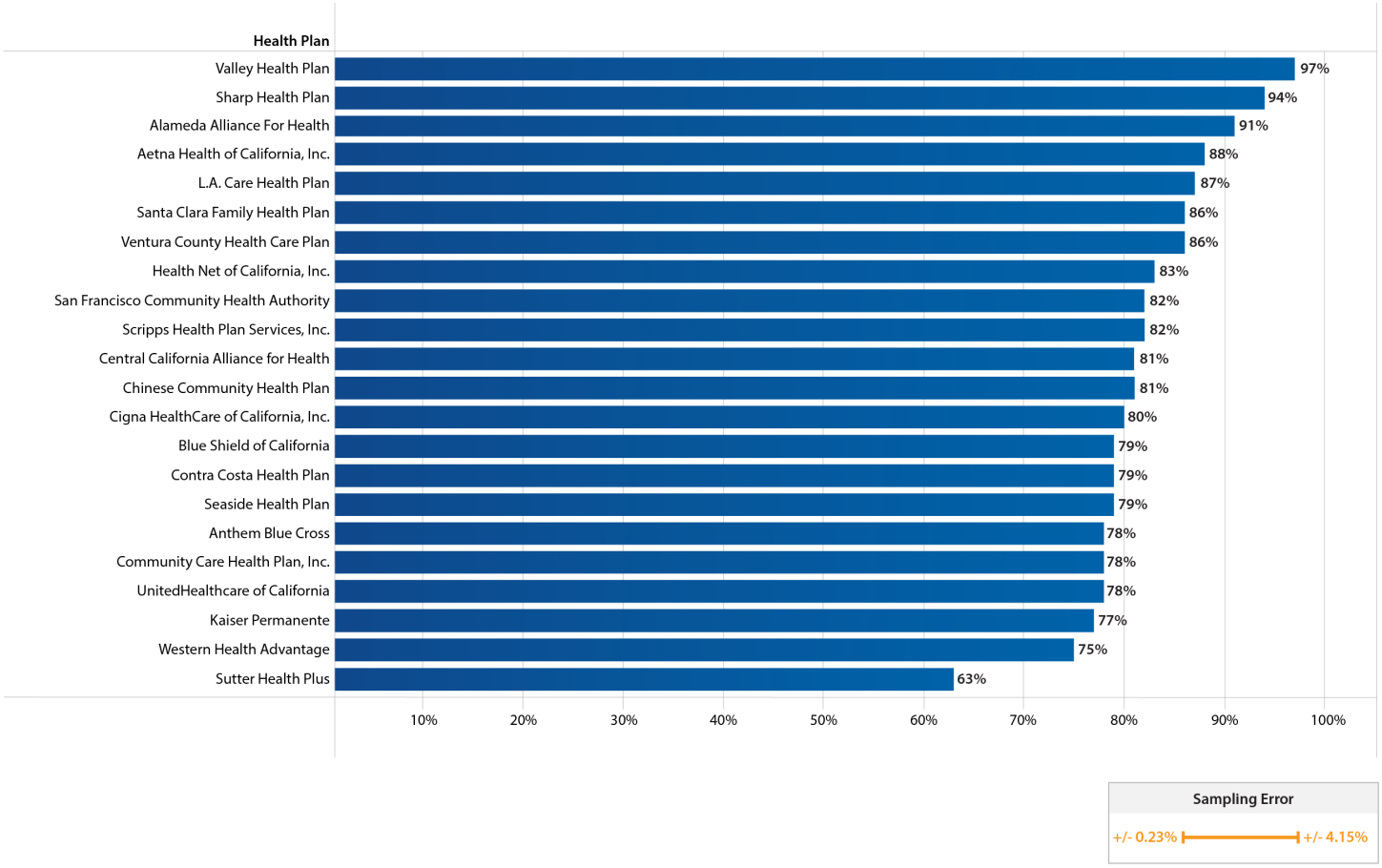


Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

Chart 2

Full Service Health Plans - Commercial

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

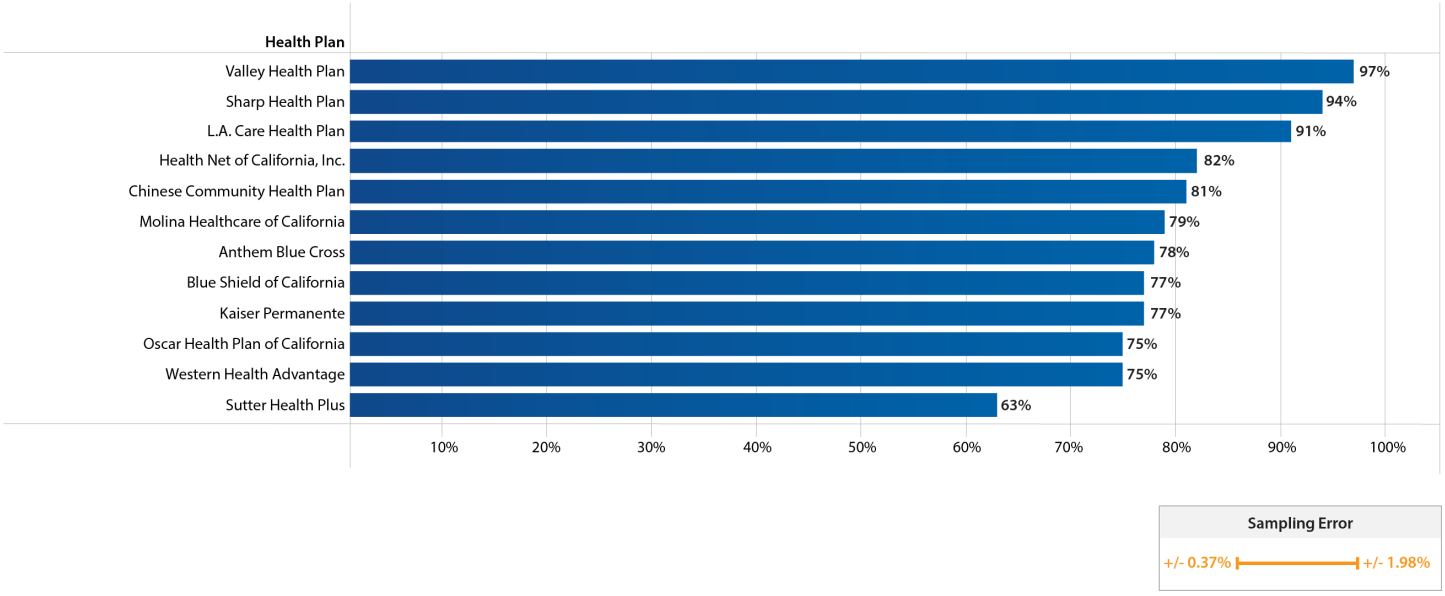


Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

Chart 3

Full Service Health Plans - Individual/Family

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

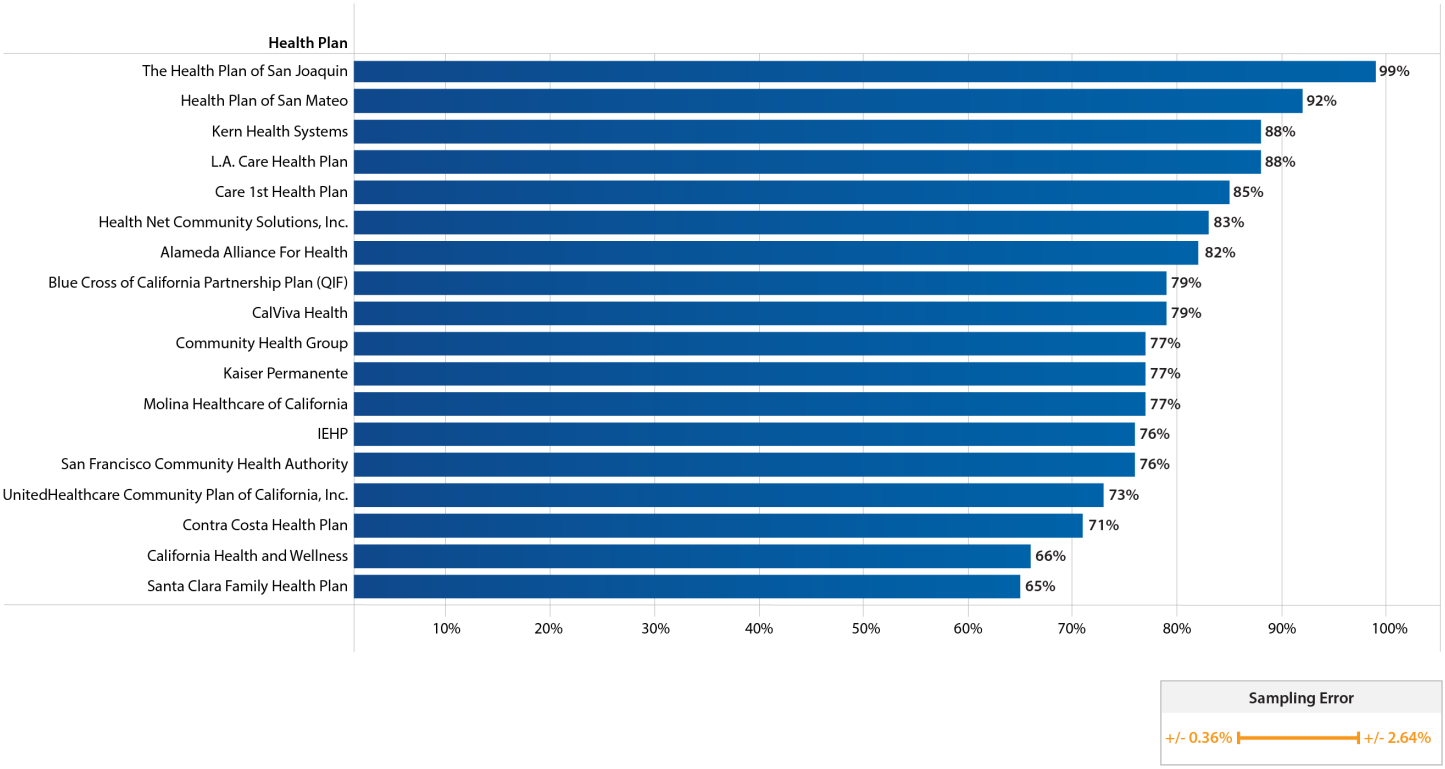


Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

Chart 4

Full Service Health Plans - Medi-Cal

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



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.

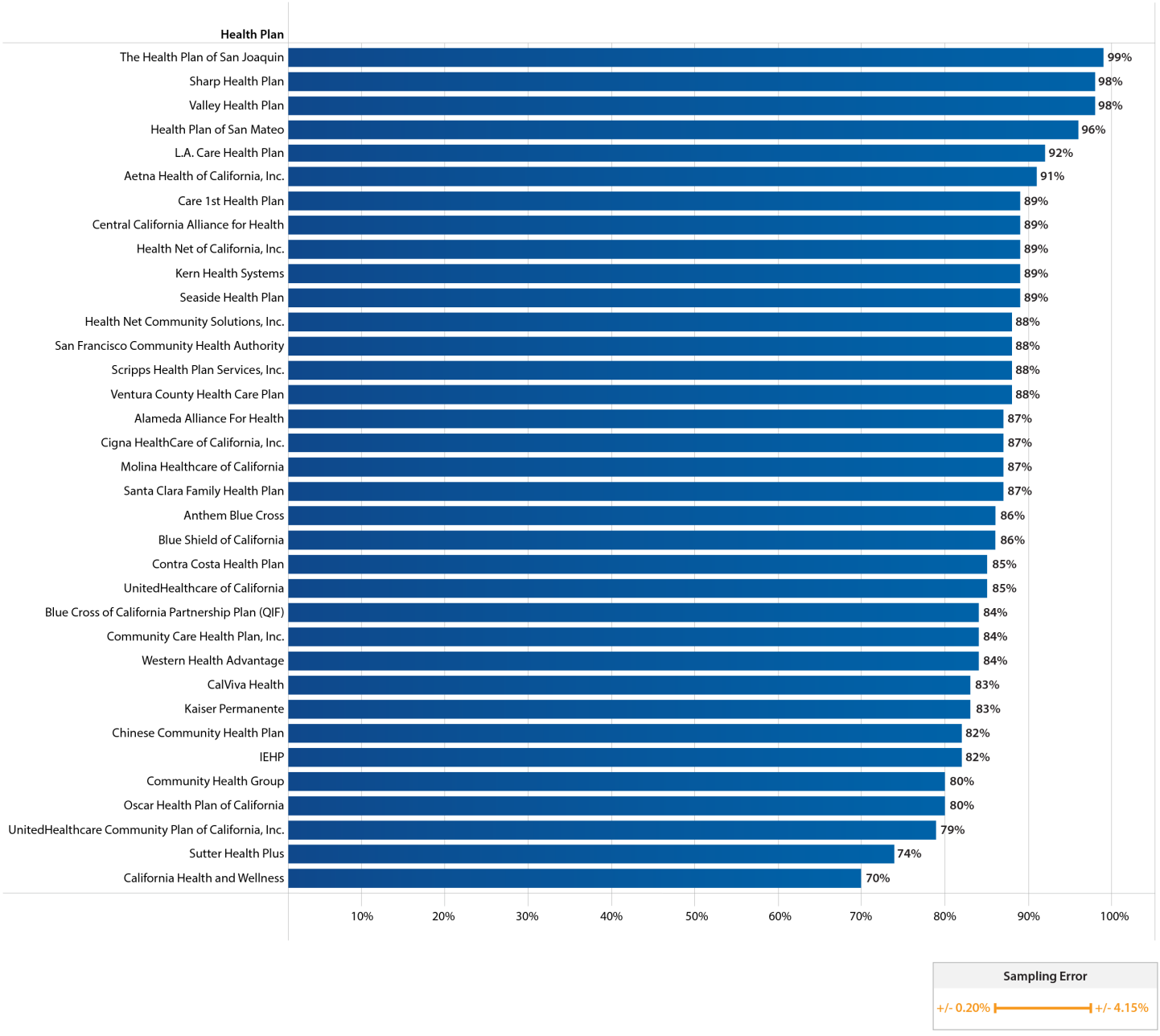


Chart 6

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.

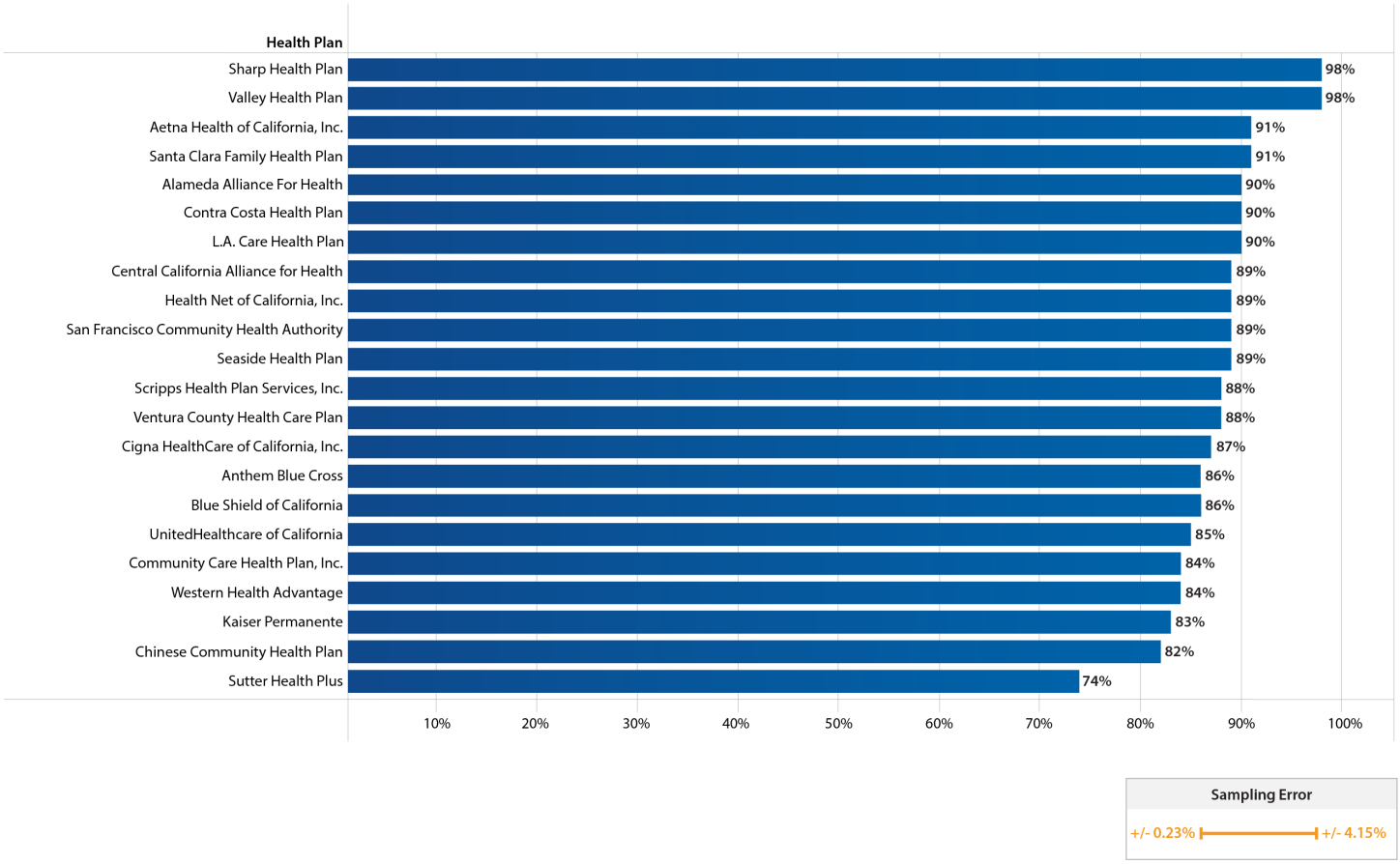
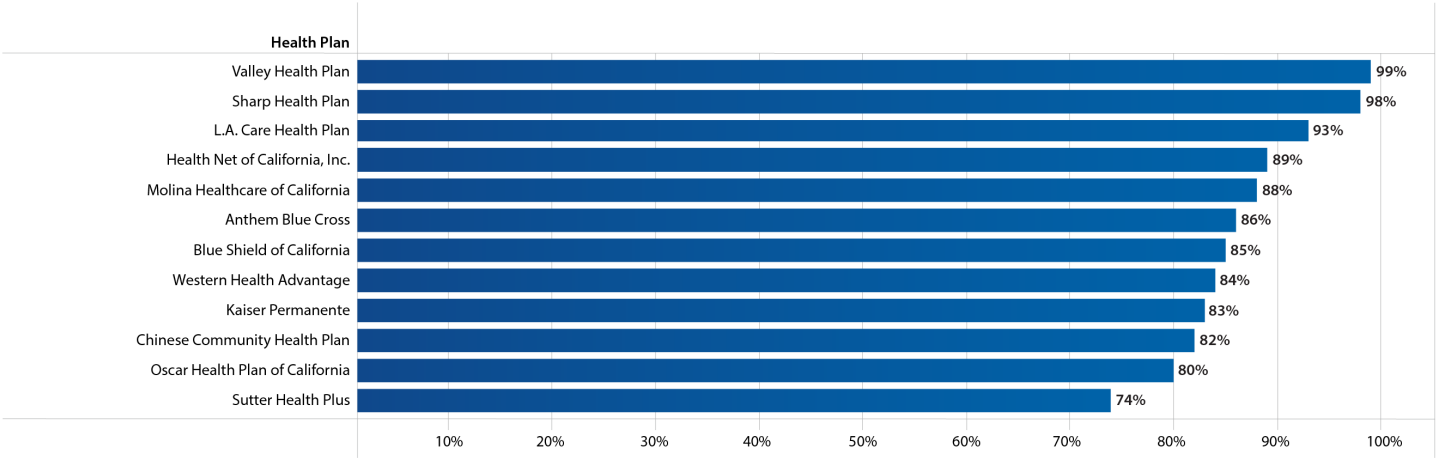


Chart 7

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.



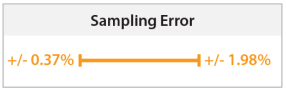
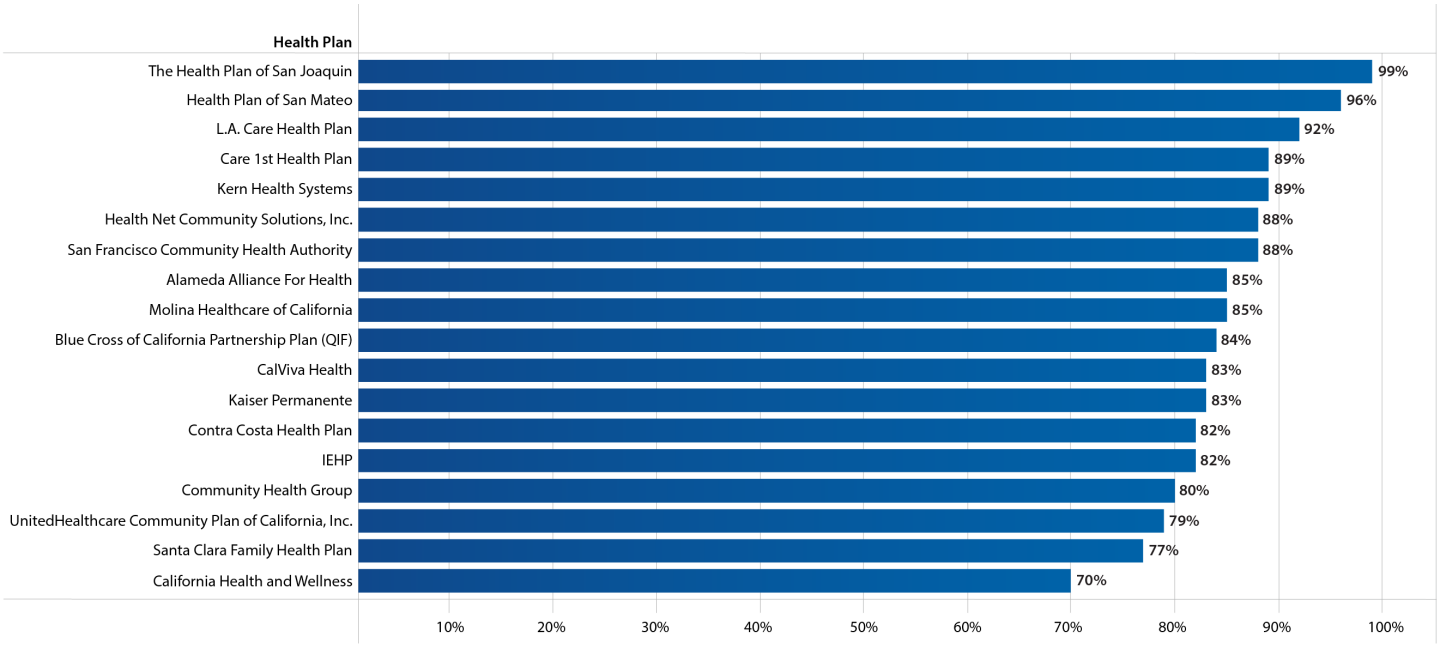


Chart 8

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.



Urgent Appointments

Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards

Chart 9

Full Service Health Plans

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

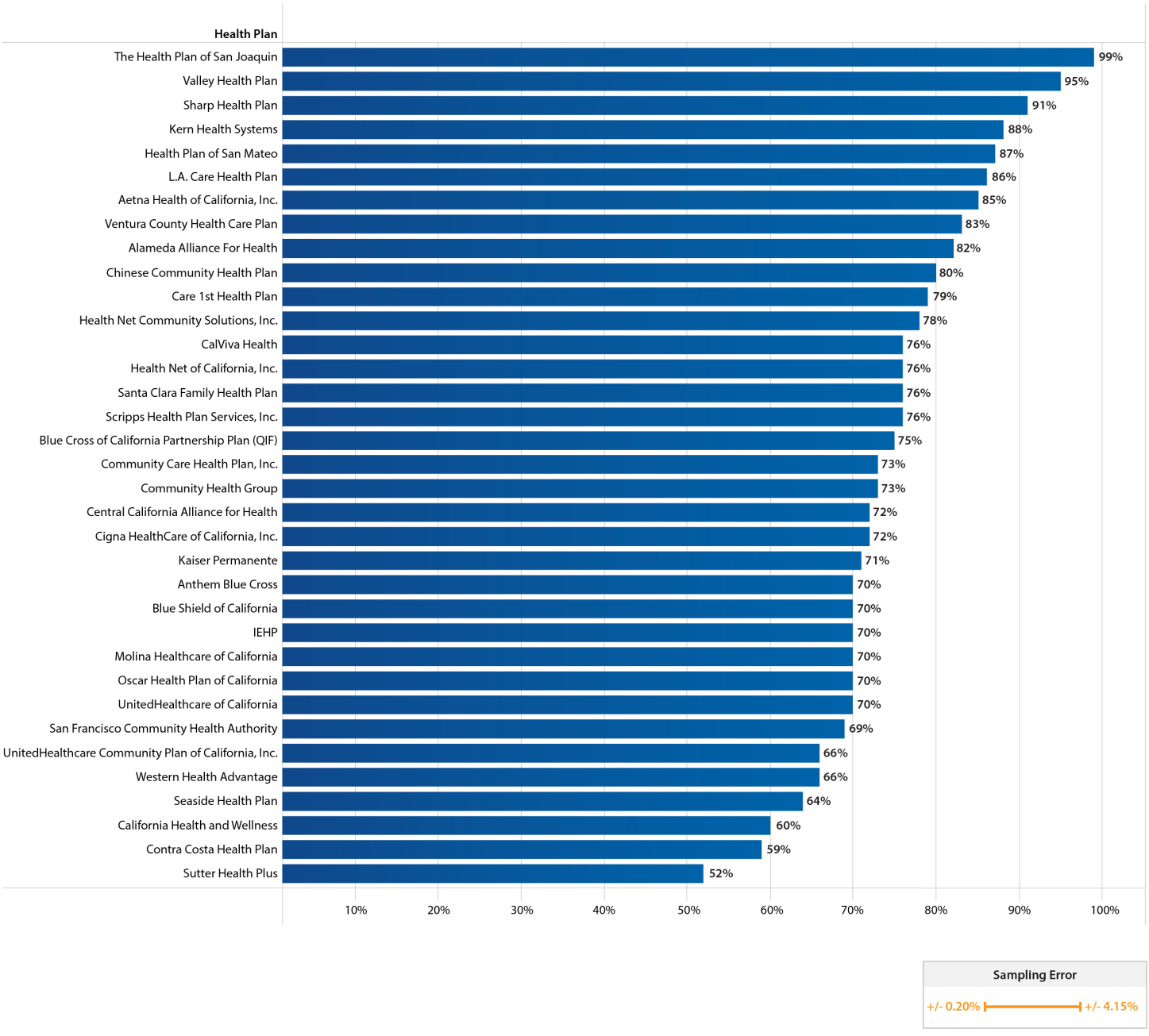


Chart 10

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.

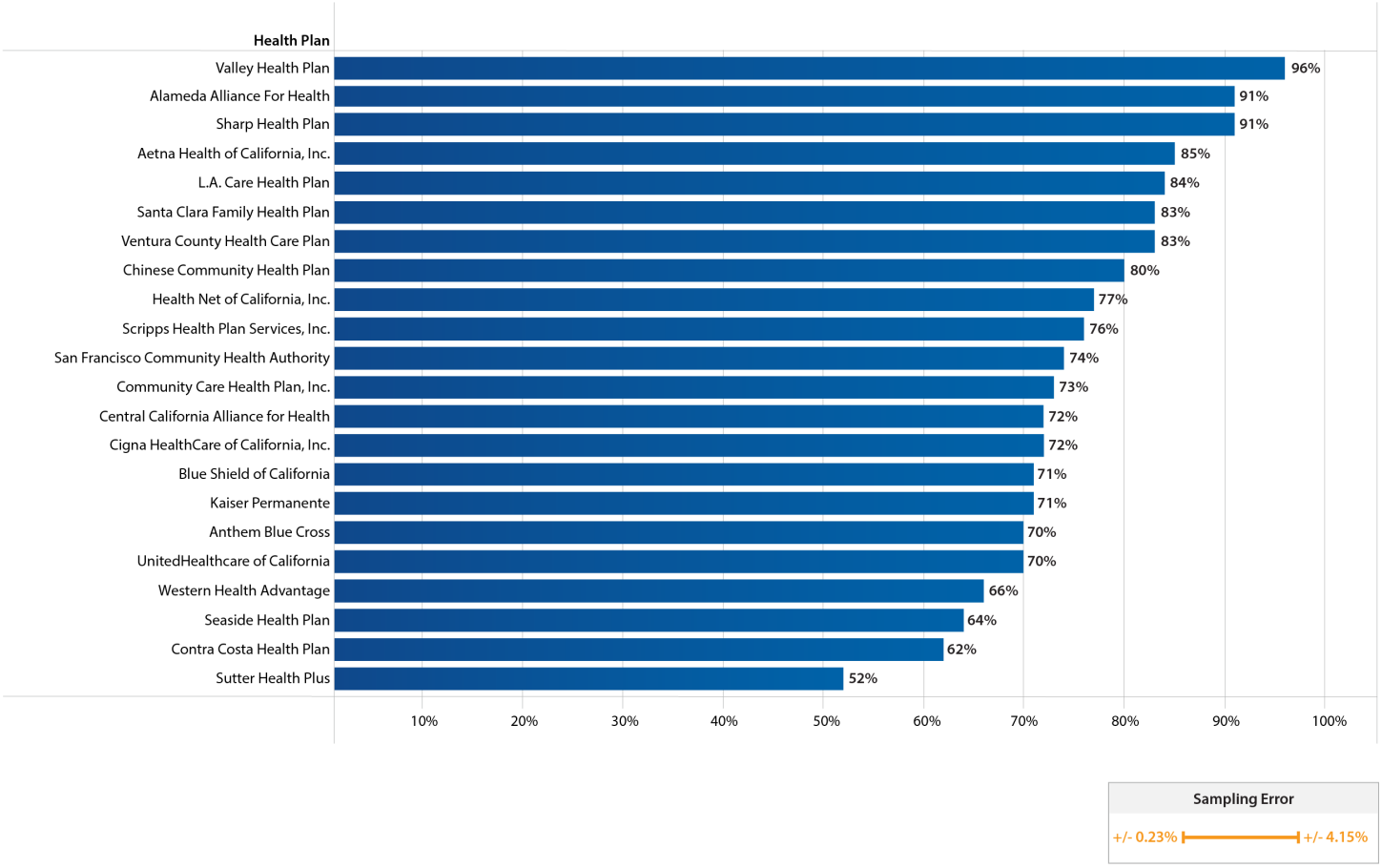


Chart 11

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.

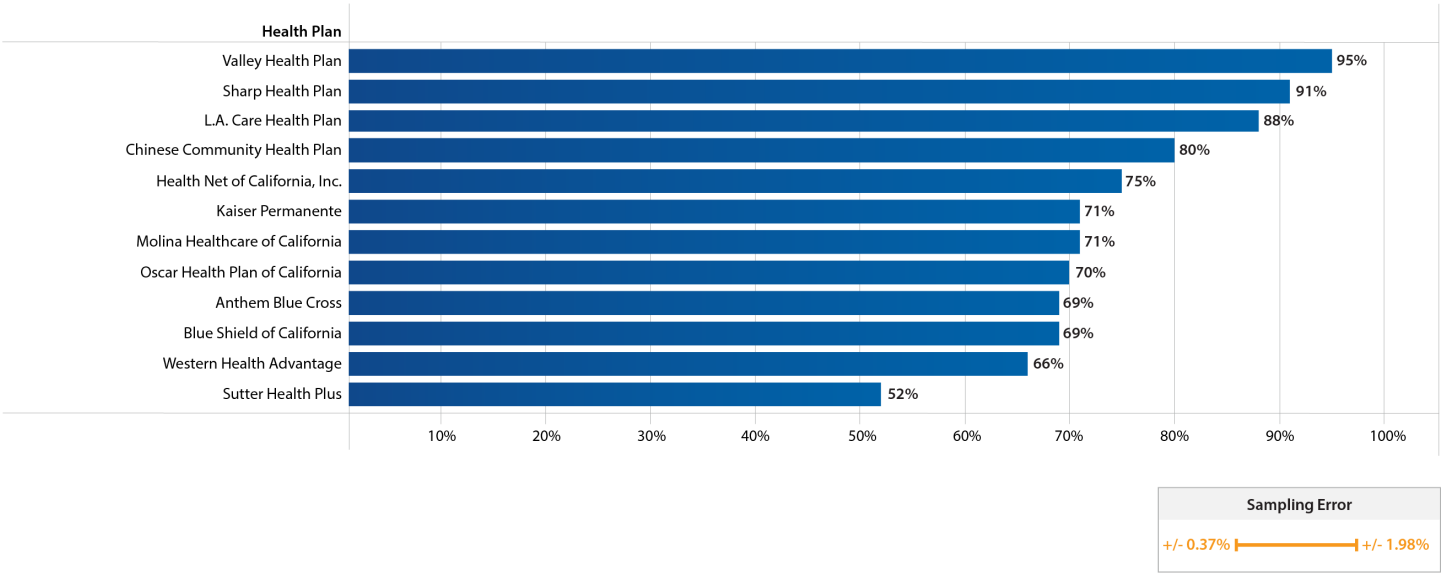
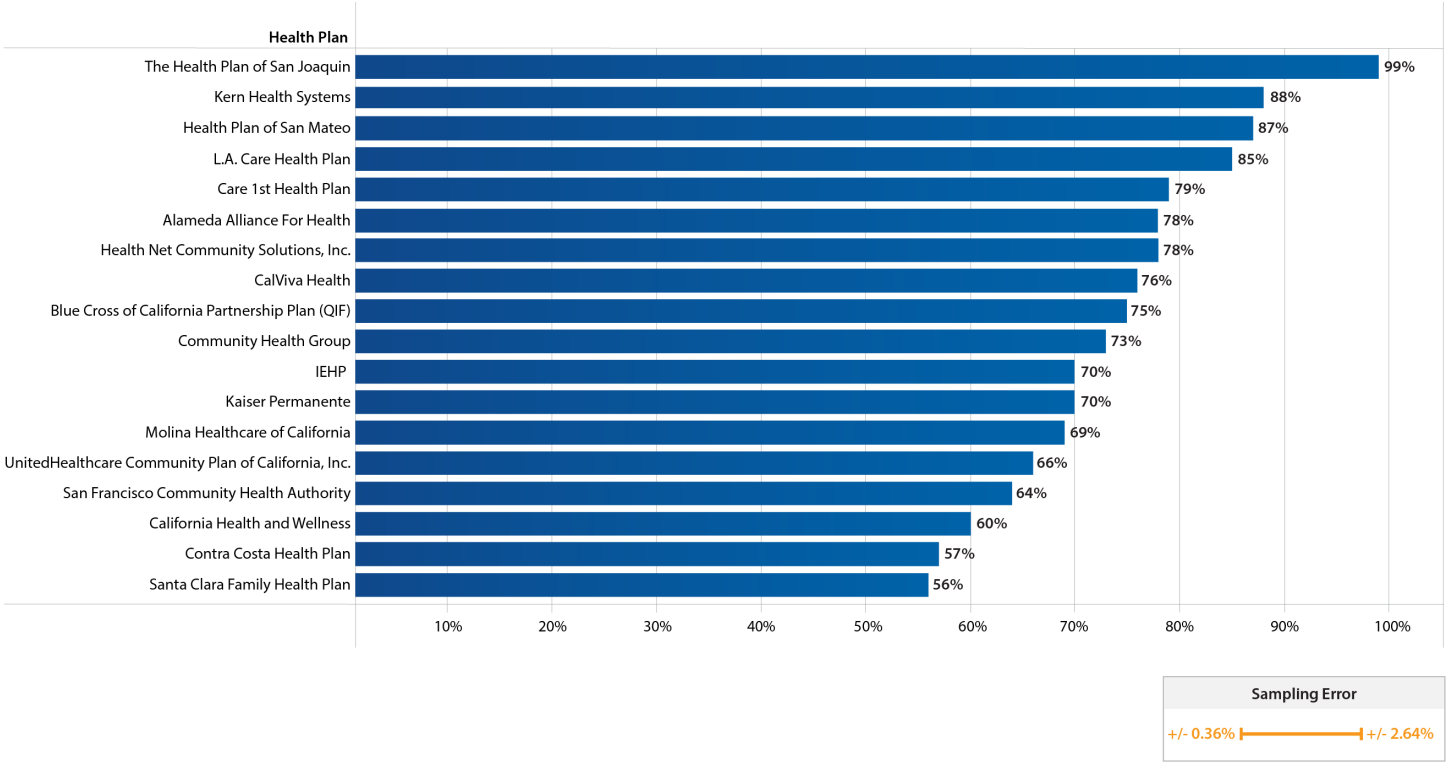


Chart 12

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.



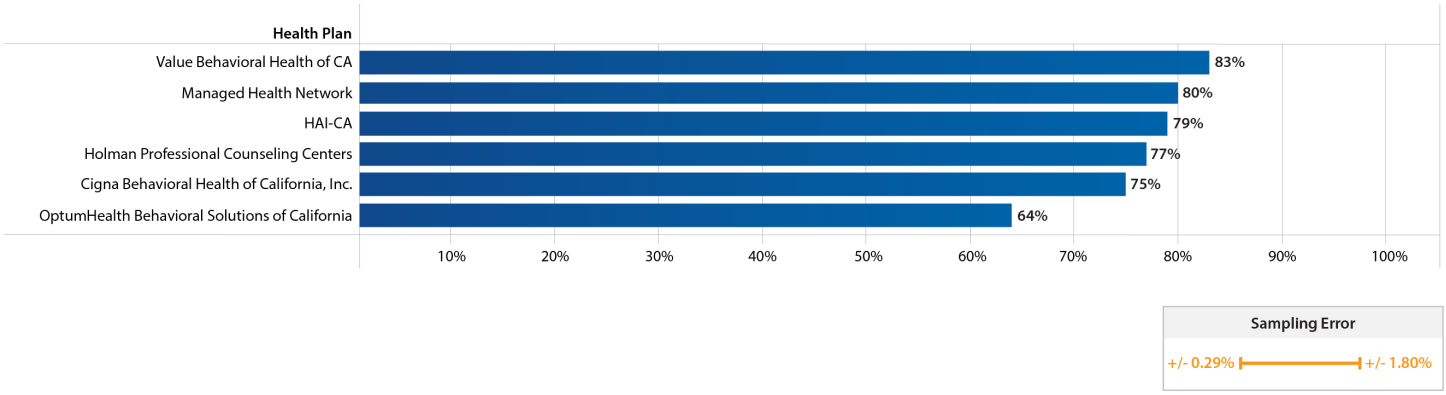
Behavioral Health Plan Survey Data

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.

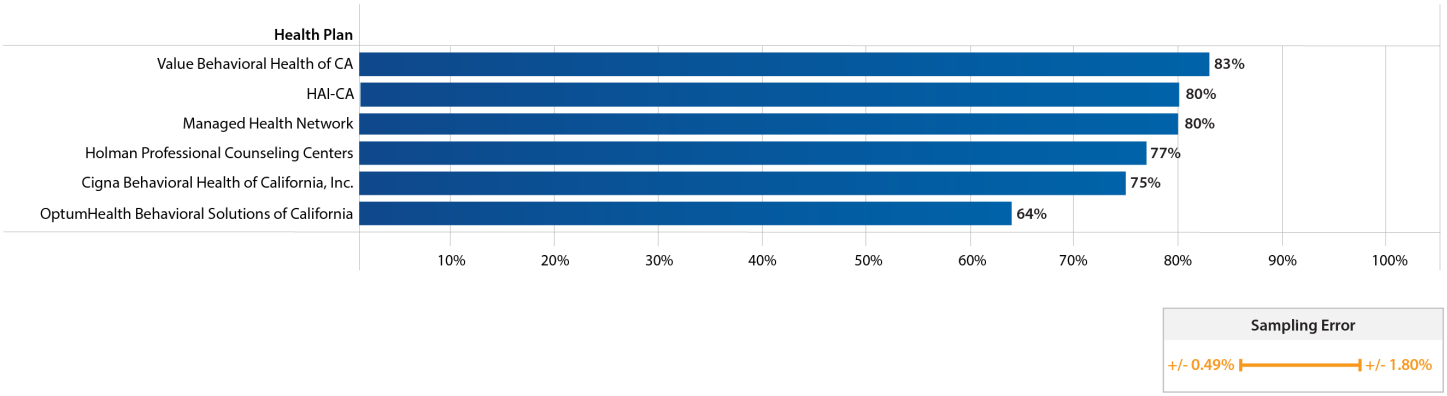


Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

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.

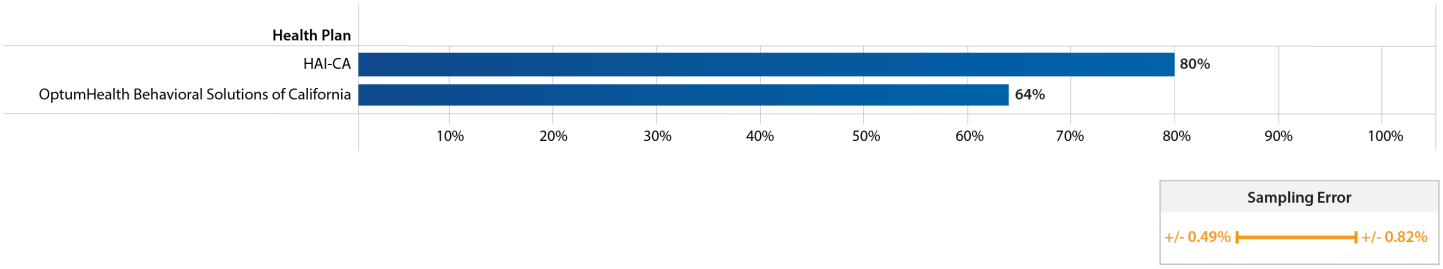


Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

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.

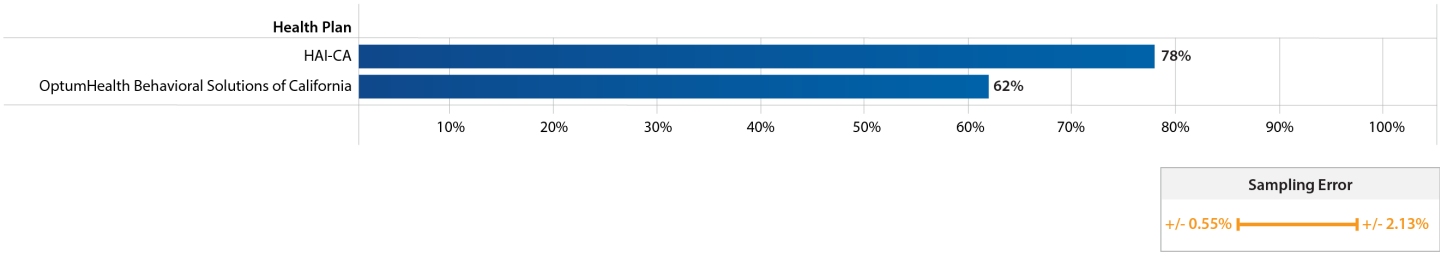


Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

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.

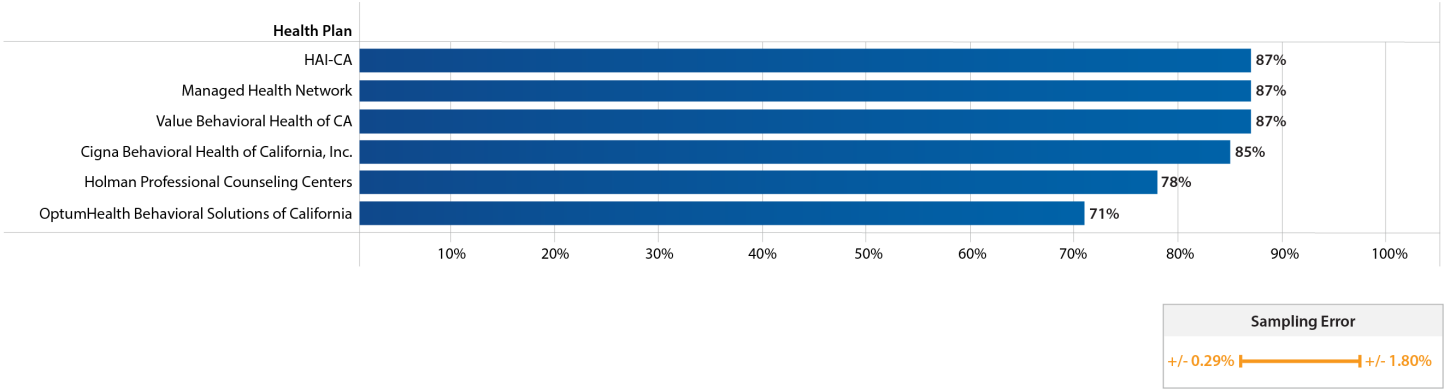


Chart 18

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.

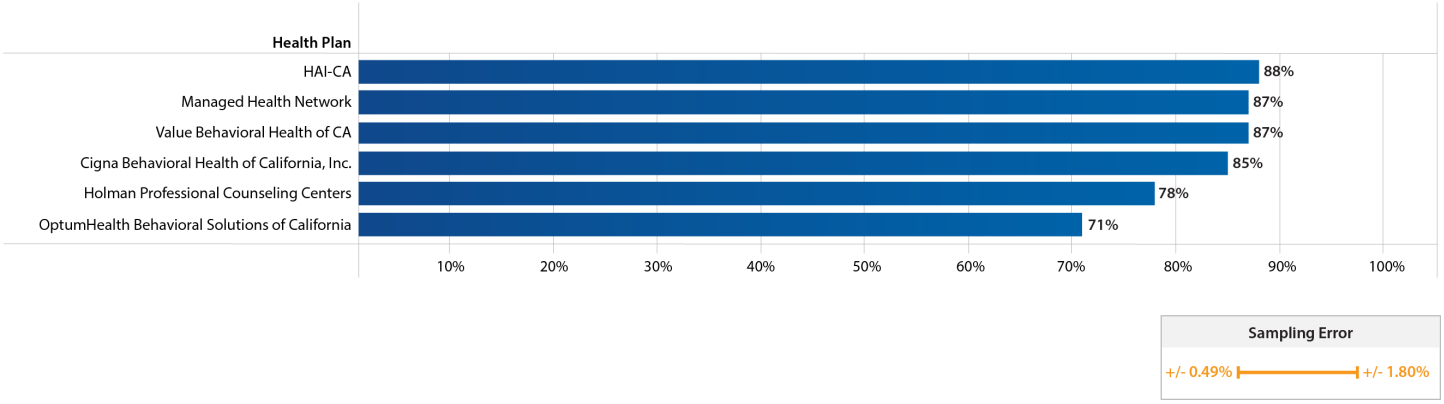


Chart 19

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.

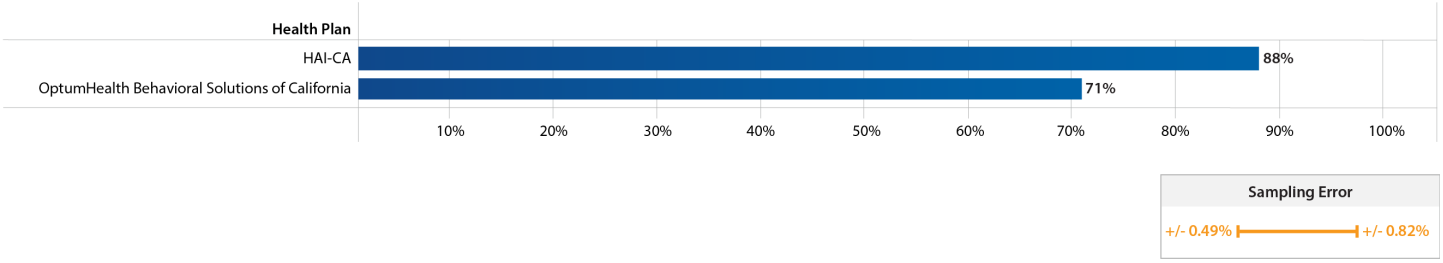
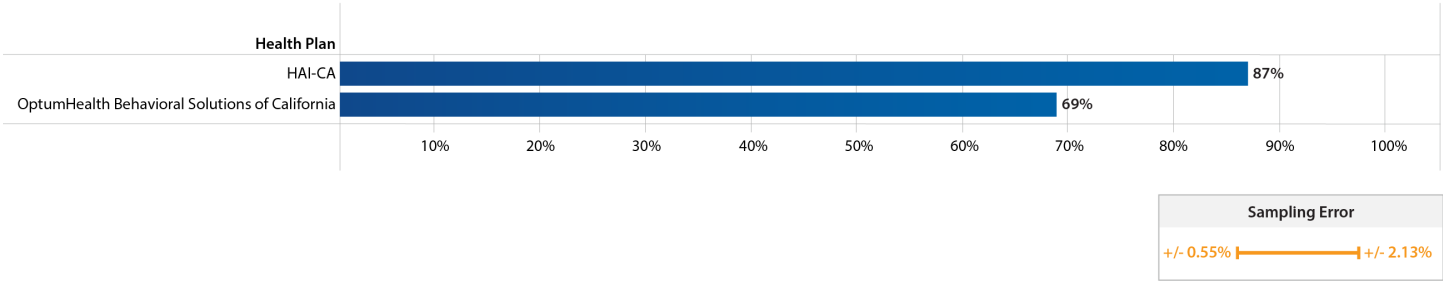


Chart 20

Behavioral Health Plans - Medi-Cal

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



Urgent Appointments

Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards

Chart 21

Behavioral Health Plans

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

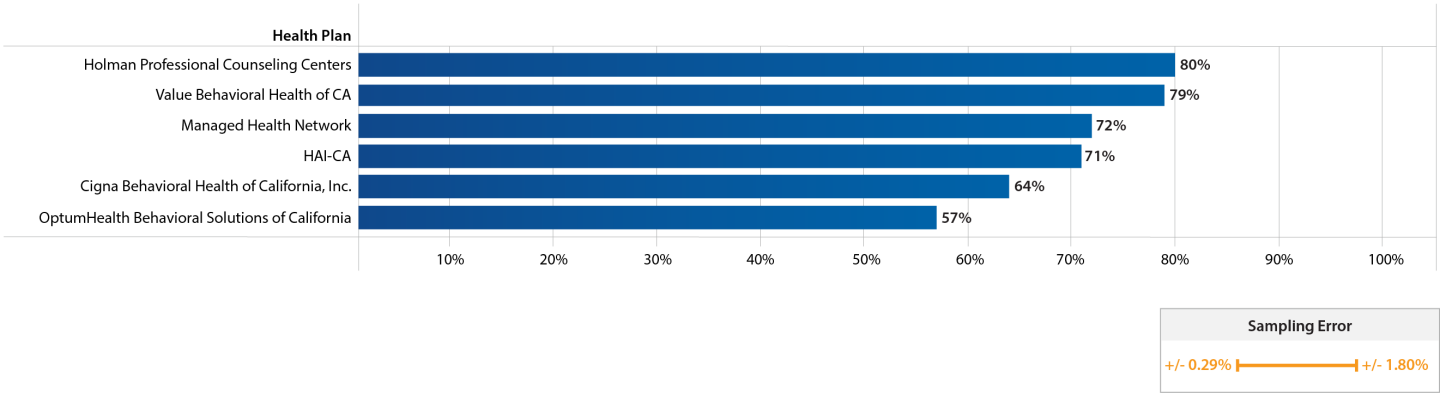


Chart 22

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

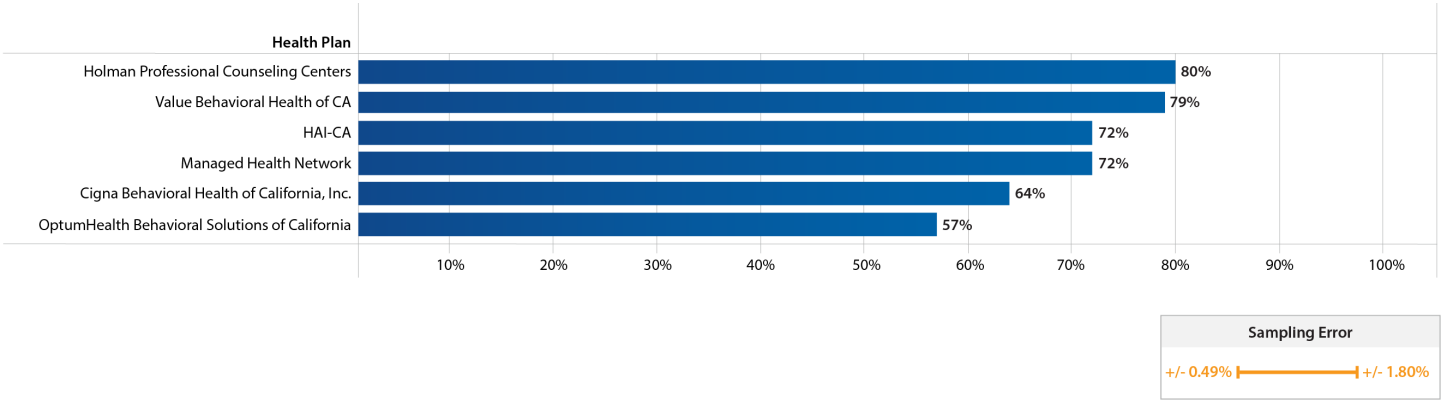


Chart 23

Behavioral Health Plans - Individual/Family

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

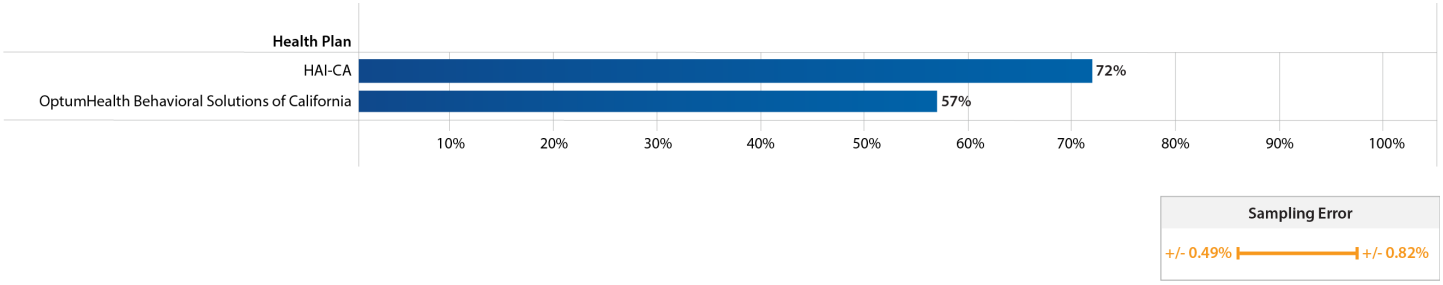
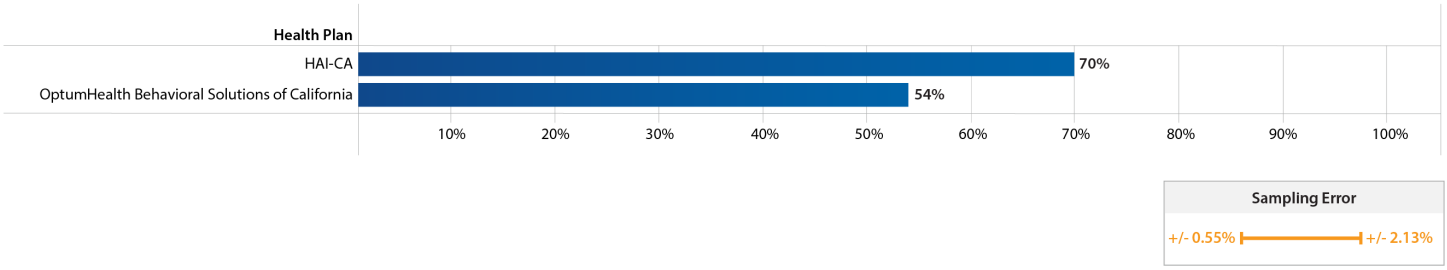


Chart 24

Behavioral Health Plans - Medi-Cal

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



Health Plan Audit Data
Kaiser Permanente

The following charts show appointments scheduled within timely access standards, based on audited health plan records. Kaiser Permanente is the only health plan that used the audit methodology for its integrated providers, which does not rely on sampling.

Full Service Health Plan Audit Data

Percentage of Audited Appointments Meeting both Urgent and Non-Urgent Appointment Wait Time Standards

Chart 25

Full Service Health Plan

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

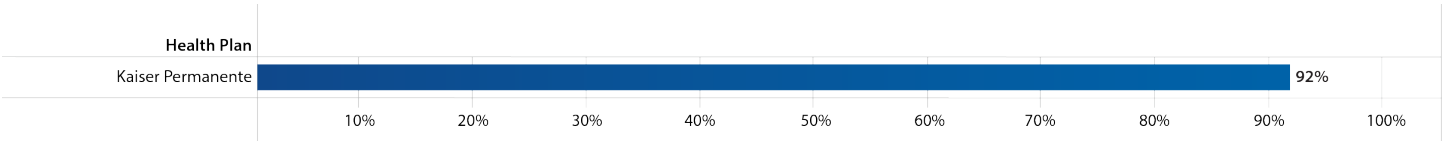


Chart 26

Full Service Health Plan - Commercial

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

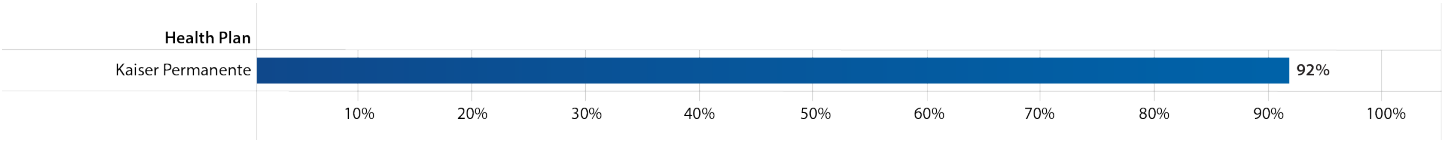


Chart 27

Full Service Health Plan - Individual/Family

This chart combines Kaiser Permanente's Individual/Family product audit results, across all provider types (primary care, specialty, non-physician mental health and ancillary) for both urgent and non-urgent appointments.

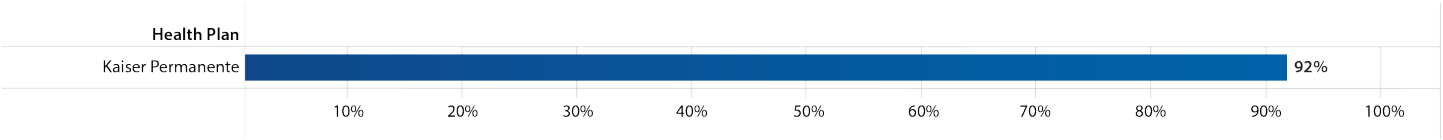
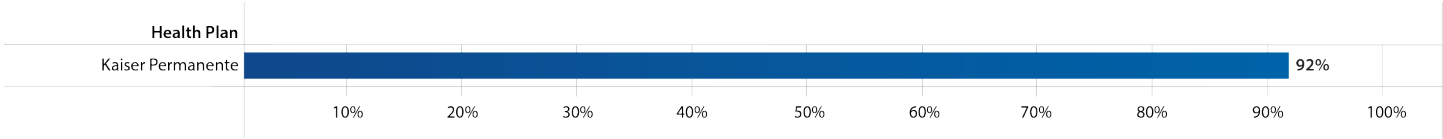


Chart 28

Full Service Health Plan - Medi-Cal

This chart combines Kaiser Permanente's Medi-Cal product audit results, across all provider types (primary care, specialty, non-physician mental health and ancillary) for both urgent and non-urgent appointments.



Full Service Health Plan Audit Data - Non-Urgent Appointments

Percentage of Audited Appointments Meeting Non-Urgent Appointment Wait Time Standards

Chart 29

Full Service Health Plan

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

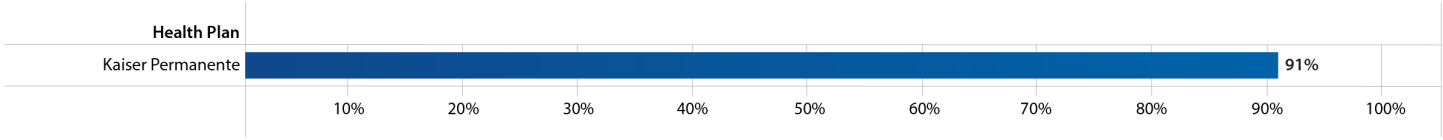


Chart 30

Full Service Health Plan - Commercial

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

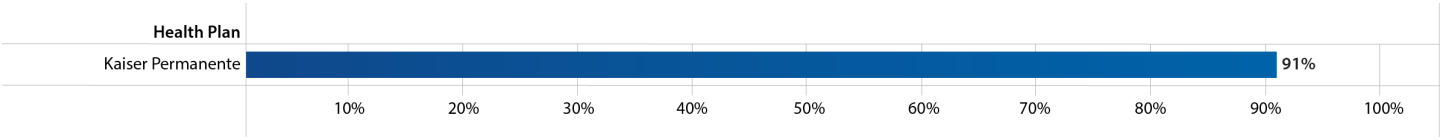


Chart 31

Full Service Health Plan - Individual/Family

This chart combines Kaiser Permanente's Individual/Family product audit results, across all provider types (primary care, specialty, non-physician mental health and ancillary) for non-urgent appointments.

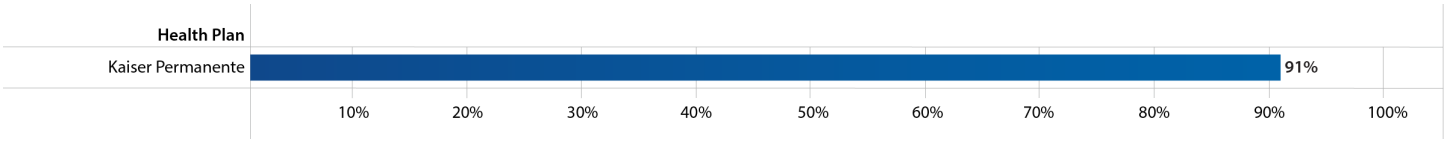
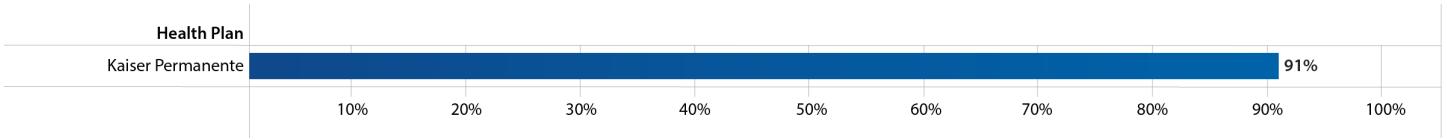


Chart 32

Full Service Health Plan - Medi-Cal

This chart combines Kaiser Permanente's Medi-Cal product audit results, across all provider types (primary care, specialty, non-physician mental health and ancillary) for non-urgent appointments.



Full Service Health Plan Audit Data - Urgent Appointments

Percentage of Audited Providers Meeting Urgent Appointment Wait Time Standards

Chart 33

Full Service Health Plan

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

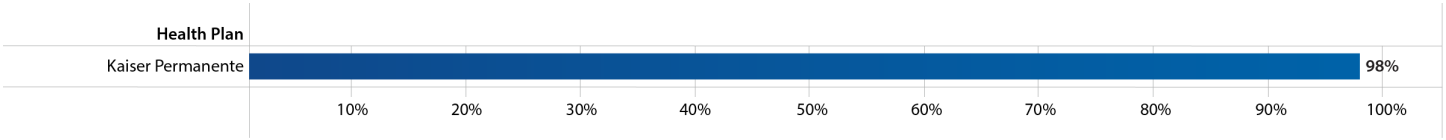


Chart 34

Full Service Health Plan - Commercial

This chart combines Kaiser Permanente's Commercial product audit results, across all provider types (primary care, specialty, non-physician mental health, and ancillary) for urgent appointment types.

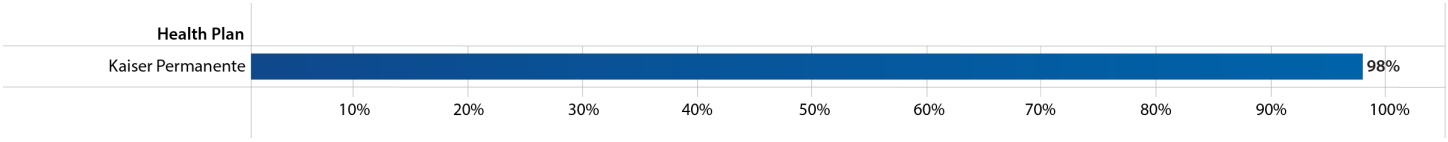


Chart 35

Full Service Health Plan - Individual/Family

This chart combines Kaiser Permanente's Individual/Family product audit results, across all provider types (primary care, specialty, non-physician mental health, and ancillary) for urgent appointments.

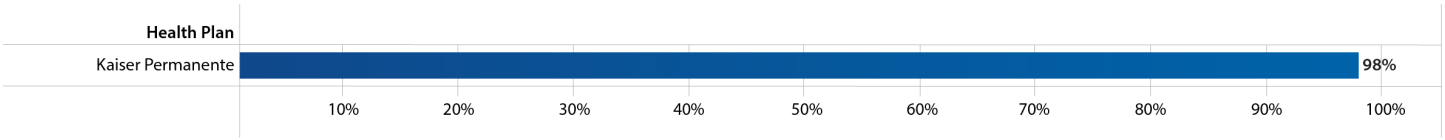
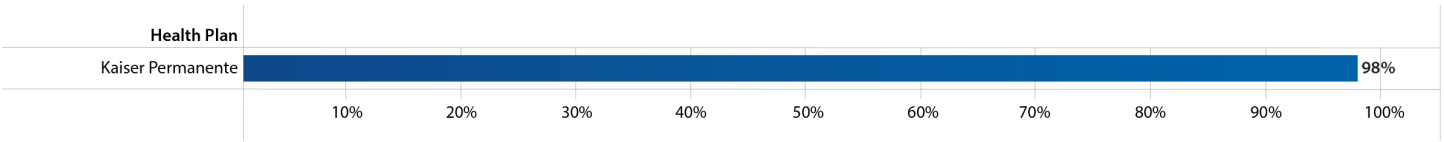


Chart 36

Full Service Health Plan - Medi-Cal

This chart combines Kaiser Permanente's Medi-Cal product audit results, across all provider types (primary care, specialty, non-physician mental health, and ancillary) for urgent appointments.



Next Steps

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

- Require health plans to continue utilizing an external vendor for MY 2019 to perform a quality assurance review and include a validation report of the health plans data prior to submission to the DMHC.
- Continue to work with health plans, providers and consumer advocates to develop a standardized reporting template to increase the comparability of data, reduce the resources necessary to standardize data, and allow for better analytics and comparisons of health plans' timely access data.
- Continue to refine the mandatory provider survey methodology to achieve greater data accuracy while also providing health plans with flexibility to gather data and minimize the reporting burden on providers.
- Release the MY 2019 mandatory methodology and reporting templates in the first quarter of 2019.
- Work with stakeholders, including health plans, providers and consumer advocates, to promulgate regulations in 2020 and develop an acceptable rate of compliance that health plans must meet for provider appointment wait times.
- Continue to work with, and provide timely access compliance data to, the Office of the Patient Advocate (OPA) for incorporation into the OPA Quality of Care Report Card.

Conclusion

While this report shows MY 2017 data across health plans at a more granular level than in previous reports, efforts by health plans to improve the accuracy and completeness of their timely access compliance data must still continue. For example, all health plans must follow the mandatory methodology, complete all of the required surveys in the measurement year, and survey all available providers to meet the required sample size.

This year's report demonstrates the DMHC's continued commitment to its mission of protecting consumers' health care rights and ensuring a stable health care delivery system by increasing and providing comparable timely access data to the public and other interested parties. The DMHC looks forward to continuing this work with stakeholders, including health plans, providers and consumer advocates, to further increase the usability of the timely access data and develop an acceptable rate of compliance.

Know Your Health Care Rights: Timely Access to Care

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

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

DMHC Help Center:

The DMHC Help Center has provided assistance to over 2 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.

Appendices

Appendix A: Timely Access Compliance Data Discrepancies & Analysis

The charts in this report include data for primary care providers (PCPs), specialists, ancillary providers, and non-physician mental health providers[2] for both urgent and non-urgent appointments. The data is presented separately for survey data and audit data. The majority of charts identify the percentage of providers who indicated appointment availability within the wait-time standards set forth in the Knox-Keene Act (survey methodology).[3] Other charts identify the percentage of booked appointments in which the records indicated appointment availability within the wait time standards (audit methodology).

A number of data discrepancies were identified in plan reports for 2017. This appendix explains what these discrepancies were and how they were addressed in the report charts.

Data – Survey Methodology

The timely access rates were calculated based on survey responses from provider groups and individual providers that contract with health plans. The surveys identified whether the first available appointment with a provider fell within the timely access standards. Providers may have been surveyed multiple times.

Data – Audit Methodology

Kaiser Permanente utilized the audit methodology for its integrated network of providers and the telephone survey methodology for its external network of providers. Kaiser Permanente's audit data is discussed separately in this report because the differences between the survey methodology (appointment availability checks) and the audit methodology (compliance calculations for appointments that occurred in the past) make the data non-comparable. The audit methodology measures appointments from the date of the request to the date the appointment was scheduled or the date on which the appointment actually occurred. Sampling errors are not applicable to the audit methodology. However, the audit methodology utilized the same weighting principles (described below) as the survey data.

Overall Rate

The overall timely access rate is computed at the provider group level by summing the weighted, blended urgent care rate and non-urgent care rate. The weighting entails multiplying the blended urgent and non-urgent care rates by the percentage of all respondents (e.g., the sum of respondents for urgent and non-urgent care) that responded to the urgent care appointment requests and non-urgent care appointment requests, respectively.

Each chart includes the timely access rates and provides the "sampling error," or the range within which the analysis is 85 percent certain the actual rate falls.[4] Sampling errors were calculated using a finite population correction. The variability in sampling errors resulted from the varying size of health plan networks as well as the degree to which target sample sizes were achieved. Multiple factors led plans failing to achieve target samples. For MY 2017, providers who refused to respond to the survey were no longer considered non-compliant, so surveyors had to replace refusals with other providers. In some cases surveyors exhausted the providers on the contact list due to non-response/refusals. In some cases, though, it appears that plans did not adequately replace non-responders and failed to contact all potential respondents.

Urgent Appointments

For urgent care appointments, the analysis utilized a combined rate for urgent care appointments with and without prior authorization. The analysis calculated this rate as follows: at the provider group level, the analysis first calculated a blended urgent care rate. This was completed by multiplying each urgent care rate (prior and no prior authorization needed) by a weight. The weight is the percentage of the number of respondents for that urgent care question, out of the total number of urgent care respondents. These weighted urgent care rates are then added together. For provider groups with only one urgent care appointment type (e.g., either prior or no prior, but not both), the analysis used the rate for just that appointment type as the urgent care rate. The process for weighting non-urgent rates was repeated on the blended urgent care rates.

All Plan-Level Rates

For overall, urgent, and non-urgent care appointments, the analysis created a weighted mean of the timely access rate across all health plan and provider groups, using as weights the number of providers within a county provider group. Rates for ancillary providers are weighted by the number of entities or facilities within a county provider group. This provider (entity or facility) weighting means that a timely access rate for a health plan's provider group in a county with 100 providers (entity or facility) receives a weight ten times the weight of a rate for a provider group with 10 providers (entity or facility). 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.

Data Issues

The validation process the DMHC required health plans to undergo identified numerous data issues. Though issues with the data were common, many of those issues did not substantively impact statistically valid results.

- Erroneous compliance calculations:
    - These errors include improperly including ineligible providers in the denominator of the compliance rate (deflating compliance rates) or miscellaneous calculation errors where calculations from raw data did not exactly match rates calculated for some county provider groups. For the calculation errors with a specific bias (either expected to inflate or deflate the compliance rate), the impact on the compliance rate was expected to be less than two percentage points, and was determined to be non-substantive.
- Failure to report compliance rates for all product types:
    - Health Plan of San Mateo failed to submit commercial data. As a result, the results for the plan overall may not be representative of the omitted products.
    - L.A. Care Health Plan failed to report commercial data for Ancillary providers.

- Miscategorization of data:
    - HAI-CA failed to submit rates for Individual/Family products, miscategorizing that data as Commercial. This data was corrected in the published analysis.
    - San Francisco Community Health Authority failed to submit rates for their Commercial products, miscategorizing that data as Individual/Family. This data was adjusted for in the published analysis.
    - Blue Cross of California Partnership Plan (QIF) (a Medi-Cal plan) miscategorized some data as Individual/Family.
    - CalViva Health (a Medi-Cal plan) miscategorized some data as Commercial and Individual/Family. This data was excluded from the published analysis.
    - Managed Health Network (a Behavioral plan) miscategorized some data as Individual/Family and Medi-Cal. This data was excluded from the published analysis.
    - Central California Alliance for Health miscategorized some Commercial data as Medi-Cal. This data was excluded from the published analysis.
    - IEHP (a Medi-Cal plan) miscategorized some data as Commercial and Individual/Family. This data was excluded from the published analysis.
    - Seaside Health Plan miscategorized some data as Individual/Family. This data was excluded from the published analysis.
    - Health Plan of San Mateo (a Medi-Cal plan) miscategorized some data as Individual/Family. This data was excluded from the published analysis.
- De-duplication errors:
    - These errors occurred due to a failure to properly de-duplicate providers to a single provider group in a county where providers had multiple locations. These errors may lead to overrepresentation for some providers or provider groups in the results.
- Contact list or survey data does not completely represent plan network:
    - Differences were identified between plan rosters and contact lists, and contact lists and raw results.
- Survey timing:
    - Some surveys were conducted outside the measurement year. Some plans failed to conduct two distinct surveys with at least a six-week separation. In cases where only a small number of surveys fell outside the measurement year, it was determined the results would not substantively impact results. For plans that did not allow a six week separation between surveys, it was determined that the time frame for the survey provided a sufficient representation of appointments over time.

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

Full Service	
Health Plan Legal Name	**Doing Business As (DBA)**
Aetna Health of California, Inc.	
Alameda Alliance for Health	
Blue Cross of California	Anthem Blue Cross
Blue Cross of California Partnership Plan (QIF)	
California Health and Wellness Plan	California Health and Wellness
California Physicians' Service	Blue Shield of California
Care 1st Health Plan	
Chinese Community Health Plan	
Cigna HealthCare of California, Inc.	
Community Care Health Plan, Inc.	
Community Health Group	
Contra Costa County Medical Services	Contra Costa Health Plan
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	
Local Initiative Health Authority for L.A. County	L.A. Care Health Plan
Molina Healthcare of California	
Oscar Health Plan of California	
San Francisco Community Health Authority	
San Joaquin County Health Commission	The Health Plan of San Joaquin
San Mateo Health Commission	Health Plan of San Mateo
Santa Clara County	Valley Health Plan
Santa Clara County Health Authority	Santa Clara Family Health Plan
Santa Cruz-Monterey-Merced Managed Medical Care Comm.	Central California Alliance for Health
Scripps Health Plan Services, Inc.	
Seaside Health Plan	
Sharp Health Plan	
Sutter Health Plan	Sutter Health Plus
UHC of California	UnitedHealthcare of California
UnitedHealthcare Community Plan of California, Inc.	
Western Health Advantage	
Behavioral Health	
Cigna Behavioral Health of California, Inc.	
Human Affairs International of California	HAI-CA
Managed Health Network	
U.S. Behavioral Health Plan, California	OptumHealth Behavioral Solutions of California
ValueOptions of California, Inc.	Value Behavioral Health of CA
Holman Professional Counseling Centers	

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 providers 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.

Appointment Type	Time frame
Urgent Care (prior authorization not required by health plan)	48 hours
Urgent Care (prior authorization required by health plan)	96 hours
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[1])	10 business days
Non-Urgent 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 a mammogram or MRI, and treatment of an illness or injury such as physical therapy.

Health plans must also meet the following requirements to ensure customers have timely access to care:

Health plans are required to provide access to a primary care provider (PCP) or a hospital within 15 miles or 30 minutes from where enrollees live or work. (Alternate geographic access standards are evaluated when a health plan is unable to meet these standards).

Health plans are required to provide (or arrange for) telephone triage or screening services on a 24/7 basis. Patients can get help to determine how urgent their condition is, 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 knowledgeable and competent health plan customer service representative shall not exceed 10 minutes.

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

980 9th Street, Suite 500
Sacramento, CA 95814

1-888-466-2219
HealthHelp.ca.gov

HAVE A PROBLEM WITH YOUR HEALTH PLAN?
CONTACT THE DMHC HELP CENTER

CaliforniaDMHC
@CADMHC
CaliforniaDMHC

Endnotes

1. The DMHC allowed two types of standardized methodologies: telephone survey and audit. Of the health plans reporting, only Kaiser Permanente utilized both the telephone survey and audit methodologies.
2. Specialists consist of allergists, dermatologists, cardiologists, and adult and child psychiatrists. Ancillary providers consist of MRI, mammography, and physical therapist providers.
3. The provider appointment availability survey measures only a provider's next available appointment and does not take into account whether a provider has multiple appointments available within the appointment wait time standards or whether there is another provider within the group that is available within the standards. For example, the survey results would not differentiate between a provider with one timely appointment and a provider with 10 timely appointments.
4. The timely access survey is administered to a sample of health plan providers within each provider group, 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 group in a health plan if they were able to provide an appointment within the appropriate time frame.