DEPARTMENT OF
Managed
Health Care

Timely Access Report

Measurement Year 2023

1-888-466-2219

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HAVE A PROBLEM WITH YOUR HEALTH PLAN? CONTACT THE DMHC

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Executive Summary

Providing timely access to health care services is required under the law and is also a health plan's fundamental duty to its members. This report summarizes the results of the Measurement Year (MY) 2023 provider appointment availability surveys submitted by full service and behavioral health plans to the Department of Managed Health Care (DMHC). This is the first time in which the DMHC is presenting provider appointment availability survey data at the health plan network level, including how many and which networks met the required 70% rate of compliance for urgent and non-urgent appointments. In addition, the DMHC set an initial 80% performance target for non-physician mental health provider follow-up appointments, and this is the first time plans reported on this appointment type. The DMHC has also amended the Timely Access Regulation to incorporate the 80% performance target for non-physician mental health provider follow-up appointments. This target will become a timely access standard that will be effective starting with MY 2024.

To promote additional transparency, the DMHC has published the Health Plan Timely Access Data on its website through a new interactive data analytics tool where users can explore the timely access data. This feature provides new tools to filter and sort timely access data by health plan, product type, provider type, and appointment type. Data provided includes detailed health plan network level timely access data, such as the network performance against the rate of compliance and average appointment wait times, as well as provider response rates and enrollment by network.

Key Rate of Compliance Findings for Full Service and Behavioral Health Plan Networks:

- Approximately 90% of the full service heath plan networks met the rate of compliance for non-urgent appointments and approximately 65% of the full service health plan networks met the rate of compliance for urgent appointments. Approximately 80% of the full service health plan networks met the non-physician mental health provider follow-up appointment performance target.
- All five behavioral health plan networks met the minimum rate of compliance of 70% for non-urgent and urgent appointments and the non-physician mental health provider follow-up appointment performance target.

Key Rate of Compliance Findings for Full Service Health Plans:

- For non-urgent appointments, the percentage of providers who had an appointment available within the applicable non-urgent wait time standards ranged from a high of 91% to a low of 56%. (Chart 1)
- For urgent appointments, the percentage of providers who had an appointment available within the applicable wait time standards ranged from a high of 91% to a low of 43%. (Chart 2)
- For non-physician mental health follow-up appointments, the percentage of providers who had an appointment available within the non-physician mental health follow-up wait time standard ranged from a high of 99% to a low of 76%. (Chart 3)

- Of the providers selected to be surveyed across full service health plans, 45% completed the survey, 29% did not respond to the survey, and 25% were ineligible to participate in the survey.[1,2] (Table 1). Health plans were required to replace non-responding and non-eligible providers with another network provider to meet the required statistically significant sample.

Key Rate of Compliance Findings for Behavioral Health Plans:

- For non-urgent appointments, the percentage of providers who had an appointment available within the applicable non-urgent wait time standards ranged from a high of 91% to a low of 87%. (Chart 4)
- For urgent appointments, the percentage of providers who had an appointment available within the applicable wait time standards ranged from a high of 86% to a low of 76%. (Chart 5)
- For non-physician mental health follow-up appointments, the percentage of providers who had an appointment available within the non-physician mental health follow-up wait time standard ranged from a high of 94% to a low of 87%. (Chart 6)
- Of the providers selected to be surveyed across behavioral health plans, 49% completed the survey, 35% did not respond to the survey, and 16% were ineligible to participate in the survey.[3] (Table 2). Health plans were required to replace non-responding and non-eligible providers with another network provider to meet the required statistically significant sample.

[1] Due to rounding, these numbers add up to 99% or 101%.
[2] A provider may be ineligible to participate in the survey due to a change in the provider's information (e.g., after the contact list is created the provider retires, ceases practicing, changed jobs, or the health plan contract terminates), the contact list contains an error, or the provider cannot respond to the appointment availability questions because the provider does not offer health care services through an appointment (e.g., the provider delivers health care services in a hospital or on walk-in basis).
[3] See footnote 2 for additional information regarding providers who are ineligible to participate in the survey.

Introduction

Created by consumer-sponsored legislation in 1999, the DMHC regulates licensed 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 health plan members. The DMHC protects the health care rights of 29.8 million Californians by regulating health plans, assisting consumers through the DMHC Help Center, educating consumers on their rights and responsibilities, and regulating health plans in a manner that preserves the financial stability of the managed health care system.

Health plans are required to ensure that all health care services are readily available and that their networks have adequate capacity and availability to meet the timely access standards, including specific appointment wait time standards for urgent appointments, non-urgent appointments, and non-physician mental health follow-up appointments. Notably, if a member is offered an appointment within the wait time standards and the member chooses to select a later appointment, the health plan has met the standard. Additionally, a licensed health care professional may determine and note in the relevant record that a later appointment will not negatively affect the member's health.

Background

The Timely Access Regulation, which became effective in 2010, required health plan networks be sufficient to meet a set of standards, which include specific timeframes under which the plan's members can obtain care. These standards include wait times to access urgent and non-urgent appointments, as well as the availability of telephone triage or screening services during and after regular business hours. In recent years, there has been legislation that provided the DMHC with additional authority to update timely access requirements, including:

- SB 221 (2021) added a new appointment wait time standard requiring non-physician mental health follow-up appointments to be offered within 10 business days of the prior appointment and provided the DMHC the authority to amend its standardized methodology to include this new standard.[4] SB 221 also required the DMHC to develop a methodology to determine the average appointment wait time, which was implemented in the MY 2022 Timely Access Report.
- SB 225 (2022) made further clarifications to the law, and mandated health plans to monitor all timely access standards, including the new wait time standard for non-physician mental health follow-up appointments, and provided the DMHC additional authority to enact new standards regarding timely access.

[4] A qualified health care provider or triage professional may extend the waiting time for an appointment if the provider determines and notes in the record that a longer waiting time will not have a detrimental impact to the member's health.

After working closely with stakeholders, the DMHC amended the Timely Access Regulation and full implementation was achieved for MY 2023 The amendments updated standardized reporting, implemented the new follow-up appointment standard for non-physician mental health providers, incorporated DMHC's timely access survey methodology, and required health plans to demonstrate through the survey that each of their networks[5] meets a 70% minimum rate of compliance for non-urgent and urgent appointments. If a health plan's network does not meet the minimum 70% rate of compliance, the health plan is required to submit a corrective action plan to the DMHC. Moreover, the health plan may be subject to disciplinary action. This report is the first time the DMHC is presenting data at the network level and showing the percentage of networks that met the 70% minimum rate of compliance.

The DMHC has also implemented new requirements under SB 221 and SB 225 by requiring health plans that do not meet an 80% initial performance target for non-physician mental health follow-up appointments to submit a corrective action plan. The DMHC has adopted the 80% minimum rate of compliance performance target as a standard into the Timely Access Regulation, which will take effect beginning with MY 2024 reporting.

With these new requirements in the amended Timely Access Regulation, the DMHC is now able to hold health plans accountable for meeting a minimum rate of compliance and ultimately ensure health plans provide members timely access to critical health care services. By displaying rates of compliance for each network, the DMHC is able to better coordinate its review of timely access compliance and network adequacy. Further, network level results ensure that health plan monitoring of timely access compliance is more consistent with the way members access health care services from their health plan and provides better transparency into health plan compliance with the timely access to care standards.

[5] A network is a discrete set of network providers the health plan has designated to deliver all covered services to members covered by a health plan within its approved network service area. (Title 28 CCR section 1300.67.2.2(b)(5).)

Timely Access Standards

The specific wait time standards in the Timely Access Statute and Regulation are provided in the chart below. It is important to note that there are two separate standards for urgent appointments. A 48-hour (2 days) wait time standard applies when a health plan does not require authorization be obtained in advance of the delivery of care. A 96-hour (4 days) wait time standard applies when the health plan requires authorization be obtained prior to the delivery of care.

Urgent Care

prior authorization **not required** by health plan

48 hours

prior authorization **required** by health plan

96 hours

Non-Urgent Care

Doctor Appointment

PRIMARY CARE PHYSICIAN

10 business days

SPECIALTY CARE PHYSICIAN

15 business days

Mental Health Appointment

(non-physician[1])

10 business days

Appointment

(ancillary provider[2])

15 business days

Follow-Up Care

Mental Health / Substance Use Disorder Follow-Up Appointment

(non-physician)

10 business days from prior appointment

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

[2] Examples of ancillary services include lab work or diagnostic testing, such as mammogram or MRI, or treatment such as physical therapy.

Health plans are required to ensure that each of its provider networks has the capacity to offer members appointments within the timely access standards. Members may access urgently needed services in a variety of ways depending on the delivery model of the health plan, aside from emergency treatment obtained at an emergency room. For example, many health plan members who require urgent care may obtain same-day appointments through their primary care provider or through another doctor within their medical group. Some health plans offer the capability to meet urgent primary care treatment needs by offering advanced access, which is the ongoing availability of primary care services on the same day or the next business day of the member's request. Additionally, some health plans allow members to access urgent care through contracts with dedicated urgent care centers located within the member's local service area. Some methods of meeting member urgent care needs may not be measured in the timely access survey and displayed in this report. The timely access survey measures the next available appointment. Thus, other methods of meeting members' urgent care needs that are not delivered via appointments cannot be measured by the timely access survey. However, the DMHC included a new survey question in MY 2024 to evaluate other methods providers employ to ensure members are able to access urgent care services in a timely manner. The results of this question will be reported to the DMHC in 2025 and will be included in next year's report.

Evolving Methodology Results in Non-Comparable Year-Over-Year Data

While the DMHC strives to maintain comparability, the MY 2023 timely access data is not comparable to prior years due to a number of changes in the law impacting the survey methodology, such as a change in the calculation of urgent appointment wait times and an increase in the number of physician specialties (from three to ten) included in the survey. While the change in specialty types also impacts comparability, it will ensure that the results better represent access for specialist physicians that treat critical conditions and are highly utilized. The DMHC will continue working to implement the timely access requirements under the law, including forthcoming amendments to the reporting methodology, some of which have already been mentioned.

How the DMHC Monitors Timely Access

In addition to the review of health plan timely access compliance reports, the DMHC uses a variety of regulatory oversight tools to ensure members have timely access to care. These oversight tools include:

- Monitoring member complaints submitted to the DMHC's Help Center to identify trends and take appropriate action, including potential referral to the DMHC's Office of Enforcement.
- Evaluating health plan networks when there is a contract termination between a health plan and provider group that impacts 2,000 or more members to ensure health plans have an adequate number of providers to offer timely access to care to their members.
- Performing network adequacy reviews annually and when a health plan seeks to make a significant change to its license, including changes to its service area, or a change in its roster of providers that would require a health plan filing with the DMHC.

- Auditing of health plan operations through routine medical surveys, which include an assessment of health plan compliance with the timely access standards and an evaluation of whether the health plan took actions in response to access and availability issues identified. The DMHC assesses the health plan's quality assurance review processes and may identify instances in which a health plan fails to comply with quality assurance and oversight requirements. Where a health plan determines there are timely access or network adequacy issues based on audits, oversight, or other information such as member grievances that concern timely access to appointments, the DMHC evaluates whether the health plan implemented corrective action as required by the health plan's written quality assurance process. The DMHC also reviews the health plan's processes for coordinating language assistance services when members obtain health care services, including at the time of a scheduled appointment.
- Taking enforcement action against health plans that violate timely access requirements, which may include monetary penalties and corrective action.

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

DISTANCE

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

AVAILABILITY

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

INTERPRETER

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

Timely Access Compliance Report Findings

The DMHC requires health plans to use the timely access survey methodology to measure its network capacity to offer members appointments within the required wait time standards, and then to annually report the results to the DMHC. The timely access survey methodology requires health plans to capture its network providers' next available appointment and does not measure actual member experiences. Tables 1 and 2 include provider response rates. Tables 3 and 4 include the average appointment wait time by provider and appointment type. Charts 1 through 6 include the percentage of surveyed providers who indicated they had an appointment available within the applicable appointment wait time standard.

The timely access survey methodology requires a health plan to use a randomly selected stratified sample of each provider type within a health plan network in each county. The health plans contact a random sample of the health plan's network providers and ask for the provider's next available urgent and non-urgent appointment. The health plan may survey all or a statistically significant sample of its network providers. In addition, during the survey non-physician mental health providers are asked to provide their next available follow-up appointment.

Survey Response Rate Tables

The tables below list the response (completed survey), non-response, and ineligible rates for full service and behavioral health plans. These figures were calculated based on the number of providers that were sent a written survey (e.g., email or fax), received a phone call survey or a call was attempted, appointment data was extracted from the provider's appointment schedule, or the provider was identified as a verified advanced access primary care provider.[6]

Table 1 and 2 identify the response, non-response, and ineligible rates for full service and behavioral health plans by product type. Health plans are required to use a statistically significant sample of providers in the survey. For full service health plans, 45% of the providers selected to be surveyed responded to the survey, 29% did not respond, and 25% were ineligible to participate. For behavioral health plans, 49% of providers responded to the survey, 35% did not respond, and 16% were ineligible. The primary reason for a non-response was due to providers failing to respond to the survey within the 15 business days allowed for a response or issues with the providers contact information.

[6] As previously indicated, providers who contract with multiple health plans or practice in multiple counties may be contacted by multiple surveyors. A single provider may complete the survey during some survey attempts but then fail to respond or be deemed ineligible for other attempts. The figures presented in the tables below are calculated for each survey attempt for all providers who surveyors attempted to survey.

Table 1: Full Service Health Plans
Summary of Survey Response Rates[7]

Survey Outcome	All Products	Commercial	Individual/ Family	Medi-Cal
Completed Survey	45%	46%	44%	44%
Non-Response				
Declined to Respond	5%	6%	5%	4%
No Response within Required Timeframe	24%	23%	25%	25%
Ineligible				
Contact Information Issue	11%	11%	12%	12%
Provider Not in Plan Network	2%	1%	2%	3%
Provider Retired or Ceasing to Practice	1%	1%	1%	1%
Provider Not in County	6%	7%	7%	5%
Provider Listed Under Incorrect Specialty	1%	1%	1%	2%
Provider Does Not Offer Appointments	4%	4%	4%	4%

Table 2: Behavioral Health Plans
Summary of Survey Response Rates[8]

Survey Outcome	All Products	Commercial	Individual/ Family	Medi-Cal
Completed Survey	49%	50%	46%	39%
Non-Response				
Declined to Respond	4%	4%	4%	0%
No Response within Required Timeframe	31%	30%	33%	37%
Ineligible				
Contact Information Issue	6%	6%	8%	14%
Provider Not in Plan Network	3%	3%	3%	4%
Provider Retired or Ceasing to Practice	0%	0%	0%	0%
Provider Not in County	3%	4%	1%	0%
Provider Listed Under Incorrect Specialty	0%	0%	0%	1%
Provider Does Not Offer Appointments	4%	4%	4%	5%

[7] Due to rounding, these numbers may add up to 99% or 101%.
[8] Due to rounding, these numbers may add up to 99% or 101%.

Networks Meeting the Minimum Rate of Compliance

This is the first time the DMHC is presenting provider appointment availability data at the health plan network level. The percentages are calculated from 121 full service health plan networks and five behavioral health plan networks that reported the percentage of providers with an appointment within the applicable appointment wait time standard to meet the minimum rate of compliance.

Overall, approximately 90% of the 121 full service heath plan networks met the rate of compliance for non-urgent appointments, approximately 65% of the full service health plan networks met the rate of compliance for urgent appointments and approximately 80% of all full service health plan networks met the non-physician mental health provider follow-up appointment performance target. The five behavioral health plan networks met the minimum rate of compliance for non-urgent and urgent appointments and the non-physician mental health provider follow-up appointment performance target.

The DMHC has published the Health Plan Timely Access Data on its website through a new interactive data analytics tool where users can explore the timely access data at the network level.

Full Service Health Plan
Rate of Compliance Charts

Rate of Compliance Charts

Rate of Compliance Charts

The Rate of Compliance Charts (Charts 1 through 6 below) display the results of the survey and set forth the percentage of providers with an appointment available within the timely access standards. Full service and behavioral health plans' timely access data are presented in the Rate of Compliance Charts separately; however, full service health plans include survey responses for behavioral health services. A health plan with more than one network may have aggregated results within a product designation in the charts. For individual health plan network-level rates of compliance, please review the DMHC's new Health Plan Timely Access Data web page. Health plan timely access survey results reflect only the time period in which a provider was surveyed and are based on the sample of providers who responded to the survey.

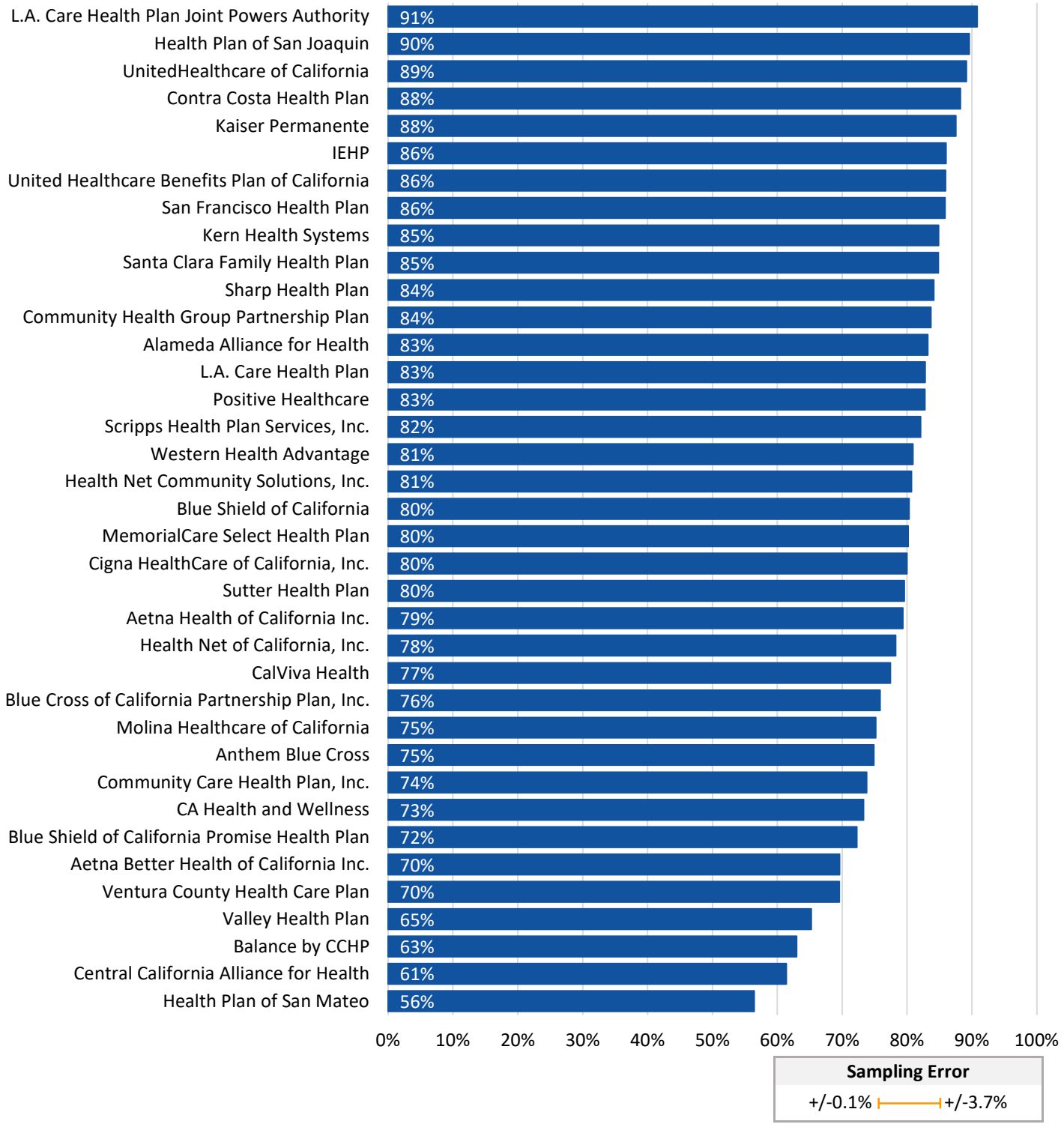
Non-Urgent Appointments

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

Chart 1

Full Service Health Plans

This chart combines all health plans' non-urgent appointment survey results for all provider types (primary care, specialist physicians, psychiatrists, non-physician mental health providers, and ancillary providers) across all networks combined, including Commercial products, Individual/Family products, and Medi-Cal products.



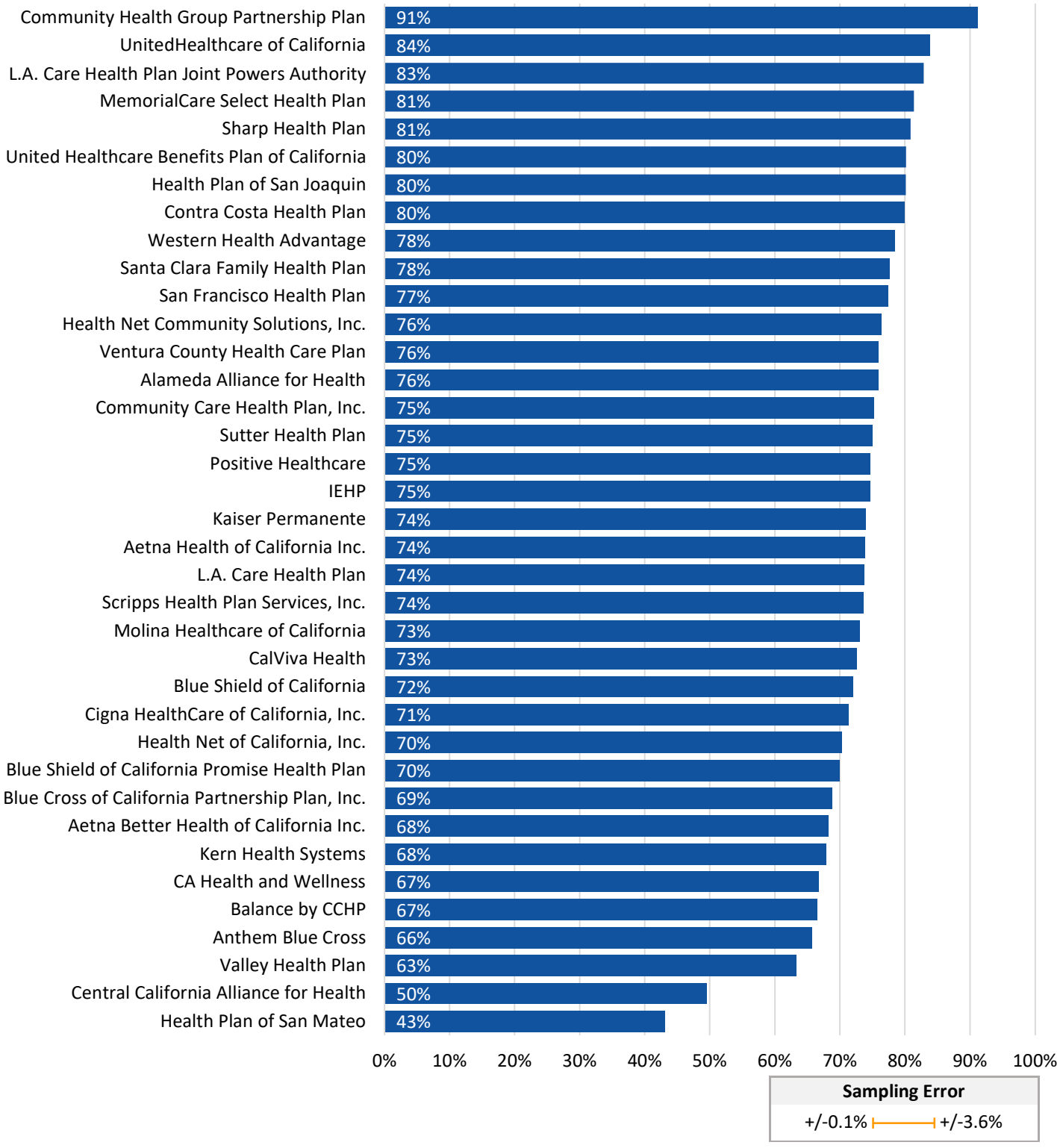
Urgent Appointments

Percentage of Providers Meeting the Urgent Appointment Wait Time Standards

Chart 2

Full Service Health Plans

This chart combines all health plans' urgent appointment survey results for primary care, specialist physicians, psychiatrists, and non-physician mental health providers across all networks combined, including Commercial products, Individual/Family products, and Medi-Cal products.



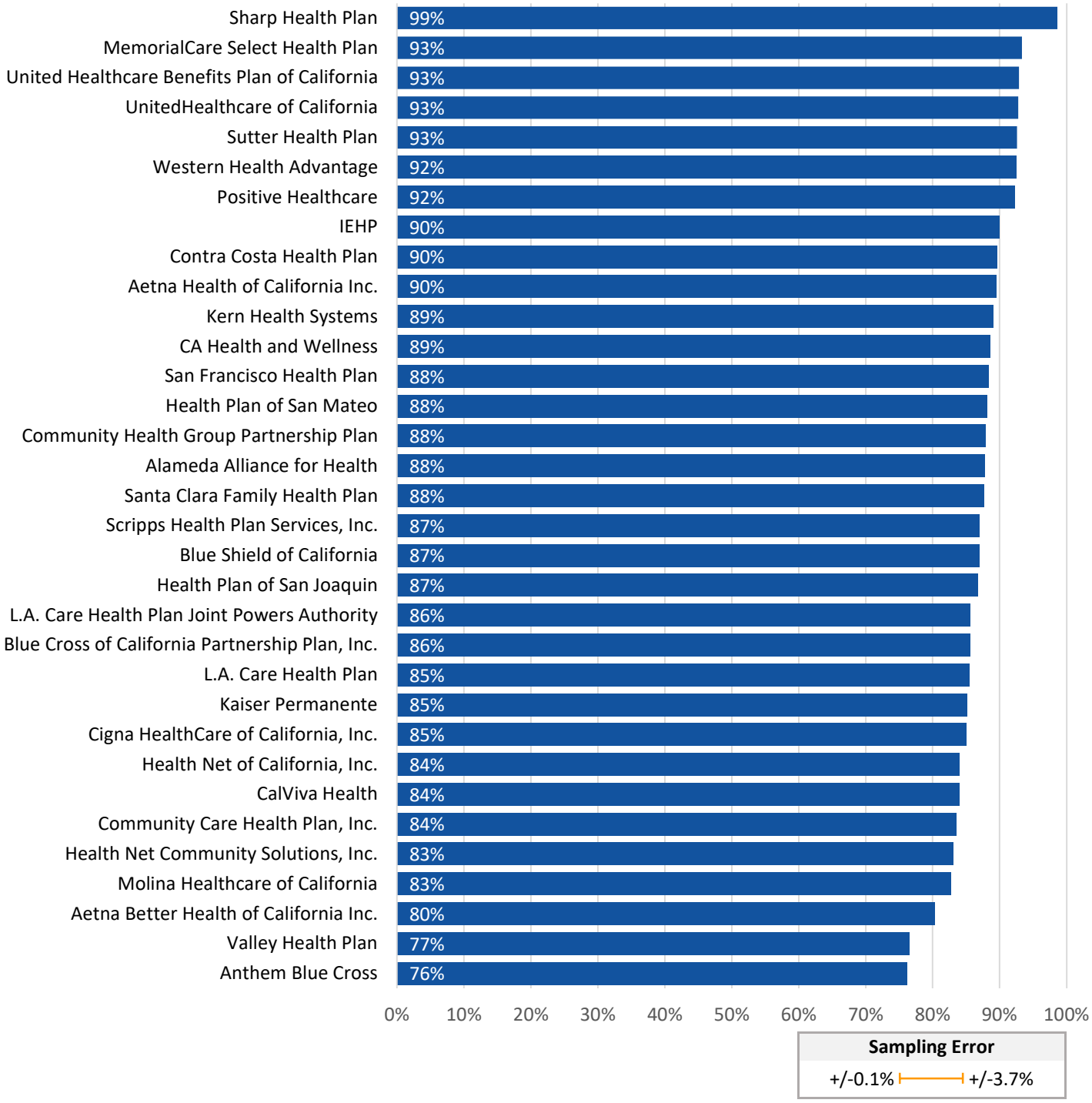
Non-Physician Mental Health Follow-Up Appointments

Percentage of Providers Meeting the Non-Physician Mental Health Follow-Up Appointment Wait Time Standard

Chart 3

Full Service Health Plans

This chart combines all health plans' non-physician mental health provider follow-up appointment survey results across all networks combined, including Commercial products, Individual/Family products, and Medi-Cal products.



Behavioral Health Plans
Rate of Compliance Charts

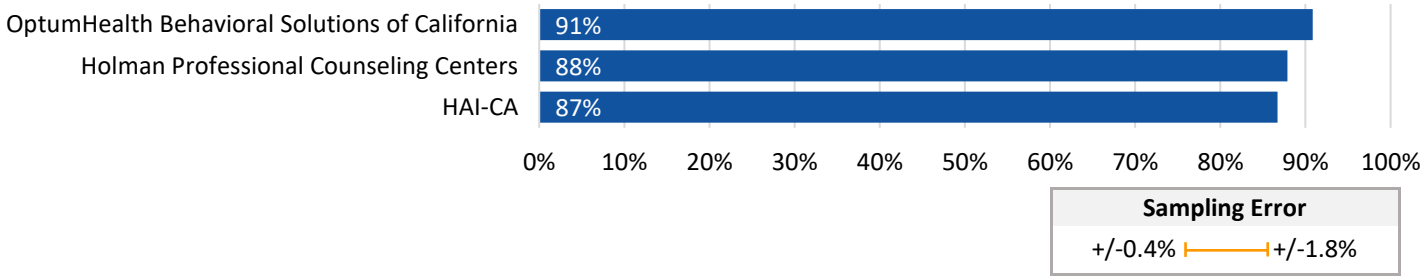
Non-Urgent Appointments

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

Chart 4

Behavioral Health Plans

This chart combines behavioral health plans' non-urgent survey results for mental health providers (non-physician mental health providers, psychiatrists, including child and adolescent psychiatrists) across all networks combined, including Commercial products, Individual/Family products, and Medi-Cal products.



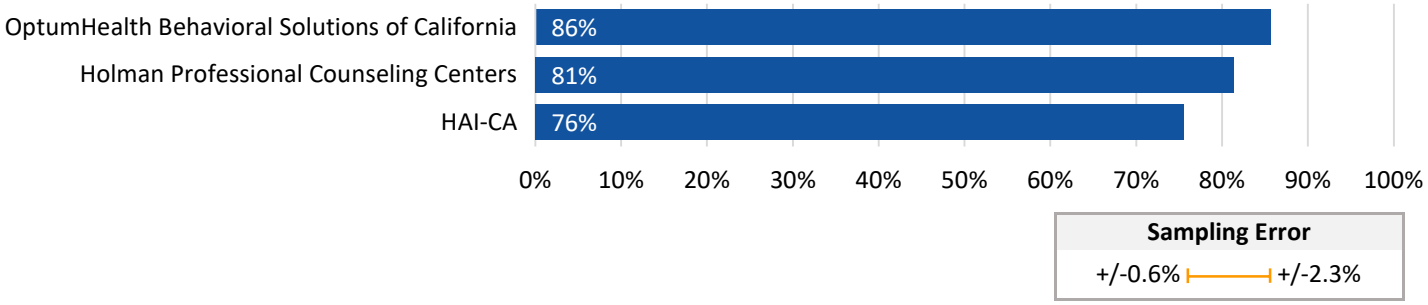
Urgent Appointments

Percentage of Providers Meeting the Urgent Appointment Wait Time Standards

Chart 5

Behavioral Health Plans

This chart combines behavioral health plans' urgent appointment survey results for mental health providers (non-physician mental health providers, psychiatrists, and child and adolescent psychiatrists) across all networks combined, including Commercial products, Individual/Family products, and Medi-Cal products.



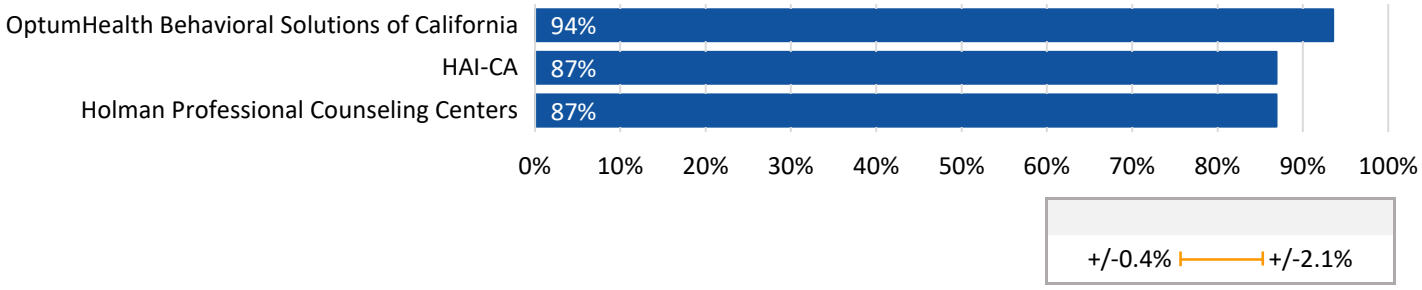
Non-Physician Mental Health Follow-Up Appointments

Percentage of Providers Meeting the Non-Physician Mental Health Follow-Up Appointment Wait Time Standard

Chart 6

Behavioral Health Plans

This chart combines behavioral health plans' follow-up appointment survey results for non-physician mental health providers across all networks combined, including Commercial products, Individual/Family products, and Medi-Cal products.



Average Appointment Wait Time Tables

Average Appointment Wait Times by Product

Average Appointment Wait Time Tables

The mean and median appointment wait times are calculated by measuring the wait time between the date of the provider's response to the survey and the next available appointment. The mean wait time is the average of the appointment wait times obtained from the timely access survey. The median wait time is the middle point of all reported wait times where half of all appointments are at or below the median. In order to calculate a mean and median that more closely reflects a member experience, both the mean and median were calculated after outliers with the most extreme wait times were removed in accordance with accepted statistical standards and practices.

Tables 3 and 4 identify the mean and median appointment wait times for non-urgent and urgent appointments for full service and behavioral health plans' networks by product. Non-urgent and follow-up appointment wait times are measured in business days. Urgent appointment wait times are measured in hours. The applicable wait time standard is included in the table below for reference. For additional information regarding calculation of the mean and median appointment see Appendix A in this report.

Table 3: Full Service and Behavioral Health Plans
Average Non-Urgent Appointment Wait Times by Business Days

Provider Type	Non-Urgent Appointment Wait Time Standard	All Products		Commercial		Individual/Family		Medi-Cal	
		Mean	Median	Mean	Median	Mean	Median	Mean	Median
Primary Care Providers	10 Business Days	3	2	3	2	3	2	3	2
Specialist Physicians	15 Business Days	12	8	11	7	11	7	11	6
Psychiatrists	15 Business Days	4	3	4	3	4	3	4	3
Non-Physician Mental Health Care Providers	10 Business Days	3	2	3	2	3	2	3	3
	10 Business Days (Follow-Up Standard)	4	5	4	5	4	5	4	5
Ancillary Service Providers	15 Business Days	4	3	4	3	4	2	3	2

Table 4: Full Service and Behavioral Health Plans
Average Urgent Appointment Wait Times by Hours[9]

Provider Type	Non-Urgent Appointment Wait Time Standard[10]	All Products		Commercial		Individual/Family		Medi-Cal	
		Mean	Median	Mean	Median	Mean	Median	Mean	Median
Primary Care Providers	48 hours	48	24	51	24	49	24	35	23
Specialist Physicians	48 hours or 96 hours	148	68	143	64	127	50	118	47
Psychiatrists	48 hours or 96 hours	75	46	76	46	73	43	64	30
Non-Physician Mental Health Care Providers	48 hours or 96 hours	46	30	46	31	44	30	42	26

[9] The urgent appointment survey question does not include Ancillary Service Providers.
[10] If no prior authorization is required by the health plan, an urgent appointment must be made available to the member within 48 hours of the request for the appointment. If prior authorization is required by the health plan, an urgent appointment must be made available to the member within 96 hours of the request for the appointment.

Next Steps

The DMHC remains focused on ensuring health plan members can access health care services within the timely access standards. The DMHC will also utilize the newly established rates of compliance and regulatory tools, which were developed in consultation with stakeholders over several years, to hold health plans accountable.[11]

The DMHC will take steps to implement the following actions:

- The DMHC will hold health plans accountable to demonstrate each network is sufficient to meet the required 70% rate of compliance for urgent and non-urgent appointments and the new 80% minimum rate of compliance for non-physician mental health follow-up appointments recently enacted into regulation beginning in MY 2024. If a network fails to meet the urgent, non-urgent, or non-physician mental health follow-up minimum rates of compliance, the DMHC will require that health plan to implement corrective action to bring its network into compliance. The non-compliant health plans may also be referred to the DMHC's Office of Enforcement for further review and potential action.
- The DMHC will monitor the effectiveness of previously submitted corrective action plans where a network did not meet the minimum rates of compliance. In addition to requiring corrective action, the DMHC may take enforcement action against a health plan for failing to meet compliance standards, where appropriate.
- The DMHC will evaluate the results of a new survey question related to other methods providers use to offer members urgent care. The results of this survey question are anticipated to help the DMHC better understand how urgent care is delivered when an appointment with a specific provider is not available within the urgent appointment wait time standards. This change will be implemented in MY 2024, and the results under the updated methodology will be reported to the DMHC in 2025.
- The DMHC will update its timely access survey methodology to require health plans to measure urgent appointment wait time compliance for specialist physicians, psychiatrists, and non-physician mental health providers against either a 48-hour urgent appointment standard if no prior authorization is required or a 96-urgent appointment standard if prior authorization is required. This change will be implemented in MY 2025, and the results under the updated methodology will be reported to the DMHC in 2026.

[11] The DMHC updated the standardized timely access survey methodology and rate of compliance incorporated in the amended Timely Access Regulation under the authority established by SB 221 and SB 225.

Conclusion

One of the DMHC's top priorities is to ensure health plan members can access the care they need, when they need it. This includes making sure health plans are providing care within the timely access standards. The DMHC will continue to monitor health plan compliance with the timely access standards through the annual timely access data reports and the additional regulatory oversight tools available to the DMHC. The DMHC will hold health plans accountable that fail to meet the required 70% and 80% rate of compliance standards by requiring corrective action plans and/or taking enforcement action, as appropriate.

The DMHC Help Center continues to be a valuable resource to members facing issues with their health plan, including getting timely access to care. If a health plan member is unable to obtain a timely appointment, they should first contact their health plan directly for assistance. If their health plan does not resolve the issue, they should contact the DMHC Help Center for assistance at 1-888-466-2219 or www.DMHC.ca.gov.

Appendices

Appendix A: Timely Access Data Discrepancies and Analysis

The charts and tables in this report include timely access data for primary care physicians, primary care non-physician medical practitioners, specialist physicians, non-physician mental health providers, and ancillary providers. The data for non-urgent appointments includes all provider types. However, the urgent appointment data does not include ancillary providers and follow-up appointment data only includes non-physician mental health providers.

Timely Access Survey Methodology

Health plans are required to create contact lists with providers in their network on January 15 (or a later date that is representative of the health plan's network during the survey). The health plan then uses the contact list to draw samples of network providers, or it may conduct a census and select all providers. The timely access survey methodology allows health plans to conduct surveys from June through December of the measurement year. The health plan may administer the multimodal survey through a written survey (e.g., email or fax), a phone call survey, appointment data extracted from the provider's appointment schedule, or through deeming compliance when a provider is identified as a verified advanced access primary care provider. The timely access survey methodology requires the samples to be stratified by network, county, and provider type. Because of variations in the size of networks, responses may represent a sample of a relatively small share of providers for larger networks or a relatively large share or census of providers in small networks. After collecting survey responses from network providers, the health plan calculates the timely access survey results using its raw survey data and the formulas embedded in the results report form. The health plan then reports the timely access survey results to the DMHC on May 1 of the following year.

Health plans' network composition may change from the time the contact list is created to the administration of the survey, which can lead to some providers being ineligible at the time of the survey (e.g., a provider may retire or terminate their contract with a health plan between the time the contact list is created, and the survey is administered). Health plans are permitted to update contact information and must replace ineligible providers with other providers on the contact list; however, the timely access survey methodology does not permit health plans to remove or add providers following the creation of the contact list.

The survey identifies whether the wait time for the first available appointment with a provider is within the applicable wait time standard. When a provider is in more than one network or contracted with more than one health plan that uses the same survey vendor, the provider's survey responses may be applied across multiple health plan networks or across health plans. A provider may have been surveyed multiple times for several reasons, including when the provider is contracted with multiple health plans that do not use the same survey vendor, the provider practiced in multiple counties, or due to a health plan survey error.

Timely Access Report: Health Plan-Level Rates of Compliance

The DMHC-contracted statistician created a weighted mean of the timely access rate across all health plan county networks, using as weights the number of providers within a county network. Non-urgent appointment rates for ancillary providers are weighted by the number of service centers, rather

than individual providers, within a county network. This provider weighting means that a timely access rate for a health plan's county network with 100 providers receives a weight ten times the weight of a rate for a county network with 10 providers. This weighting ensures that the overall rates are not biased by rates in counties with smaller numbers of providers or service centers. The resulting rates show the expected percentage of successful appointment requests within the standard applicable to the type of provider and type of appointment.

Rate of Compliance Charts: Sampling Error Rate and Response Rates

The timely access survey methodology requires each health plan to obtain a minimum number of survey responses from providers to produce generalizable results about each health plan's network performance in providing timely access to health care services. To ensure that the Rate of Compliance Charts (Charts 1 through 6) present only reliable provider appointment data for each health plan, the DMHC only includes a health plan's timely access data in the Rate of Compliance Charts if the health plan's sampling error was at or below five percentage points (or ten percent for non-physician mental health follow-up appointments if the network contains less than 100 non-physician mental health providers).[12] When a health plan fails to meet the sampling error threshold, the results of the survey may not be sufficiently reliable to produce generalizable results.[13] Charts 1 through 6 below combine data for more than one provider type or appointment type, which increases the sample size and results in more reliable data (i.e., lower sampling errors). Each chart includes the sampling error range across all health plans.

As an example, if a health plan's timely access survey results show a 75% rate of compliance with a two-percentage point sampling error, this means 75% of providers that responded to the survey indicated their next available appointment fell within the appointment wait time standards. Because the result is calculated from a statistical reliable sample of a health plan's network providers, we can infer with a high degree of statistical reliability what the actual rate of compliance for the next available urgent and non-urgent appointment is for all health plan network providers. In this example, we are highly confident that between 73% and 77% of available appointments for all health plan network providers fall within the timely access standards.

In MY 2023, no health plans exceeded the five percent sampling error threshold for non-urgent or urgent appointments. However, Balance by CCHP, Blue Shield of California Promise Health Plan, and Central California Alliance for Health, exceeded the sampling error threshold for non-physician mental health follow-up appointments. These three health plans are omitted from Chart 3 in this report but are included in all other applicable charts and tables in this report. The high sampling error resulted from the health plans failing to obtain a sufficient number of survey responses to meet the sample size requirements. This was primarily due to a high number of ineligible and/or non-responding providers.

[12] A sampling error is the statistical error associated with estimates drawn from a sample of a population. The sampling error indicates the range where the actual rate might fall given the sample size and estimated rate and the population rate. The sampling errors for this report are calculated at a 90% confidence level, which means that a rate of compliance estimate of 75% with a sampling error of +/- 5% indicates that there is a 90% certainty that the true rate of compliance is between 70% and 80%.

[13] Sampling errors exceeding five percent for combined provider type rates indicate the health plan's failure to achieve required sample sizes for multiple provider types. Sampling errors over five percent raise concerns that the sample of responses may not be representative of the population of health plan contracted providers. Appendix A contains a detailed explanation of the data discrepancies that may lead to sampling errors at that level.

Additionally, the follow-up appointment measurement is calculated only from appointments with non-physician mental health providers leading to smaller sample sizes compared to urgent or non-urgent appointment measurements, which are aggregated across multiple provider types.

The DMHC evaluates response, non-response, and ineligible rates reported by health plans in the timely access data and requires health plans to submit corrective action when response rates do not meet the DMHC's data quality standards.[14] In addition to the reliability concerns addressed above, high non-response or ineligible rates may suggest that members could experience difficulties contacting providers to schedule timely appointments. However, it is important to note that a member's experience seeking health care services will differ from a health plan seeking appointment information through a survey.[15] For instance, a provider contracted with multiple health plans may be surveyed multiple times by different health plans, which may lead the provider to complete the first survey and decline to participate in subsequent surveys due to provider fatigue, confusion, or other reasons. Thus, the rate of non-responding and ineligible providers may not represent the member's experience in obtaining a timely appointment.

Rate of Compliance Charts: Response Rates

The DMHC evaluates response, non-response, and ineligible rates reported by health plans in the timely access data and requires health plans to submit corrective action when response rates do not meet the DMHC's data quality standards.[16] High non-response or ineligible rates may suggest that members could experience difficulties contacting providers to schedule timely appointments. Moreover, high non-response or ineligible rates may impact the ability of the health plan to produce a reliable estimated rate of compliance. For example, due to the time it takes to prepare a contact list and the coordination of health plans using a single survey vendor to conduct the survey, several months may pass between the creation of the contact list and the administration of the survey. Thus, a provider may leave the network in the interim making the contact list used by the health plan to conduct the survey out-of-date.

[14] A non-responsive provider is a provider that declines to participate or fails to respond to the survey within the required timeframe set forth in the timely access survey methodology. An ineligible provider is a provider that is not eligible to participate in the survey, if at the time the survey is conducted, the provider's information is inaccurate, the provider is no longer in network, the provider is no longer practicing, the provider does not offer health care services through appointments, or the provider is not located in the county.
[15] For example, due to the time it takes to prepare a contact list and the coordination of health plans using a single survey vendor to conduct the survey, several months may pass between the creation of the contact list and the administration of the survey. Thus, a provider may leave the network in the interim making the contact list used by the health plan to conduct the survey out-of-date, whereas a member would use a provider directory that is updated more frequently.
[16] A non-responsive provider is a provider that declines to participate or fails to respond to the survey within the required timeframe set forth in the timely access survey methodology. An ineligible provider is a provider that is not eligible to participate in the survey, if at the time the survey is conducted, the provider's information is inaccurate, the provider is no longer in network, the provider is no longer practicing, the provider does not offer health care services through appointments, or the provider is not located in the county.

The DMHC's Health Plan Timely Access Data Web Page: Health Plan Network-Level Timely Access Data

Due to the large volume of health plan networks licensed, the DMHC does not include network level information in this written report. The DMHC published network level information on its public Health Plan Timely Access Data web page. The Health Plan Timely Access Data web page presents the percentage of providers meeting timely access standards for each health plan network. The health plan network-level percentages are calculated using the same methodology used for plan-level rates of compliance; however, the plan-level rate calculations use the provider count weights summed across all networks, whereas the network-level rates are calculated using provider count weights from within each plan network.

Sampling Error: Calculation and Exclusions from this Report and the DMHC's Health Plan Timely Access Data Web Page

Each rate of compliance chart includes an estimated percentage of providers with an appointment within the applicable wait time standard and provides the corresponding sampling error range. The sampling error indicates, with 90% certainty, the range where the actual rate might fall given the sample size and estimated rate.[17] Sampling errors were calculated by the DMHC-contracted statistician using a finite population correction. The variability in sampling errors resulted from variation in rates, the size of health plan networks, and the degree to which health plans obtained a sufficient number of responses to meet the target sample sizes. Health plan results are not presented in the charts within the Timely Access Report if the sampling error for the rate of compliance was greater than five percent (or ten percent for follow-up appointments when there are less than 100 non-physician mental health providers in a health plan's network), as these results are deemed unreliable.

In this MY 2023 Timely Access Report, three health plans exceeded the sampling error threshold for follow-up appointments at the plan-level. Balance by CCHP, Blue Shield of California Promise Health Plan, and Central California Alliance for Health's unreliable follow-up appointment rate estimates resulted from failing to meet the target sample size requirements due to high numbers of ineligible and/or non-responding providers. Additionally, the follow-up appointment rate is calculated only from appointments with non-physician mental health providers, leading to smaller sample sizes for this measurement type. For Balance by CCHP, approximately 10% of the health plan's non-physician mental health providers responded to the survey, and only about 20% of California Promise and Central California Alliance for Health non-physician mental health providers responded to the survey. These issues led to an insufficient sample size to produce a reliable estimated percentage of providers with an appointment within standard for non-physician mental health follow-up appointments.

As previously indicated, the DMHC published network-level rates of compliance on its Health Plan Timely Access Data web page. The network-level rates exceeding the five percent sampling (or ten percent sampling error for follow-up non-physician mental health providers with less than 100

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

providers) thresholds are omitted from the public web page. For urgent appointments, Balance by CCHP's network, CCHP Network PPO, reported a sampling exceeding this threshold, and was omitted from the public web page. Network-level urgent and follow-up appointment rates of compliance were also omitted from the Health Plan Timely Access Data web page for networks belonging to Aetna Better Health of California, Balance by CCHP, Blue Shield of California Promise Health Plan, Central California Alliance for Health, and Molina Healthcare of California. The high sampling errors for these networks all resulted from low survey response rates.

Average Appointment Wait Times Methodology

The average (mean and median) appointment wait times presented in this report and on the DMHC's Health Plan Timely Access Data web page are calculated by the DMHC-contracted statistician for non-urgent, NPMH follow-up, and urgent appointments by each provider type. Provider appointment wait times are measured from the time and date of the survey administration to the provider's next available appointment as reported in the raw data. Weekends and holidays are excluded from the non-urgent appointment wait time.

For the industry-level average appointment wait times set forth in Tables 3 and 4 in this report, each surveyed provider represents a single appointment wait time across all plan surveys. A single appointment wait time is used where multiple health plans' raw data includes the same provider with the same next available appointment (and wait time). When a provider was surveyed multiple times (i.e., there are different survey dates for the provider in the raw data), that provider's responses are weighted such that they represent a single provider in the calculation for average appointment times.

The DMHC-contracted statistician also calculated the median and mean health plan-level appointment times presented in Appendix D of this report and on the DMHC's Health Plan Timely Access Data web page. Health plan-level appointment wait times are deduplicated based on repeated provider appointments across multiple networks within a plan, whereas appointment wait times for industry-level averages are deduplicated based on repeated provider appointments across any health plan.

In some cases the All Product mean and median appointment wait time may be longer than the Commercial, Individual/Family and Medi-Cal product calculations. The DMHC-contracted statistician reviewed the data and observed that some providers participate in multiple networks and were represented in two or three product types. These providers had, on average, shorter appointment wait times. When these providers were de-duplicated to calculate the All Product mean and median, they had less weight relative to the providers who were only in a single product type. The single product providers had, on average, longer appointment wait times. As a result, the mean and median for All Products may be longer than the Commercial, Individual/ Family and Medi-Cal product calculations for some provider types.

The DMHC also identified outlier observations that skewed the calculation of the average or mean appointment wait times. In order to produce average appointment wait time values that better reflect the overall member experience, the DMHC eliminated the most extreme wait times by excluding from the mean appointment wait time calculations all times that are above 90th percentile wait times for

each provider type.[18] To further mitigate the influence of outliers where there are few providers, the mean appointment wait times are suppressed where there are fewer than 20 providers of a specific provider type and the mean appointment wait time is greater than the median time by 96 hours for urgent appointments or 5 business days for non-urgent appointments. The median appointment wait times represent the 50th percentile appointment wait time of all appointments and do not exclude excessively long appointment wait times (or outliers). Nor does it exclude from the median appointment wait times calculated from fewer than 20 providers. Urgent appointment wait times are presented in hours, and non-urgent and follow-up appointment wait times are presented in business days.

Survey and Data Issues

In addition to the external vendor analysis health plans are required to complete prior to submission, the DMHC conducts a data validation and an analysis of the timely access data to evaluate the reliability and accuracy.[19] When an initial compliance concern is identified, the DMHC issues a finding to the health plan and requests the health plan provide an explanation for the discrepancy or engage in corrective action, where appropriate, to ensure that any discrepancies are corrected in future reporting years. After the evaluation of the issue and the health plan's response are complete, the DMHC may take further administrative actions against the health plan.

Erroneous Compliance Calculations:

- The DMHC independently verified each health plan's survey results setting forth the percentage of providers with an appointment available within standard against the health plan's corresponding raw data. As a result of this verification, the DMHC found that some health plans' raw data did not exactly match the rates of compliance the health plan submitted for a county or provider type.[20] These errors mostly produced negligible differences between the health plan's rates of compliance reported in results and raw data.

De-Duplication Errors:

- De-duplication errors occurred as a result of health plan errors, including, but not limited to health plans not properly de-duplicating providers to a single location in a county when providers had multiple locations, when duplicated records in the raw data were not properly accounted for in the results, or by the inclusion of individual-level identifiers for facility-level provider types. Though these errors may lead to overrepresentation for some providers in the results, a review of duplicated records revealed that they constituted insubstantial shares in the results and did not exhibit a specific bias.

[18] Excessively long wait times may result from several factors, including data errors, limited capacity, providers being on leave, or specific provider group scheduling processes. These groups often have other processes to ensure members receive urgent services, such as directing members to other providers or clinics for urgent care services that are not captured by the survey methodology. Thus, excessively long wait times for specific providers are likely not reflective of the member experience. To account for these issues, the 90th percentile wait time is calculated for each provider type, and appointment wait times above 90th percentile time are excluded only from the mean appointment weight time calculation.

[19] The DMHC requires health plans to contract with an external vendor to conduct a quality assurance and validation review prior to submission of the timely access data.

[20] Health plans are required to calculate the DMHC rates of compliance based on raw data (i.e., individual provider responses to the survey). Health plans then submit both the rates of compliance and the raw data to the DMHC.

Duplicate Survey Results:

- UnitedHealthcare of California submitted survey results with duplicate records for some provider types. The Results Form includes formulas that auto-calculate the rates of compliance and sampling errors using provider counts. The health plan reporting duplicate records inflates the weight of those provider responses on urgent, non-urgent, and non-urgent follow-up appointment rates of compliance. To evaluate the impact of this reporting error, the DMHC-contracted statistician recalculated the rates of compliance by omitting the duplicate records. Based on this analysis, the DMHC determined that the duplicate records reporting error had a negligible effect on the rates of compliance presented for UnitedHealthcare of California networks.

Failure to Report a Network:

- Oscar Health Plan of California failed to submit timely access survey results for its two networks, Oscar California San Francisco Network and Oscar LA/OC Narrow Network. If these networks have substantively different results, then tables presenting industry-wide results in this report may not accurately represent industry results. However, given the size of their networks relative to the total of providers in other plan networks, this omission is unlikely to produce bias in the industry-wide results presented in the Timely Access Report. However, as a result of this health plan's reporting error, the DMHC is unable to include data for the health plan's networks in this report and on its Health Plan Timely Access Data web page. The DMHC notes that Oscar Health Plan of California is maintaining its Knox-Keene Act license but no longer has enrollment as of December 31, 2023.

Omission of Provider Types:

- Ventura County Health Care Plan failed to submit timely access survey data for psychiatrist and non-physician mental health providers to the DMHC. As a result, the non-physician mental health follow-up appointment rate in Chart 3 cannot be calculated for the health plan in this report; nor may this information be included in the compliance information available on the DMHC's Health Plan Timely Access Data web page. (i.e., the DMHC is unable to include psychiatrist and non-physician mental health providers in the health plan's percentage of providers meeting wait time standards and the average appointment wait time in this report or the DMHC's Health Plan Timely Access Data web page.) To evaluate the potential bias of the compliance results in this report and the DMHC's Health Plan Timely Access Data web page, the DMHC-contracted statistician simulated Ventura County Health Care Plan's urgent and non-urgent rates of compliance using mental health provider rates from other plans. Based on this assumption, the DMHC determined that the omission likely resulted in less than a 2% difference between rates reported by the health plan without the providers and the DMHC's simulated rates. This difference would not substantially bias the results, nor would it likely impact the determination of compliance with Timely Access Standards. However, the DMHC notes that the omission of these providers could bias the health plan's urgent and non-urgent results if the health plan's actual rates of compliance for these omitted providers differ substantially from the rates of the providers submitted by other health plans.

Table 5: Health Plan Failure to Report Rates of Compliance for Certain Provider Types

Chart Number	Health Plan Name	Measurement Type	MY 2023 Rate of Compliance	MY 2023 Sampling Error
3	Ventura County Health Plan	Non-Physician Mental Health Follow-Up	Not Reported	Not Reported

Insufficient Sample Size:

- The sample size requirements established at the health plan network and county level were often not met due to the number of ineligible providers in the survey contact list or because providers failed to respond to the survey. A health plan's failure to obtain a sufficient number of survey responses to achieve the required sample size occurred mainly in counties with a small number of providers, which necessitates the health plan to survey all or nearly all providers to produce reliable county-level results. Aggregating results to the health plan level largely overcomes these issues by increasing the total sample size.

Low Sample Size Outliers:

- Average appointment wait times are calculated for each provider type, which lowers the sample size available for these measurements as compared to urgent and non-urgent rates of compliance, which is calculated across all provider types. The smaller sample size leads to a mean appointment wait time that is sensitive to undue influence by outliers. The DMHC-contracted statistician addressed these concerns by using a mean appointment wait time methodology that calculates the mean using the lowest 90 percent of appointment wait times. However, even after adjusting for outliers using this methodology, several health plans with smaller sample sizes had mean appointment wait times that were substantively higher than the calculated median times. In cases where there is a small sample size, undue influence may result even from a single outlier response. As a result, the DMHC omitted a health plan's mean appointment wait time when there are fewer than 20 survey responses and the mean appointment wait time is greater than the median wait time by 96 hours for urgent appointments or five business days for non-urgent appointments. The mean appointment wait times that were omitted from Appendix D: Full Service Health Plans Average Urgent Appointment Wait Time table and the DMHC's Health Plan Timely Access Data web page are set forth in the table below. All median appointment wait times are presented without any adjustment for outliers or the number of providers surveyed. Thus, median appointment wait times are included for each provider type for all plans in Appendix D and the DMHC's Health Plan Timely Access Data web page.

Table 6: Health Plan Survey Results Omitted from Rate of Compliance Charts in this Report Due to High Sampling Error

Chart Number	Health Plan Name	Measurement Type	MY 2023 Rate of Compliance	MY 2023 Sampling Error
3	Balance by CCHP	Non-Physician Mental Health Follow-Up	48%	14%
3	Blue Shield of California Promise Health Plan	Non-Physician Mental Health Follow-Up	74%	6%
3	Central California Alliance for Health	Non-Physician Mental Health Follow-Up	79%	6%

Table 7: Health Plan Product-Level Survey Results Omitted from Appendix C in this Report Due to High Sampling Error

Health Plan Name	Survey Product	Measurement Type	MY 2023 Rate of Compliance	MY 2023 Sampling Error
Balance by CCHP	All	Non-Physician Mental Health Follow-Up	48%	14%
Balance by CCHP	Commercial	Non-Physician Mental Health Follow-Up	47%	16%
Balance by CCHP	Individual/Family	Non-Physician Mental Health Follow-Up	48%	14%
Blue Shield of California Promise Health Plan	All	Non-Physician Mental Health Follow-Up	74%	6%
Blue Shield of California Promise Health Plan	Medi-Cal	Non-Physician Mental Health Follow-Up	74%	6%
Central California Alliance for Health	All	Non-Physician Mental Health Follow-Up	79%	6%
Central California Alliance for Health	Medi-Cal	Non-Physician Mental Health Follow-Up	79%	6%

Table 8: Health Plan Networks Survey Results Omitted from DMHC's Health Plan Timely Access Data Web Page Due to High Sampling Error

Health Plan Name	Network	Measurement Type	MY 2023 Rate of Compliance	MY 2023 Sampling Error
Aetna Better Health of California Inc.	Medi-Cal Sacramento Network	Non-Physician Mental Health Follow-Up	65%	14%
Balance by CCHP	47579CAN001	Non-Physician Mental Health Follow-Up	47%	23%
Balance by CCHP	47579CAN001	Non-Physician Mental Health Follow-Up	47%	23%
Balance by CCHP	CCHP NETWORK HMO	Non-Physician Mental Health Follow-Up	47%	23%
Balance by CCHP	CCHP NETWORK HMO	Non-Physician Mental Health Follow-Up	47%	23%
Balance by CCHP	CCHP Network PPO	Non-Physician Mental Health Follow-Up	49%	24%
Balance by CCHP	CCHP Network PPO	Urgent	59%	6%
Blue Shield of California Promise Health Plan	CA - SD Medi-Cal	Non-Physician Mental Health Follow-Up	74%	6%
Central California Alliance for Health	Alliance Care IHSS Monterey	Non-Physician Mental Health Follow-Up	79%	6%
Molina Healthcare of California	Medi-Cal	Non-Physician Mental Health Follow-Up	75%	6%

Table 9: Average Appointment Wait Times Omitted Due to Low Sample Size See Appendix D in this Report

Health Plan Name	Survey Product	Measurement Type	Provider Type	Number of Providers Surveyed	Mean Wait Time	Time Metric
Aetna Better Health of California Inc.	All	Non-Urgent	Ancillary Providers	6	22	Business Days
Aetna Better Health of California Inc.	All	Non-Urgent	Psychiatrists	12	15	Business Days
Aetna Better Health of California Inc.	All	Urgent	Psychiatrists	12	457	Hours
Positive Healthcare	All	Non-Urgent	Primary Care Providers	11	16	Business Days
Positive Healthcare	All	Urgent	Primary Care Providers	11	475	Hours
Ventura County Health Care Plan	All	Non-Urgent	Ancillary Providers	10	10	Business Days

Table 10: Average Appointment Wait Times Omitted from the DMHC's Health Plan Timely Access Data Web Page Due to Low Sample Size

Health Plan Name	Survey Product	Measurement Type	Provider Type	Number of Providers Surveyed	Mean Wait Time	Time Metric
Aetna Better Health of California Inc.	All	Non-Urgent	Ancillary Providers	6	22	Business Days
Aetna Better Health of California Inc.	All	Non-Urgent	Psychiatrists	12	15	Business Days
Aetna Better Health of California Inc.	Medi-Cal	Non-Urgent	Ancillary Providers	6	22	Business Days
Aetna Better Health of California Inc.	Medi-Cal	Non-Urgent	Psychiatrists	12	15	Business Days
Aetna Better Health of California Inc.	All	Urgent	Psychiatrists	12	457	Hours
Aetna Better Health of California Inc.	Medi-Cal	Urgent	Psychiatrists	12	457	Hours
Positive Healthcare	All	Non-Urgent	Primary Care Providers	11	16	Business Days
Positive Healthcare	Medi-Cal	Non-Urgent	Primary Care Providers	11	16	Business Days
Positive Healthcare	All	Urgent	Primary Care Providers	11	475	Hours
Positive Healthcare	Medi-Cal	Urgent	Primary Care Providers	11	475	Hours
Ventura County Health Care Plan	All	Non-Urgent	Ancillary Providers	10	10	Business Days
Ventura County Health Care Plan	Commercial	Non-Urgent	Ancillary Providers	10	10	Business Days

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

The tables below set forth the health plans' legal name and trade name or DBA used in this report.

Full Service Health Plans

Health Plan Legal Name	Doing Business As (DBA)
Aetna Better Health of California Inc.	
Aetna Health of California Inc.	
AIDS Healthcare Foundation	Positive Healthcare
Alameda Alliance for Health	
Blue Cross of California	Anthem Blue Cross
Blue Cross of California Partnership Plan, Inc.	
Blue Shield of California Promise Health Plan	
California Health and Wellness Plan	CA Health and Wellness
California Physicians' Service	Blue Shield of California
CHG Foundation	Community Health Group Partnership Plan
Chinese Community Health Plan	Balance by CCHP
Cigna HealthCare of California, Inc.	
Community Care Health Plan, Inc.	
Contra Costa County Medical Services	Contra Costa Health Plan
County of Ventura	Ventura County Health Care Plan
Fresno-Kings-Madera Regional Health Authority	CalViva Health
Health Net Community Solutions, Inc.	
Health Net of California, Inc.	
Inland Empire Health Plan	IEHP
Kaiser Foundation Health Plan, Inc.	Kaiser Permanente
Kern Health Systems	
L.A. Care Health Plan Joint Powers Authority	
Local Initiative Health Authority for Los Angeles County	L.A. Care Health Plan
MemorialCare Select Health Plan	
Molina Healthcare of California	
Oscar Health Plan of California	
San Francisco Health Authority	San Francisco Health Plan
San Joaquin County Health Commission	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-San Benito-Mariposa Managed Medical Care Commission	Central California Alliance for Health
Scripps Health Plan Services, Inc.	

Full Service Health Plans (Continued)

Health Plan Legal Name	Doing Business As (DBA)
Sharp Health Plan	
Sutter Health Alliance	Sutter Health Plan
UHC of California	UnitedHealthcare of California
United Healthcare Benefits Plan of California	
Western Health Advantage	

Behavioral Health Plans

Health Plan Legal Name	Doing Business As (DBA)
Holman Professional Counseling Centers	
Human Affairs International of California	HAI-CA
U. S. Behavioral Health Plan, California	OptumHealth Behavioral Solutions of California

Appendix C: Health Plan Rates of Compliance Summary

The rates of compliance in the tables below include Commercial products, Individual/Family products, Medi-Cal products, and all products combined. The rates of compliance for All Products are included in Charts 1-3 within this Timely Access Report. An asterisk (*) indicates that the health plan did not report timely access data for this product. “Omitted” indicates that the health plan exceeded the sampling error threshold and was omitted from one or more charts.

Full Service Health Plans
Rates of Compliance

Health Plan Name	All Products			Commercial			Individual/Family			Medi-Cal		
	Non-Urgent	Non-Physician Mental Health Follow-Up	Urgent	Non-Urgent	Non-Physician Mental Health Follow-Up	Urgent	Non-Urgent	Non-Physician Mental Health Follow-Up	Urgent	Non-Urgent	Non-Physician Mental Health Follow-Up	Urgent
Aetna Better Health of California Inc.	70%	80%	68%	*	*	*	*	*	*	70%	80%	68%
Aetna Health of California Inc.	79%	90%	74%	79%	90%	74%	78%	88%	71%	*	*	*
Alameda Alliance For Health	83%	88%	76%	61%	87%	58%	*	*	*	87%	88%	79%
Anthem Blue Cross	75%	76%	66%	75%	76%	66%	74%	76%	65%	*	*	*
Balance by CCHP	63%	Omitted	67%	65%	Omitted	69%	63%	Omitted	67%	*	*	*
Blue Cross of California Partnership Plan, Inc.	76%	86%	69%	*	*	*	*	*	*	76%	86%	69%
Blue Shield of California	80%	87%	72%	81%	87%	73%	78%	87%	69%	*	*	*
Blue Shield of California Promise Health Plan	72%	Omitted	70%	*	*	*	*	*	*	72%	Omitted	70%
CA Health and Wellness	73%	89%	67%	*	*	*	*	*	*	73%	89%	67%
CalViva Health	77%	84%	73%	*	*	*	*	*	*	77%	84%	73%
Central California Alliance for Health	61%	Omitted	50%	61%	Omitted	50%	*	*	*	*	*	*
Cigna HealthCare of California, Inc.	80%	85%	71%	80%	85%	71%	*	*	*	*	*	*
Community Care Health Plan, Inc.	74%	84%	75%	74%	84%	75%	*	*	*	*	*	*
Community Health Group Partnership Plan	84%	88%	91%	*	*	*	*	*	*	84%	88%	91%
Contra Costa Health Plan	88%	90%	80%	79%	97%	78%	*	*	*	90%	88%	80%
Health Net Community Solutions, Inc.	81%	83%	76%	*	*	*	*	*	*	81%	83%	76%
Health Net of California, Inc.	78%	84%	70%	78%	84%	70%	80%	83%	73%	*	*	*

Full Service Health Plans
Rates of Compliance (Continued)

Health Plan Name	All Products			Commercial			Individual/Family			Medi-Cal		
	Non-Urgent	Non-Physician Mental Health Follow-Up	Urgent	Non-Urgent	Non-Physician Mental Health Follow-Up	Urgent	Non-Urgent	Non-Physician Mental Health Follow-Up	Urgent	Non-Urgent	Non-Physician Mental Health Follow-Up	Urgent
Health Plan of San Joaquin	90%	87%	80%	*	*	*	*	*	*	90%	87%	80%
Health Plan of San Mateo	56%	88%	43%	41%	86%	30%	*	*	*	65%	89%	50%
IEHP	86%	90%	75%	*	*	*	*	*	*	87%	90%	74%
Kaiser Permanente	88%	85%	74%	86%	84%	73%	86%	84%	73%	90%	88%	76%
Kern Health Systems	85%	89%	68%	*	*	*	*	*	*	85%	89%	68%
L.A. Care Health Plan	83%	85%	74%	*	*	*	83%	86%	74%	83%	85%	73%
L.A. Care Health Plan Joint Powers Authority	91%	86%	83%	91%	86%	83%	*	*	*	*	*	*
MemorialCare Select Health Plan	80%	93%	81%	80%	93%	81%	*	*	*	*	*	*
Molina Healthcare of California	75%	83%	73%	*	*	*	76%	83%	74%	74%	83%	73%
Positive Healthcare	83%	92%	75%	*	*	*	*	*	*	83%	92%	75%
San Francisco Health Plan	86%	88%	77%	80%	92%	76%	*	*	*	86%	88%	77%
Santa Clara Family Health Plan	85%	88%	78%	*	*	*	*	*	*	85%	88%	78%
Scripps Health Plan Services, Inc.	82%	87%	74%	82%	87%	74%	*	*	*	*	*	*
Sharp Health Plan	84%	99%	81%	84%	99%	81%	85%	99%	81%	*	*	*
Sutter Health Plan	80%	93%	75%	80%	93%	75%	80%	93%	75%	*	*	*
UnitedHealthcare Benefits Plan of California	86%	93%	80%	86%	93%	80%	*	*	*	*	*	*
UnitedHealthcare of California	89%	93%	84%	89%	93%	84%	*	*	*	*	*	*
Valley Health Plan	65%	77%	63%	64%	75%	61%	68%	80%	67%	*	*	*
Ventura County Health Care Plan	70%	*	76%	70%	*	76%	*	*	*	*	*	*
Western Health Advantage	81%	92%	78%	81%	92%	78%	81%	92%	78%	*	*	*

Behavioral Health Plans
Rates of Compliance

Health Plan Name	All Products			Commercial			Individual/Family			Medi-Cal		
	Non-Urgent	Non-Physician Mental Health Follow-Up	Urgent	Non-Urgent	Non-Physician Mental Health Follow-Up	Urgent	Non-Urgent	Non-Physician Mental Health Follow-Up	Urgent	Non-Urgent	Non-Physician Mental Health Follow-Up	Urgent
HAI-CA	87%	87%	76%	87%	87%	76%	*	*	*	*	*	*
Holman Professional Counseling Centers	88%	87%	81%	88%	87%	81%	*	*	*	*	*	*
OptumHealth Behavioral Solutions of California	91%	94%	86%	90%	93%	85%	91%	94%	86%	84%	87%	84%

Appendix D: Average Appointment Wait Times by Health Plan

The Average Appointment Wait Time tables below set forth each health plan's mean and median appointment wait time by all health plan-reported products combined. Urgent appointment wait times are measured in hours and non-urgent appointment wait times are measured in business days. The applicable appointment wait time standard is set forth in the table below for reference.[21] An asterisk (*) indicates that the health plan did not report timely access data for this provider type. "Omitted" indicates that the metric was omitted because there was not a sufficient number of responding providers of that type to report representative data. For additional information regarding calculation of the average appointment wait time, see Appendix A.

Full Service Health Plans
Average Non-Urgent Appointment Wait Time

Health Plan Name	PCP 10 Business Days		Specialist Physician 15 Business Days		Psychiatrist 15 Business Days		Non-Physician Mental Health 10 Business Days		Non-Physician Mental Health 10 Business Days (Follow-Up)		Ancillary 15 Business Days	
	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Aetna Better Health of California Inc.	3	3	16	11	Omitted	5	5	4	6	5	Omitted	2
Aetna Health of California Inc.	4	3	14	10	6	4	3	3	4	5	4	2
Alameda Alliance For Health	2	2	8	5	4	3	2	2	4	5	2	1
Anthem Blue Cross	4	3	14	9	6	4	3	3	4	5	4	3
Balance by CCHP	3	1	21	15	4	4	5	3	9	13	20	21
Blue Cross of California Partnership Plan, Inc.	3	2	13	9	6	4	3	3	5	5	2	1
Blue Shield of California	3	1	13	9	5	4	4	3	5	5	3	2
Blue Shield of California Promise Health Plan	6	3	13	8	5	3	5	5	5	5	3	1

[21] There are two urgent appointment wait time standards. If no prior authorization is required, an urgent appointment must be offered to the member within 48 hours of the request for the appointment. If prior authorization is required, an urgent appointment must be offered to the member within 96 hours of the request for the appointment.

Full Service Health Plans
Average Non-Urgent Appointment Wait Time (Continued)

Health Plan Name	PCP 10 Business Days		Specialist Physician 15 Business Days		Psychiatrist 15 Business Days		Non-Physician Mental Health 10 Business Days		Non-Physician Mental Health 10 Business Days (Follow-Up)		Ancillary 15 Business Days	
	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
CA Health and Wellness	5	3	15	9	8	7	3	3	4	5	3	2
CalViva Health	2	1	15	11	6	5	3	3	5	5	4	3
Central California Alliance for Health	1	1	21	17	7	7	3	3	5	5	10	9
Cigna HealthCare of California, Inc.	4	3	13	9	5	4	3	3	4	5	4	3
Community Care Health Plan, Inc.	4	2	23	9	7	6	3	3	5	5	3	2
Community Health Group Partnership Plan	1	1	8	5	2	1	3	2	3	2	3	2
Contra Costa Health Plan	2	2	5	3	3	2	2	2	3	4	5	1
Health Net Community Solutions, Inc.	3	2	11	8	6	5	3	3	4	5	3	2
Health Net of California, Inc.	4	2	13	9	6	5	3	3	4	5	3	2
Health Plan of San Joaquin	2	2	3	2	4	3	2	2	4	5	2	1
Health Plan of San Mateo	4	2	15	5	5	4	4	4	4	5	5	1
IEHP	3	3	7	5	3	2	3	3	4	5	4	2
Kaiser Permanente	2	2	3	2	3	2	3	3	4	5	3	1
Kern Health Systems	3	2	10	6	1	1	3	2	4	5	3	2
L.A. Care Health Plan	3	2	15	11	4	3	3	3	5	5	4	3
L.A. Care Health Plan Joint Powers Authority	1	1	5	5	4	3	3	3	4	5	5	2

Full Service Health Plans
Average Non-Urgent Appointment Wait Time (Continued)

Health Plan Name	PCP 10 Business Days		Specialist Physician 15 Business Days		Psychiatrist 15 Business Days		Non-Physician Mental Health 10 Business Days		Non-Physician Mental Health 10 Business Days (Follow-Up)		Ancillary 15 Business Days	
	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
MemorialCare Select Health Plan	2	2	10	8	6	3	4	3	5	5	3	2
Molina Healthcare of California	4	3	14	10	10	8	5	4	5	5	2	1
Positive Healthcare	Omitted	2	17	13	6	4	4	4	4	5	3	1
San Francisco Health Plan	2	2	6	3	4	3	2	2	3	4	2	1
Santa Clara Family Health Plan	2	2	7	3	4	3	2	2	3	4	3	1
Scripps Health Plan Services, Inc.	3	2	18	13	5	4	3	3	4	5	23	1
Sharp Health Plan	2	2	9	6	1	1	1	1	2	1	4	2
Sutter Health Plan	6	4	19	13	5	3	3	2	3	4	7	5
UnitedHealthcare Benefits Plan of California	4	3	13	9	5	3	3	2	3	4	4	3
UnitedHealthcare of California	3	2	7	6	5	4	3	2	3	4	4	3
Valley Health Plan	5	3	21	18	3	2	3	2	5	4	7	6
Ventura County Health Care Plan	5	4	17	13	*	*	*	*	*	*	Omitted	3
Western Health Advantage	2	1	16	11	5	3	3	2	3	5	9	4

Behavioral Health Plans
Average Non-Urgent Appointment Wait Time

Health Plan Name	PCP 10 Business Days		Specialist Physician 15 Business Days		Psychiatrist 15 Business Days		Non-Physician Mental Health 10 Business Days		Non-Physician Mental Health 10 Business Days(Follow-Up)		Ancillary 15 Business Days	
	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
HAI-CA	*	*	*	*	5	4	4	3	5	5	*	*
Holman Professional Counseling Centers	*	*	*	*	4	4	3	3	4	5	*	*
OptumHealth Behavioral Solutions of California	*	*	*	*	5	3	3	2	3	3	*	*

Full Service Health Plans
Average Urgent Appointment Wait Time[22]

Health Plan Name	PCP 48 Hours		Specialist Physician 48 Hours or 96 Hours		Psychiatrist 48 Hours or 96 Hours		Non-Physician Mental Health 48 Hours or 96 Hours	
	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Aetna Better Health of California Inc.	32	21	114	44	Omitted	239	95	65
Aetna Health of California Inc.	32	21	160	77	89	52	46	29
Alameda Alliance For Health	16	21	82	41	55	29	38	24
Anthem Blue Cross	55	24	187	77	117	74	54	29
Balance by CCHP	104	25	207	95	70	70	88	94
Blue Cross of California Partnership Plan, Inc.	32	20	213	92	131	73	53	44
Blue Shield of California	66	25	185	90	115	89	59	44
Blue Shield of California Promise Health Plan	81	27	154	48	90	65	92	46
CA Health and Wellness	65	23	243	96	189	90	44	41
CalViva Health	27	17	168	113	86	68	45	26
Central California Alliance for Health	70	66	677	551	51	51	50	27
Cigna HealthCare of California, Inc.	42	23	179	73	119	89	54	31
Community Care Health Plan, Inc.	26	17	270	66	99	82	44	27
Community Health Group Partnership Plan	20	20	44	23	26	23	48	23
Contra Costa Health Plan	14	7	48	24	56	48	39	25
Health Net Community Solutions, Inc.	24	20	99	52	119	74	44	25
Health Net of California, Inc.	40	23	162	74	138	93	52	30
Health Plan of San Joaquin	15	21	25	21	55	27	39	24

[22] There are two urgent appointment wait time standards. If no prior authorization is required, an urgent appointment must be offered to the member within 48 hours of the request for the appointment. If prior authorization is required, an urgent appointment must be offered to the member within 96 hours of the request for the appointment.

Full Service Health Plans
Average Urgent Appointment Wait Time (Continued)

Health Plan Name	PCP 48 Hours		Specialist Physician 48 Hours or 96 Hours		Psychiatrist 48 Hours or 96 Hours		Non-Physician Mental Health 48 Hours or 96 Hours	
	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Health Plan of San Mateo	58	26	366	69	113	96	92	46
IEHP	38	25	62	26	42	24	40	25
Kaiser Permanente	29	24	35	23	43	24	51	31
Kern Health Systems	55	45	97	47	27	22	40	26
L.A. Care Health Plan	25	20	208	92	47	23	27	21
L.A. Care Health Plan Joint Powers Authority	13	19	20	23	46	23	26	20
MemorialCare Select Health Plan	15	18	71	51	71	74	41	25
Molina Healthcare of California	31	21	112	67	169	95	65	29
Positive Healthcare	Omitted	21	160	97	129	72	59	48
San Francisco Health Plan	14	18	64	25	65	26	39	24
Santa Clara Family Health Plan	18	21	52	24	63	31	38	24
Scripps Health Plan Services, Inc.	46	31	137	71	117	78	61	46
Sharp Health Plan	37	25	77	64	16	17	10	8
Sutter Health Plan	85	46	149	71	63	36	51	49
UnitedHealthcare Benefits Plan of California	51	24	175	77	58	31	44	48
UnitedHealthcare of California	38	22	79	46	56	30	42	48
Valley Health Plan	78	39	223	97	54	31	45	24
Ventura County Health Care Plan	39	24	61	44	*	*	*	*
Western Health Advantage	96	29	144	73	62	32	42	44

Behavioral Health Plans
Average Urgent Appointment Wait Time[23]

Health Plan Name	PCP 48 Hours		Specialist Physician 48 Hours or 96 Hours		Psychiatrist 48 Hours or 96 Hours		Non-Physician Mental Health 48 Hours or 96 Hours	
	Mean	Median	Mean	Median	Mean	Median	Mean	Median
HAI-CA	*	*	*	*	115	89	59	44
Holman Professional Counseling Centers	*	*	*	*	57	68	56	48
OptumHealth Behavioral Solutions of California	*	*	*	*	58	31	44	49

[23] There are two urgent appointment wait time standards. If no prior authorization is required, an urgent appointment must be offered to the member within 48 hours of the request for the appointment. If prior authorization is required, an urgent appointment must be offered to the member within 96 hours of the request for the appointment.

KNOW YOUR HEALTH CARE RIGHTS

Timely Access to Care

Health plans must ensure their network of providers, including doctors, can provide health plan members an appointment within specific timeframes.

A qualified health care provider may extend the waiting time for an appointment if they determine a longer waiting time will not be harmful to the member's health.

Urgent Care

prior authorization **not required** by health plan
48 hours

prior authorization **required** by health plan
96 hours

Non-Urgent Care

Doctor Appointment

PRIMARY CARE PHYSICIAN
10 business days

SPECIALTY CARE PHYSICIAN
15 business days

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

Appointment
(ancillary provider[2])
15 business days

Follow-Up Care

Mental Health / Substance Use Disorder Follow-Up Appointment
(non-physician)
10 business days from prior appointment

Timely Access to Care Requirements

DISTANCE

A primary care provider / hospital within 15 miles or 30 minutes from where health plan members live or work

AVAILABILITY 24/7

Telephone services to talk to your health plan should be available 24/7

INTERPRETER

Interpreter services must be coordinated and provided with scheduled appointments for health care services

Unable to get an Appointment Within the Timely Access Standard?

If you are not able to get an appointment within the timely access standard, you should first contact your health plan for assistance. The DMHC Help Center is available at 1-888-466-2219 (TDD: 1-877-688-9891) or www.DMHC.ca.gov to assist you if your health plan does not resolve the issue. The DMHC Help Center will work with you and your health plan to ensure you receive timely access to care. If you believe you are experiencing a medical emergency, dial 9-1-1 or go to the nearest hospital.

DEPARTMENT OF Managed Health Care

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

[2] Examples of ancillary services include lab work or diagnostic testing, such as mammogram or MRI, or treatment such as physical therapy.