DEPARTMENT OF
Managed
Health Care

Timely Access Report

Measurement Year 2024

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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) 2024 provider appointment availability surveys submitted by full service and behavioral health plans to the Department of Managed Health Care (DMHC) in 2025. This report includes health plan provider appointment availability survey and average appointment wait times data by product for each health plan. The DMHC is also presenting provider appointment availability survey data at the health plan network level, including the number and percentage of networks meeting the three required rate of compliance standards of 70% for urgent appointments, 70% for non-urgent appointments and 80% for non-physician mental health provider follow-up appointments.

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

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

- Approximately 90% for non-urgent appointments and 43% for urgent appointments met the minimum rate of compliance standards for full service health plans.
- Approximately 97% of the full service health plan networks met the minimum rate of compliance for non-physician mental health provider follow-up appointments.
- The two behavioral health plan networks met the minimum rates of compliance for non-urgent, urgent, and non-physician mental health provider follow-up appointments.

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 95% to a low of 53%. (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 87% to a low of 27%. (Chart 2)
- For non-physician mental health follow-up appointments, the percentage of providers who had an appointment available within the follow-up wait time standard ranged from a high of 100% to a low of 43%. (Chart 3)

- Among the providers selected to be surveyed by full service health plans, 47% responded, 30% did not respond, and 23% were ineligible to participate in the survey.[1] (Table 1) The timely access methodology required health plans 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 95% to a low of 90%. (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 76% to a low of 71%. (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 96% to a low of 91%. (Chart 6)
- Among the providers selected to be surveyed by behavioral health plans, 62% responded, 31% did not respond, and 7% were ineligible to participate in the survey. (Table 2) The timely access methodology required health plans to replace non-responding and non-eligible providers with another network provider to meet the required statistically significant sample.

[1] 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 a walk-in basis).

Introduction

Created by consumer-sponsored legislation in 1999, the DMHC regulates licensed health plans under the Knox-Keene Health Care Service Plan Act of 1975, as amended (Knox-Keene Act). The mission of the Department of Managed Health Care is to ensure health plan members have access to equitable, high-quality, timely, and affordable health care within 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 30.2 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.[2] 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 requires health plan networks be sufficient to meet a set of standards, which include specific timeframes under which the health plan's members can obtain care.[3] 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:

- Senate Bill 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. Senate Bill 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.
- Senate Bill 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 provider follow-up appointments, and provided the DMHC additional authority to enact new standards regarding timely access.

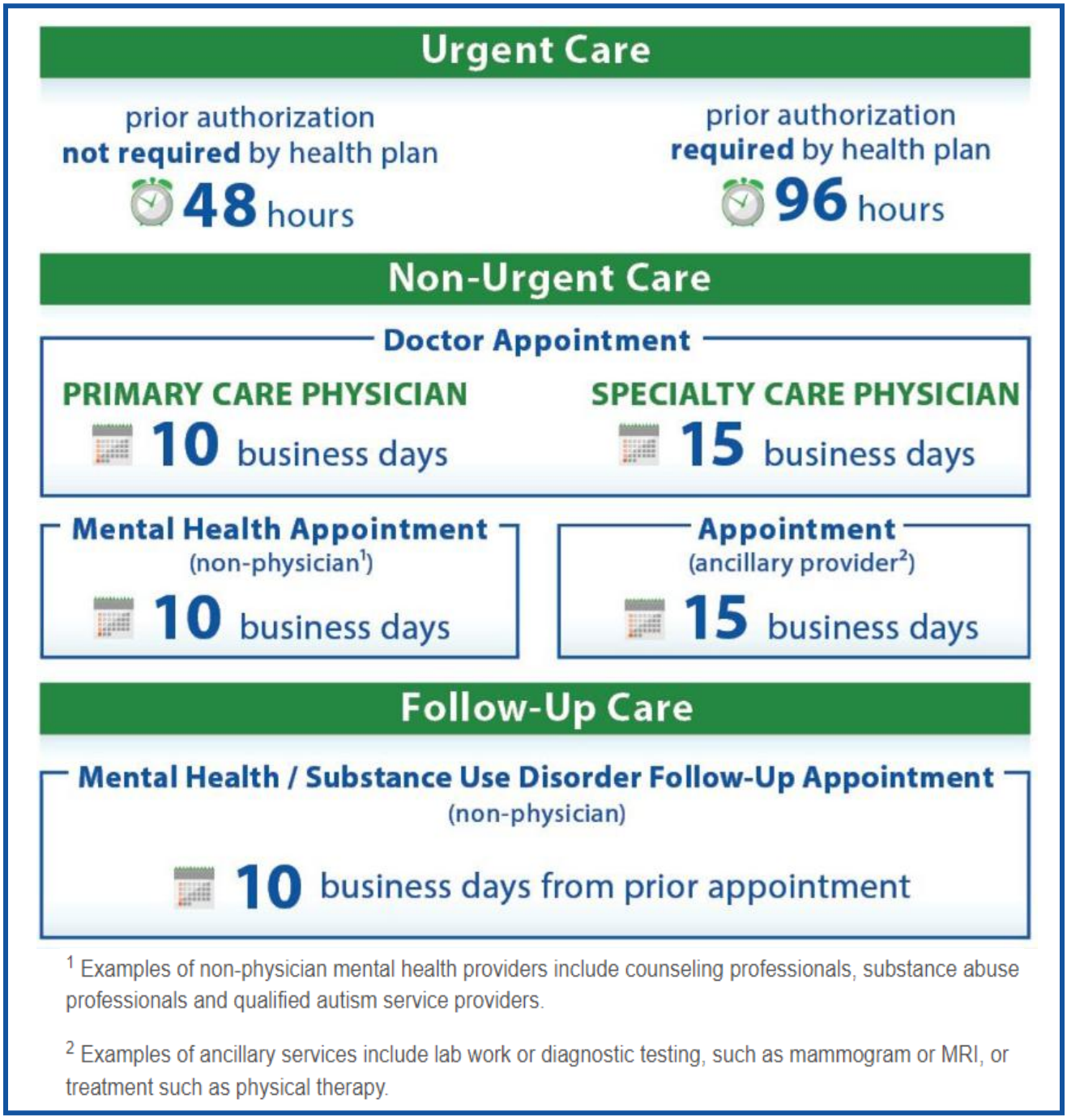
[2] A network is a discrete set of network providers the health plan has designated to deliver all covered services to members covered by a health plan within its approved network service area. (Title 28 CCR section 1300.67.2.2(b)(5).)
[3] The Timely Access Regulation is set forth in Title 28 CCR section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

After working closely with stakeholders for over five years to develop and refine reporting and the timely access methodology, the DMHC amended the Timely Access Regulation. In MY 2023, the DMHC fully implemented the amendments, which included updated standardized reporting, incorporation of the DMHC's timely access survey methodology, and requirements that health plans demonstrate through the survey that each of their networks meets a 70% minimum rate of compliance for non-urgent and urgent appointments. Beginning in MY 2024, the DMHC promulgated an 80% minimum rate of compliance standard for non-physician mental health provider follow-up appointments into the Timely Access Regulation. Under the amended regulation, if a health plan's network does not meet the minimum rate of compliance for any of the three appointment types, the health plan is required to submit a corrective action plan to the DMHC and may be subject to disciplinary action.

With these amendments, the DMHC is now able to hold health plans accountable for monitoring their networks and meeting a minimum rate of compliance. This allows the DMHC to better ensure that health plans are providing members with timely access to critical health care services. 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.

Timely Access Standards

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



[4] The Timely Access Statute is set forth in Section 1367.03 and the Timely Access Regulation is set forth in Title 28 CCR section 1300.67.2.2.

A health plan is 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 meet urgent primary care timely access obligations by contracting with providers who offer advanced access scheduling (i.e., the provider offers primary care services on the same day or the next business day). 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.

Historically, the methods of meeting members' urgent care needs that are not delivered via appointments could not be measured by the timely access survey because the survey measures the next available appointment. To better understand the alternative mechanisms health plans and providers use to ensure the timely delivery of urgent care, the DMHC included a new survey question in MY 2024. This survey question asked providers for their procedures when an urgent appointment is not available within the urgent appointment wait time standards. These results allow the DMHC to better evaluate other methods providers employ to ensure members are able to access urgent care services in a timely manner. The results of this survey question are not used to modify the urgent rates of compliance, but are included in this report to provide better insight into accessing urgent health care services.

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

While the DMHC strives to maintain year-over-year comparability, the MY 2024 percentage of providers with an urgent appointment within standard is not comparable to MY 2023 results due to a change to the urgent appointment survey methodology. Under the MY 2023 methodology, health plans were permitted to exclude weekends and holidays when determining whether the offered appointment was compliant with the standard. Starting in MY 2024, health plans were required to include the weekends and holidays when determining compliance. This means that fewer appointments met the required timeframe in MY 2024 than in MY 2023, resulting in lower overall rates of compliance.

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 annual network adequacy reviews 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 identified access and availability issues. 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 Members Have Timely Access to Care:

DISTANCE

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

AVAILABILITY

Health plans should have telephone services available to members 24 hours a day, seven days a week.

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. The survey does not measure actual member experiences obtaining health care services.

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. In the alternative, the health plan may survey all of its network providers of a provider type rather than a sample. The health plan contacts each of the selected providers and requests the provider's next available urgent and non-urgent appointment. In addition, during the survey, non-physician mental health providers are asked to provide their next available follow-up appointment. Health plans may conduct the survey from June 1 to December 31 of the measurement year. The health plan then reports the results to the DMHC by May 1 of the year following the survey.

Survey Response Rate Tables

The response (completed survey), non-response, and ineligible rates are set forth in the tables below for full service and behavioral health plans. These rates were calculated based on the number of providers for whom a written or phone call survey was completed or attempted, appointment data was extracted from the provider's appointment schedule, the primary care provider was previously verified as providing advanced access (i.e., same of next day appointments) or the provider was identified as ineligible to participate prior to commencing the survey (e.g., the provider retires or a provider group terminates a contract between the time the contact list is created and the survey is conducted).

Where a provider contracts with multiple health plans or practices in multiple counties, the provider 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. Moreover, a provider may be contacted multiple times by a single health plan if the provider practices in multiple counties or participates in multiple health plan networks. This could lead to a single health plan reporting different outcomes for the same provider, such as being eligible to participate in one network, but not another network. A health plan might also report the same provider as having an available appointment within standard at one location, but as not having an appointment within standard at another location.

Tables 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, 47% of the providers selected to be surveyed responded to the survey, 30% did not respond, and 23% were ineligible to participate.[5]

[5] Full service health plans made 226,804 survey attempts of almost 93,000 providers.

For behavioral health plans, 62% of the providers responded to the survey, 31% did not respond, and 7% were ineligible.[6] The most common reason for a non-response was due to the provider failing to respond to the survey within the 15 business days allowed for a response or issues with the provider's contact information.

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

Survey Outcome	All Products	Commercial	Individual/ Family	Medi-Cal
Total Completed Survey	**47%**	**49%**	**47%**	**45%**
Total Non-Response	**30%**	**27%**	**30%**	**35%**
Declined to Respond	4%	5%	4%	4%
No Response within Required Timeframe	25%	23%	26%	31%
Total Ineligible	**23%**	**23%**	**23%**	**20%**
Contact Information Issue	11%	12%	10%	8%
Provider Not in the Plan's Network	1%	1%	2%	3%
Provider Retired or Ceasing to Practice	1%	1%	1%	1%
Provider Not in the County	4%	5%	5%	2%
Provider Listed Under Incorrect Specialty	1%	1%	1%	2%
Provider Does Not Offer Appointments	4%	3%	4%	4%

Table 2: Behavioral Health Plans
Summary of Survey Response Rates

Survey Outcome	All Products	Commercial	Individual/ Family	Medi-Cal
Total Completed Survey	**62%**	**62%**	**63%**	**NA**
Total Non-Response	**31%**	**31%**	**30%**	**NA**
Declined to Respond	3%	3%	3%	NA
No Response within Required Timeframe	28%	28%	28%	NA
Total Ineligible	**7%**	**7%**	**7%**	**NA**
Contact Information Issue	1%	1%	1%	NA
Provider Not in the Plan's Network	1%	1%	1%	NA
Provider Retired or Ceasing to Practice	1%	1%	1%	NA
Provider Not in the County	1%	1%	1%	NA
Provider Listed Under Incorrect Specialty	0%	0%	0%	NA
Provider Does Not Offer Appointments	3%	3%	3%	NA

[6] Behavioral health plans made 15,895 survey attempts of over 12,000 providers.

Networks Meeting the Minimum Rate of Compliance

Health plans are required to report to the DMHC the percentage of providers with an appointment within the applicable appointment wait time standard to meet the minimum rate of compliance. The DMHC uses this information to calculate the percentage of networks meeting the minimum rate of compliance, set forth below. The percentages are calculated from 118 full service health plan networks and 2 behavioral health plan networks.

Overall, approximately 90% of the 118 full service health plan networks met the minimum rate of compliance for non-urgent appointments, approximately 43% of the full service health plan networks met the minimum rate of compliance for urgent appointments and approximately 97% of all full service health plan networks met the minimum rate of compliance for non-physician mental health provider follow-up appointments. Both of the behavioral health plan networks met the minimum rate of compliance for non-urgent appointments, urgent appointments, and non-physician mental health provider follow-up appointments.

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

Delivery of Urgent Care Services Outside of an Appointment

The urgent appointment rate of compliance may not paint the complete picture of how easily members can access urgent services because it only measures the next available urgent appointment offered by the provider being surveyed. Members may access urgently needed services in a variety of ways depending on the delivery model of the health plan and provider group that go beyond an urgent appointment with a specific provider. Historically, the methods of meeting members' urgent care needs that are not delivered via appointments could not be measured by the timely access survey because the survey only measured the next available appointment for individual providers (e.g., where an urgent care clinic does not offer appointments, the providers in that clinic are not eligible to participate in the survey). To better understand the mechanisms used to ensure the timely delivery of urgent care when a provider does not have a timely appointment available, the DMHC included a new survey question in the MY 2024 timely access survey. This survey question asks providers for their procedures when an urgent appointment is not available within the urgent appointment wait time standards. The results of this question allow the DMHC to better evaluate urgent rates of compliance and other methods providers employ to ensure members are able to access urgent care services in a timely manner.

The results of the alternative appointment methods question are set forth in Table 3. When asked how a provider would handle a situation where they did not have an urgent appointment within timely access standards, the most common response was to schedule an appointment with another provider in the office, followed by referring the patient to an after-hours or urgent care clinic. The patterns of alternative methods were similar across the provider types surveyed.

Table 3 identifies the percentage of providers who responded to the urgent appointment survey question and selected one or more of the delineated alternative methods for accessing urgent care. Most providers responded to the survey with at least two alternative urgent care delivery methods; therefore, the total response rate adds up to over 100% for some methods and provider types. In the

table below, the columns indicate the percentage of all providers and the percentage of each provider grouping (PCP, non-physician mental health, specialist) that indicated they use the identified method for providing urgent care. Non-physician mental health providers are abbreviated as “NPMH" and specialist physicians include psychiatrists.

Table 3: Alternative Urgent Care Methods

Provider Response(s)	All Providers	PCPs	NPMH Providers	Specialist Physicians
Schedule the patient with another provider in the office	62%	70%	53%	63%
Refer the patient to an after-hours or urgent care clinic	44%	53%	45%	38%
Triage to assess the appropriate wait time	29%	28%	31%	28%
Other	25%	27%	19%	30%
Refer the patient to a provider in another office	24%	20%	32%	21%
Refer the patient to their health plan for assistance obtaining a timely appointment	19%	9%	36%	13%
Schedule more than one patient for the same appointment time	11%	17%	1%	15%
No Response	2%	1%	2%	3%

Timely Access to Children’s Behavioral Health Services

In response to recommendations from the California State Auditor’s Office, the DMHC evaluated timely access data for behavioral health providers who were reported by health plans as offering services to children and adolescents. Notably, the timely access methodology does not include a requirement to sample these providers separately from providers who treat adults. Within the timely access data reported by health plans, there are a limited number of survey responses from non-physician mental health providers who were reported as only treating children and adolescents (ages 0-17). Further, health plans reported this information inconsistently. As a result, the DMHC was unable to produce a reliable statistical assessment of the percentage of non-physician mental health providers treating children and adolescents who met the applicable appointment wait time standards.[7] The DMHC compared appointment wait times for board-certified child and adolescent psychiatrists against the appointment wait times for all psychiatrists. There were a total of 968 board-certified child and adolescent psychiatrists who responded to the timely access survey out of a total 3,157 psychiatrists. The non-urgent rates of compliance for board-certified child and adolescent psychiatrists differed by only one percentage point compared to the rates for all psychiatrists, while urgent rates of compliance were the same and neither difference was statistically significant.

[7] Only 154 non-physician mental health providers were reported consistently by health plans as only treating children and adolescents were found in the survey results. Half of these providers responded to at least one or more of the urgent, non-urgent, and the follow-up appointment survey questions, leaving approximately 70 survey responses for each appointment type.

Table 4: Percentage of Psychiatrists Meeting the Appointment Wait Time Standards

Provider Types	Non-Urgent	Urgent
Board-Certified Child and Adolescent Psychiatrists	84%	61%
All Psychiatrists	83%	61%

Full Service Health Plan
Rate of Compliance Charts

Rate of Compliance Charts

The Rate of Compliance Charts (Charts 1 through 6) 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 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.

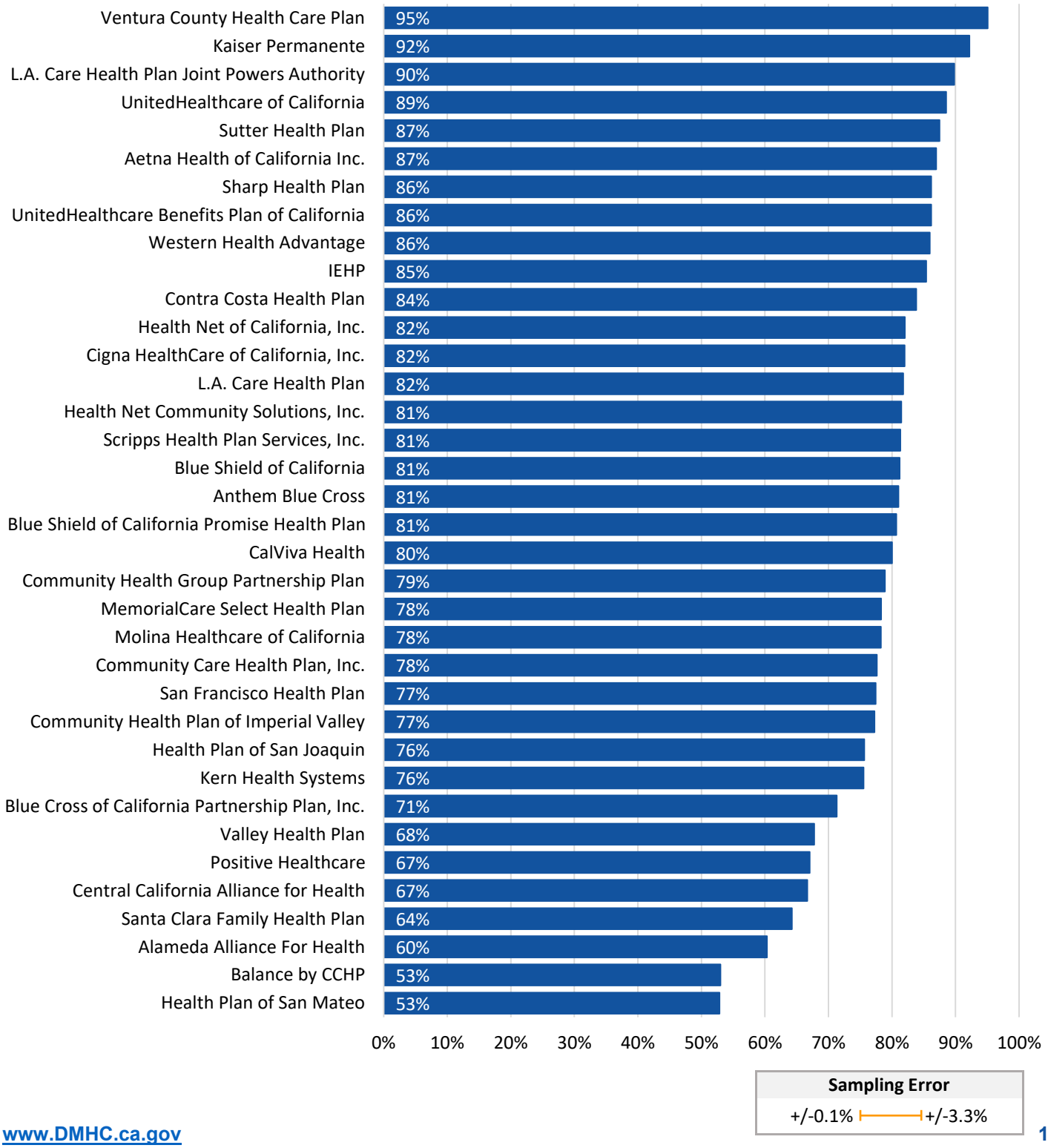
Non-Urgent Appointments

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

Chart 1

Full Service Health Plans

This chart displays 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.



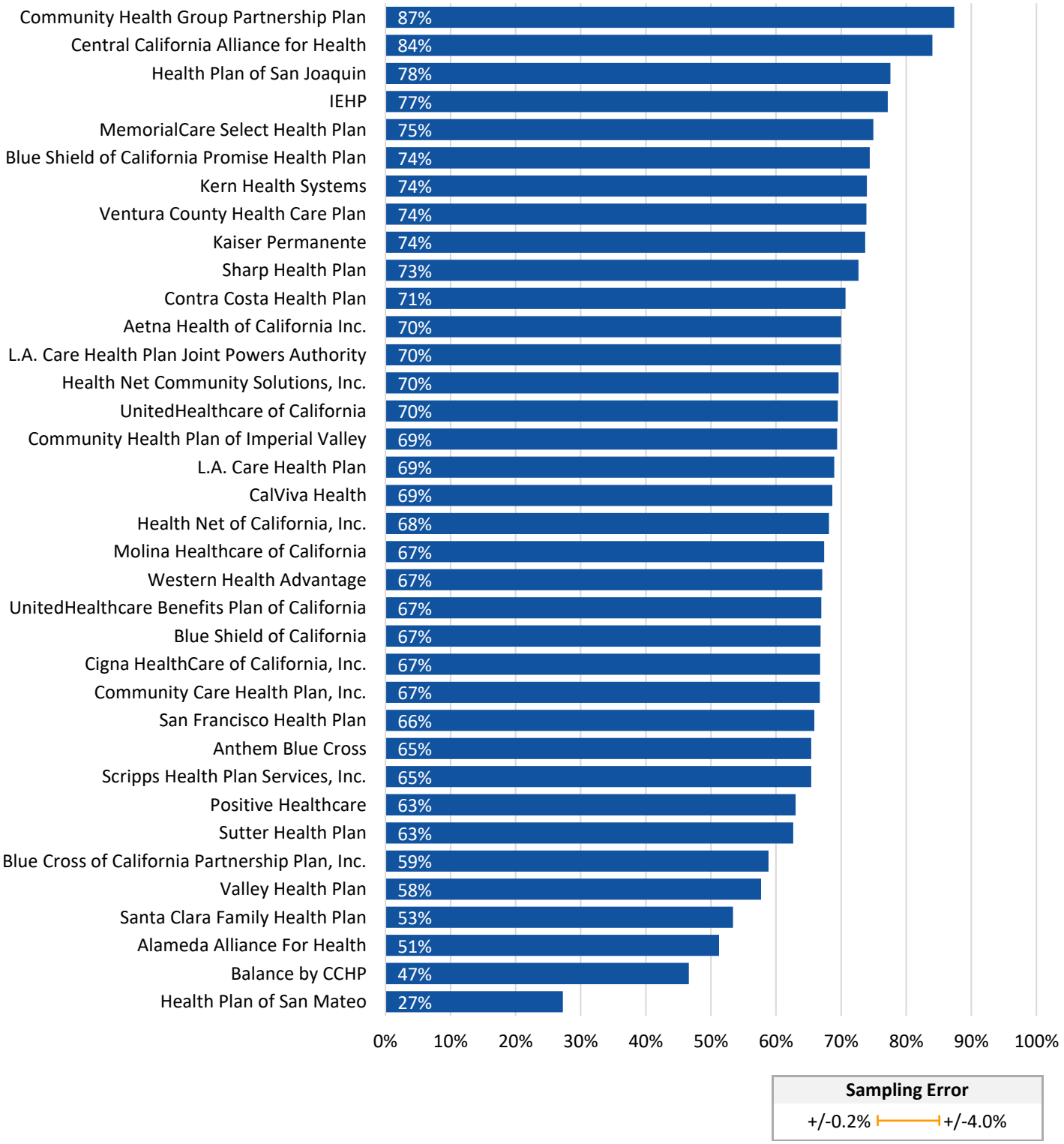
Urgent Appointments

Percentage of Providers Meeting the Urgent Appointment Wait Time Standards

Chart 2

Full Service Health Plans

This chart displays 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. (Table 3 includes additional urgent care delivery results not captured in the survey.)



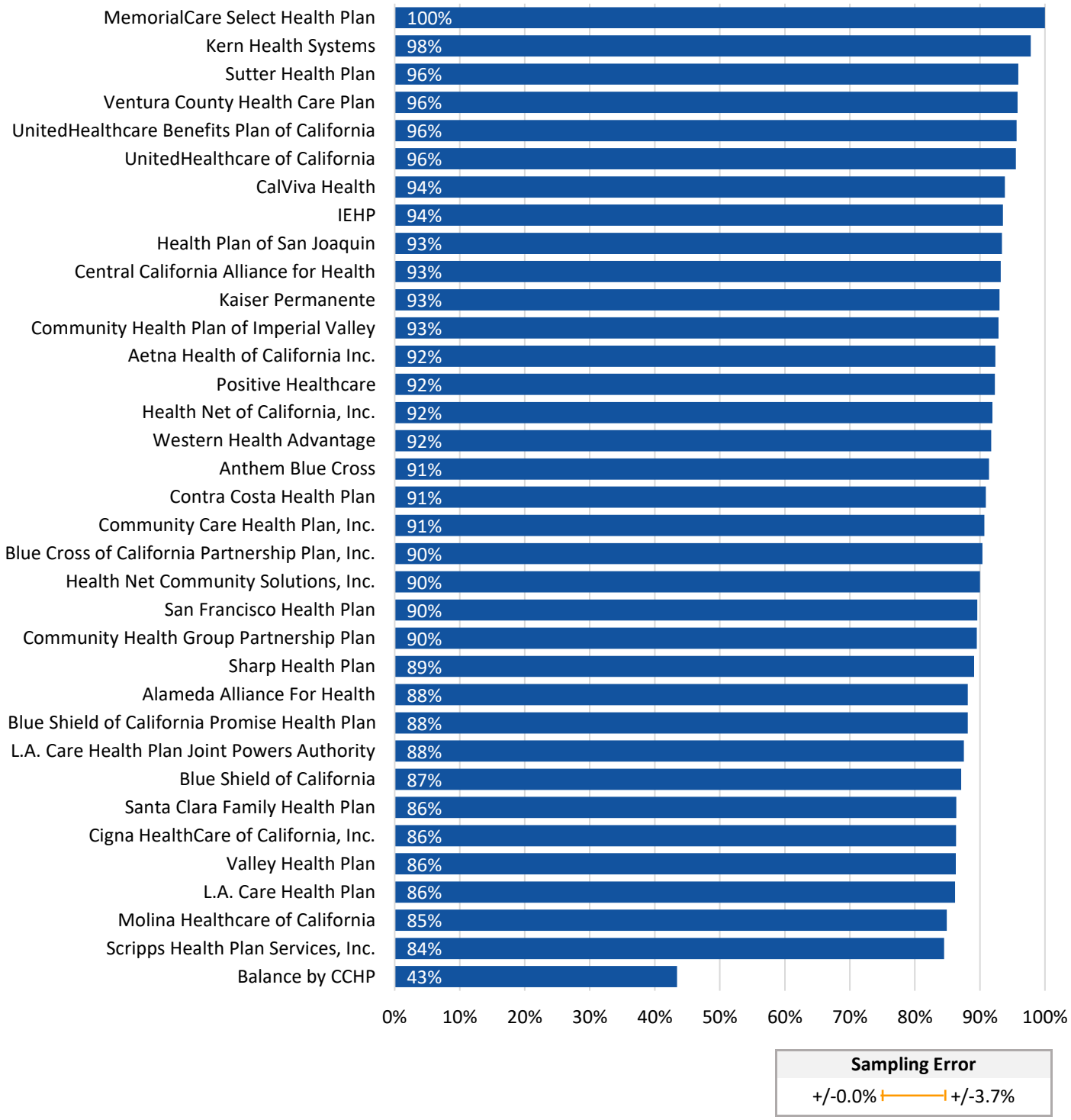
Non-Physician Mental Health Follow-Up Appointments

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

Chart 3

Full Service Health Plans

This chart displays 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. See Appendix A for information regarding data or health plans that have been excluded from this chart due to data discrepancies.



Behavioral Health Plans
Rate of Compliance Charts

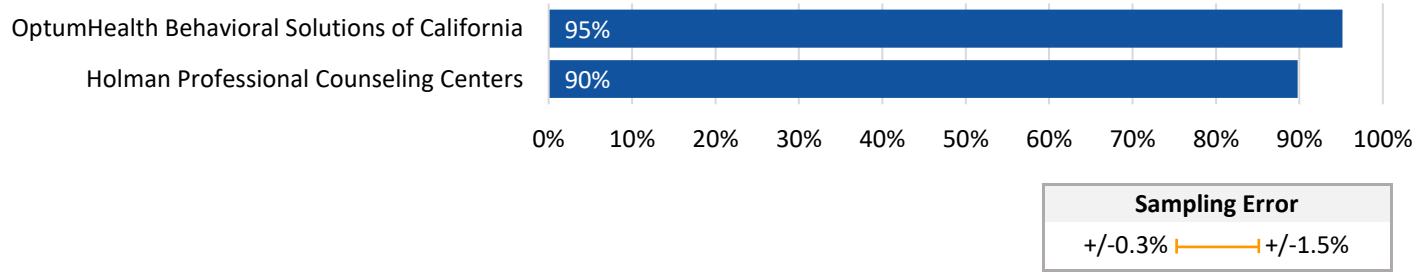
Non-Urgent Appointments

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

Chart 4

Behavioral Health Plans

This chart displays 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.



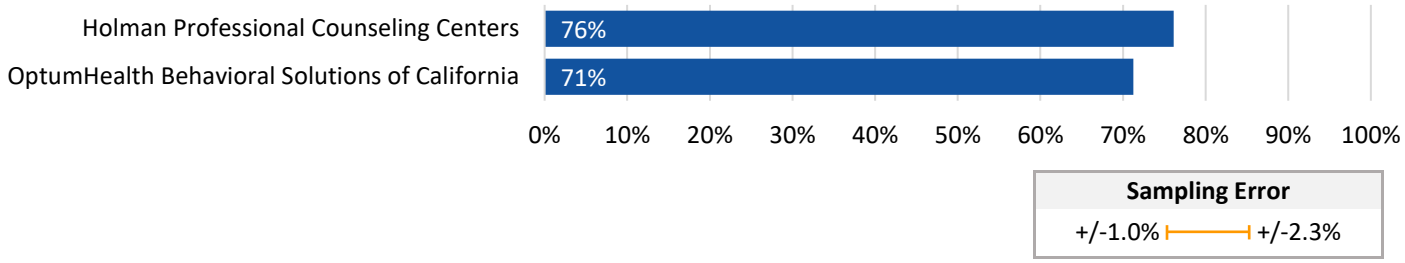
Urgent Appointments

Percentage of Providers Meeting the Urgent Appointment Wait Time Standards

Chart 5

Behavioral Health Plans

This chart displays 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. (Table 3 includes additional urgent care delivery results not captured in the survey.)



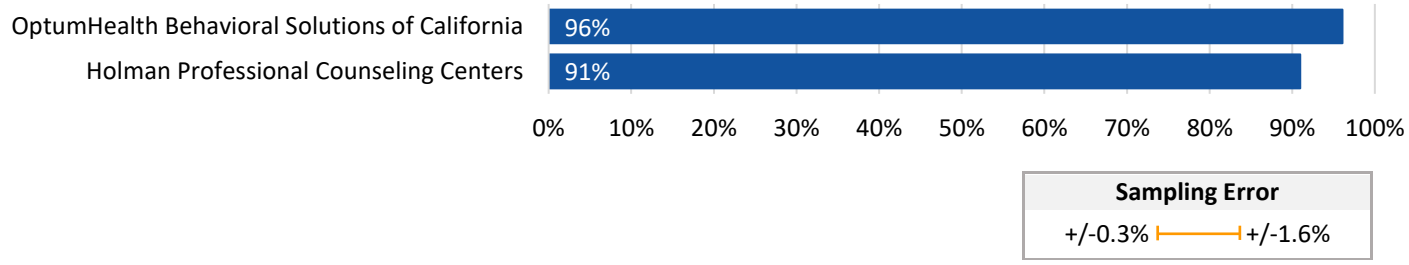
Non-Physician Mental Health Follow-Up Appointments

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

Chart 6

Behavioral Health Plans

This chart displays 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

The mean and median appointment wait times are calculated by measuring the wait time from the date and time of the provider's response to the survey and the next available appointment. The mean wait time is the average of the reported survey appointment wait times. The median wait time is the middle point of all reported wait times (i.e., the point where half of all appointments are at or below). To calculate a mean that more closely reflects a member experience, the mean was calculated after outliers with the most extreme wait times were removed in accordance with accepted statistical standards and practices. The median appointment wait time is less sensitive to outliers and does not exclude outliers.

Tables 5 and 6 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 the 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 each table below for reference. There are two urgent appointment wait time standards in the tables below. An urgent appointment must be made available to the member within 48 hours of the request for the appointment if no prior authorization is required and 96 hours if prior authorization is required. For additional information regarding calculation of the mean and median appointment, see Appendix A in this report.

Table 5: Full Service and Behavioral Health Plans
Average Non-Urgent Appointment Wait Times by Business Days

Provider Type	All Products Mean	All Products Median	Commercial Mean	Commercial Median	Individual/ Family Mean	Individual/ Family Median	Medi-Cal Mean	Medi-Cal Median
Primary Care Providers (10 Business Days Standard)	4	2	4	2	4	3	3	2
Specialist Physicians (15 Business Days Standard)	13	9	13	8	12	8	13	9
Psychiatrists (15 Business Days Standard)	5	3	5	3	4	3	4	3
Non-Physician Mental Health Providers (10 Business Days Standard)	3	2	3	2	3	2	3	2
Non-Physician Mental Health Providers - Follow-Up (10 Business Days Standard)	4	4	4	4	4	4	4	5
Ancillary Service Providers (15 Business Days Standard)	4	3	4	3	5	4	3	2

Table 6: Full Service and Behavioral Health Plans
Average Urgent Appointment Wait Times by Hours

Provider Type	All Products Mean	All Products Median	Commercial Mean	Commercial Median	Individual/ Family Mean	Individual/ Family Median	Medi-Cal Mean	Medi-Cal Median
Primary Care Providers (48 Hours Standard)	50	23	54	24	51	24	34	22
Specialist Physicians (48 or 96 Hours Standard)	170	68	184	70	149	55	155	50
Psychiatrists (48 or 96 Hours Standard)	91	45	91	45	82	43	56	25
Non-Physician Mental Health Providers (48 or 96 Hours Standard)	47	29	48	30	45	27	36	24

Next Steps

Looking forward, the DMHC will remain focused on ensuring health plan members can access health care services within the timely access standards. The DMHC will utilize the established rates of compliance and regulatory tools, which were developed in consultation with stakeholders over several years, to hold health plans accountable in meeting timely access and reporting standards.

The DMHC will take steps to implement the following actions:

- The DMHC will continue to hold health plans accountable to demonstrate each network is sufficient to meet the required minimum rates of compliance of 70% for urgent and non-urgent appointments and 80% for non-physician mental health provider follow-up appointments. If a network fails to meet one or more of the minimum rates of compliance, the DMHC will require that health plan to implement corrective action to bring its network(s) into compliance. A non-compliant health plan, including those who are found to be non-compliant multiple years in a row, 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 health plan's network did not meet the minimum rates of compliance.
- The DMHC will report results from the updated timely access survey methodology that required 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-hour urgent appointment standard if prior authorization is required. This change was implemented for MY 2025, and the results will be reported to the DMHC under the updated methodology in 2026.
- The DMHC will implement enhanced reporting and oversight requirements in the amended timely access regulation beginning in MY 2026. The regulatory changes will allow the DMHC to improve oversight over health plans' corrective action. In addition, the regulatory changes will further clarify each health plan's obligation to use the information obtained during the survey to update provider directories. Finally, the DMHC will ensure that health plans use a consistent survey methodology that results in comparable year-over-year results, including for urgent care appointments.

Conclusion

The DMHC's continued priority 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 minimum rate of compliance standards by requiring corrective action plans and/or taking enforcement action, including but not limited to, requiring non-compliant health plans to pay monetary penalties, as appropriate.

For individual issues, the DMHC Help Center is available to health plan members who need assistance getting timely access to care. If a health plan member is unable to obtain a timely appointment after contacting their health plan, they should contact the DMHC Help Center at 1-888-466-2219 or www.DMHC.ca.gov. The DMHC Help Center will work with the health plan to ensure the member receives timely and appropriate care.

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 the 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 by 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. The timely access survey methodology includes instructions for replacing ineligible providers using an oversample drawn from the contact list. The survey methodology specifies that health plans may not 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 and Network 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. To ensure that timely access rates are representative of the network as a whole, the percentage of surveyed providers with an appointment within standard is weighted by the total number of providers in each county. 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 provider type and appointment type.

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

The DMHC has 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 health 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 health plan's network. Due to the large volume of health plan networks licensed, network level information is not included in this written report.

Sampling Error

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) and the Health Plan Timely Access Data web page present only reliable provider appointment data for each health plan, a health plan's timely access data is only included in this report and the web page if the sampling error was at or below five percentage points (or ten percent for non-physician mental health provider follow-up appointments if the network contains less than 100 non-physician mental health providers).[8] When a health plan or network fails to meet the sampling error threshold, the results of the survey may not be sufficiently reliable to produce generalizable results.

Combining data for more than one network, provider type, or appointment type increases the sample size and results in more reliable data (i.e., lower sampling errors). Each chart in this report and the Health Plan Timely Access Data web page includes an estimated percentage of providers with

[8] A sampling error is the statistical error associated with estimates drawn from a sample of a population that reflects the difference between what the actual rate would be if all providers were surveyed. The sampling error identifies the range where the actual rate might fall given the sample size, estimated rate and the population rate. Under the timely access methodology, the sampling error indicates, with 90% certainty, the range where the actual rate might fall given the sample size and estimated rate. (I.e., 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%.) The DMHC-contracted statistician calculated the sampling errors 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.

an appointment within the applicable wait time standard and provides the corresponding sampling error range. Notably, 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 Rate of Compliance Charts in this report are calculated at the health plan level (i.e., results are aggregated across all networks and all applicable provider types). The Health Plan Timely Access web page presents network level results (i.e., results are only aggregated for all applicable provider types).

To be included in the charts in this Timely Access Report, a health plan may not exceed the product-level sampling error thresholds. In MY 2024, all health plans met the five percent health-plan level urgent and non-urgent appointment sampling error threshold. One health plan, Health Plan of San Mateo, exceeded the sampling error threshold for non-physician mental health provider follow-up appointments. This health plan's results are omitted from Chart 3 in this report, but its results are included in all other applicable charts and tables in this report. The health plan's high sampling error resulted from its failure 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. Approximately 30% of the health plan's non-physician mental health providers were ineligible to participate in the survey, and the remaining 40% failed to respond to the survey. 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 Health Plan of San Mateo.

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.[9] As indicated above, high non-response rates or ineligible rates may impact the ability of the health plan to produce a reliable estimated rate of compliance. Further, high non-response or ineligible rates may suggest that members could experience difficulties contacting providers to schedule timely appointments, that providers elected to not respond to the survey for reasons unrelated to appointment availability, or the health plan should have populated the survey contact list closer to the administration of the survey. 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. 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. Further, health plans using a single shared survey vendor to conduct the survey may need additional time to prepare and coordinate. As a result, several months may pass between a health plan creating its survey contact list and the administration of the survey. During this time, providers may leave the network and make the health plan's contact list used to conduct the survey out-of-date.

[9] 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.

Average Appointment Wait Times Methodology

The average (or mean) and median (middle point) 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 and urgent appointments by each provider type and for non-physician mental health provider follow-up appointments. 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. Urgent appointment wait times are presented in hours. Non-urgent and follow-up appointment wait times are presented in business days.

For the industry-level mean and median appointment wait times set forth in Tables 5 and 6 in this report, each surveyed provider represents a single appointment wait time across all health 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 wait times.

The DMHC-contracted statistician also calculated the health plan-level mean and median appointment wait 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 health plan, whereas appointment wait times for industry-level averages are deduplicated based on repeated provider appointments across any health plan.

To ensure that the average or mean appointment wait time is representative of the member's experience and the timely access data, the DMHC's statistician excluded some excessively long appointment wait times (outliers) in its average appointment wait time calculation. Excessively long wait times may result from several factors, including data errors, limited appointment capacity, providers being on leave, or specific provider group scheduling processes. These excessively long wait times for specific providers are likely not reflective of the member experience because providers often have other processes to ensure members receive timely services, such as directing members to other providers or clinics for health care services that are not captured by the survey methodology.

To address these concerns, the mean appointment wait time calculation excludes all wait times that are above the 90th percentile for each provider type. (I.e., the top 10% of the longest wait times are not used in the mean calculation.) Due to the nature of the median (the middle point of all appointment wait times), no adjustment to address the influence of excessively long appointment wait times (or outliers) to the median appointment wait time was necessary.

The DMHC also identified concerns related to smaller sample sizes, which leads to a mean appointment wait time that is sensitive to undue influence by excessively long wait times. 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 median times. To address these concerns, excessively long appointment wait times are excluded from the mean 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 10 business days for non-urgent appointments.

The mean and median for All Products may be longer than the Commercial, Individual/Family and Medi-Cal product calculations for some provider types in certain circumstances. This may occur when there are providers reported in multiple products who have lower wait times than providers who are only reported in a single product. When these providers are de-duplicated to calculate the All Product mean and median, they have less weight relative to the providers who were only in a single product type. On average, the single product providers had longer appointment wait times.

Survey and Data Issues

In addition to the external vendor analysis health plans are required to have completed prior to submission, the DMHC conducts data validation and an analysis of the timely access data. During this review the DMHC evaluates the reliability and accuracy of the health plan reported timely access data. 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. The DMHC may also take administrative actions against the health plan for violations of law.

To evaluate the impact of a data error (or potential bias) on timely access data, the DMHC's contracted statistician may stimulate (or recalculate) results using assumptions and data from the health plan's other networks or other health plans. This report and the Health Plan Timely Access Data web page includes the health plan's actual reported results, and not the rates of compliance used to evaluate the potential bias of the reporting error.

Erroneous Compliance Calculations:

- The DMHC 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.[10] These errors mostly produced negligible differences between the health plan reported rates of compliance and raw data.

De-Duplication Errors:

- De-duplication errors occurred as a result of health plan errors, including 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 skew the health plans' rate of compliance either up or down.

[10] Health plans are required to calculate the 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:

- Cigna HealthCare of California submitted survey results with duplicate records for non-physician mental health providers. The Results Form includes formulas that auto-calculate the rates of compliance and sampling errors using provider counts entered by the health plan. When a health plan reports duplicate records, it may inflate the weight of those provider responses in the calculation of the 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 led to a one percentage point difference in the urgent appointment rate of compliance for one network. The error had a negligible effect on the non-urgent and follow-up appointment rates of compliance presented for the health plan's four networks.

Omission of Provider Types:

- Health Net of California failed to submit timely access survey data for ancillary providers in its Canopy Network. To evaluate the impact of this reporting error on the Health Net of California's timely access data, the DMHC-contracted statistician recalculated its Canopy Network's non-urgent rate of compliance using ancillary provider rates from this health plan's other networks. Based on the assumption that Health Net of California's Canopy Network of ancillary providers had similar rates of compliance to its other networks, the DMHC determined that the omission likely resulted in one percentage point difference between what Health Net of California reported and the recalculated rate. If this assumption is correct, the difference would not substantially bias Health Net of California's overall results for the Canopy Network, nor would it likely impact this network's compliance with the minimum rate of compliance required under the timely access regulation. However, if the actual rates of compliance for the omitted ancillary providers in Health Net of California's Canopy Network differ substantially from its other reported rates of compliance for ancillary providers, Health Net of California's failure to submit its ancillary provider network could bias the its non-urgent appointment results.

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:

- Mean appointment wait times are calculated using only a single provider type. The sample size available for a single provider type is lower than the sample size available for calculating urgent and non-urgent rates of compliance, which is calculated across all provider types. To address concerns related to the small sample size and excessively long wait times (outliers) on the non-physician mental health provider follow-up mean appointment wait time, the DMHC's contracted statistician adjusted the mean appointment wait time methodology for outliers. (See Average

Appointment Wait Time Methodology section above.) Several health plans with smaller sample sizes had mean appointment wait times that were still substantively higher than the median times. In cases where there is a small sample size, undue influence may result even from a single outlier response. To ensure the mean appointment wait time presented in this report and the Health Plan Timely Access Data web page does not misrepresent the enrollee experience, the DMHC omitted a health plan's mean appointment wait time for small networks. The mean appointment wait time was excluded when there were 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 tables 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.

Table 7: 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 2024 Rate of Compliance	MY 2024 Sampling Error
Chart 3	Health Plan of San Mateo	Non-Physician Mental Health Follow-Up	49%	13%

Table 8: 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 2024 Rate of Compliance	MY 2024 Sampling Error
Health Plan of San Mateo	Commercial	Non-Physician Mental Health Follow-Up	47%	19%
Health Plan of San Mateo	Medi-Cal	Non-Physician Mental Health Follow-Up	51%	17%

Table 9: 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 2024 Rate of Compliance	MY 2024 Sampling Error
Health Plan of San Mateo	HealthWorx	Non-Physician Mental Health Follow-Up	47%	19%
Health Plan of San Mateo	Medi-Cal	Non-Physician Mental Health Follow-Up	51%	17%

Table 10: 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
Community Care Health Plan, Inc.	All	Urgent	Psychiatrist	9	264	Hours
Health Plan of San Mateo	All	Non-Urgent	Ancillary	10	22	Business Days
MemorialCare Select Health Plan	All	Non-Urgent	Psychiatrist	5	22	Business Days
Positive Healthcare	All	Urgent	Primary Care Provider	12	413	Hours

Table 11: 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
Community Care Health Plan, Inc.	All	Urgent	Psychiatrist	9	264	Hours
Community Care Health Plan, Inc.	Commercial	Urgent	Psychiatrist	9	264	Hours
Health Plan of San Mateo	All	Non-Urgent	Ancillary	10	22	Business Days
Health Plan of San Mateo	Commercial	Non-Urgent	Ancillary	8	22	Business Days
MemorialCare Select Health Plan	All	Non-Urgent	Psychiatrist	5	22	Business Days
MemorialCare Select Health Plan	Commercial	Non-Urgent	Psychiatrist	5	22	Business Days
Positive Healthcare	All	Urgent	Primary Care Provider	12	413	Hours
Positive Healthcare	Medi-Cal	Urgent	Primary Care Provider	12	413	Hours

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)	License Number
Aetna Health of California Inc.	-	933 0176
AIDS Healthcare Foundation	Positive Healthcare	933 0432
Alameda Alliance for Health	-	933 0328
Blue Cross of California	Anthem Blue Cross	933 0303
Blue Cross of California Partnership Plan, Inc.	-	933 0415
Blue Shield of California Promise Health Plan	-	933 0326
California Physicians' Service	Blue Shield of California	933 0043
CHG Foundation	Community Health Group Partnership Plan	933 0431
Chinese Community Health Plan	Balance by CCHP	933 0278
Cigna HealthCare of California, Inc.	-	933 0152
Community Care Health Plan, Inc.	-	933 0487
Contra Costa County Medical Services	Contra Costa Health Plan	933 0054
County of Ventura	Ventura County Health Care Plan	933 0344
Fresno-Kings-Madera Regional Health Authority	CalViva Health	933 0484
Health Net Community Solutions, Inc.	-	933 0426
Health Net of California, Inc.	-	933 0300
Imperial County Local Health Authority	Community Health Plan of Imperial Valley	933 0573
Inland Empire Health Plan	IEHP	933 0346
Kaiser Foundation Health Plan, Inc.	Kaiser Permanente	933 0055
Kern Health Systems	-	933 0335
L.A. Care Health Plan Joint Powers Authority	-	933 0504
Local Initiative Health Authority for Los Angeles County	L.A. Care Health Plan	933 0355
MemorialCare Select Health Plan	-	933 0495
Molina Healthcare of California	-	933 0322
San Francisco Health Authority	San Francisco Health Plan	933 0349
San Joaquin County Health Commission	Health Plan of San Joaquin	933 0338
San Mateo Health Commission	Health Plan of San Mateo	933 0358
Santa Clara County	Valley Health Plan	933 0236
Santa Clara County Health Authority	Santa Clara Family Health Plan	933 0351

Full Service Health Plans (Continued)

Health Plan Legal Name	Doing Business As (DBA)	License Number
Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission	Central California Alliance for Health	933 0401
Scripps Health Plan Services, Inc.	-	933 0377
Sharp Health Plan	-	933 0310
Sutter Health Alliance	Sutter Health Plan	933 0490
UHC of California	UnitedHealthcare of California	933 0126
UnitedHealthcare Benefits Plan of California	-	933 0517
Western Health Advantage	-	933 0348

Behavioral Health Plans

Health Plan Legal Name	Doing Business As (DBA)	License Number
Holman Professional Counseling Centers	-	933 0231
U.S. Behavioral Health Plan, California	OptumHealth Behavioral Solutions of California	933 0259

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 Non Urgent	All Products Urgent	All Products NPMH Follow Up	Commercial Non Urgent	Commercial Urgent	Commercial NPMH Follow Up	Individual/ Family Non Urgent	Individual/ Family Urgent	Individual/ Family NPMH Follow Up	Medi Cal Non Urgent	Medi Cal Urgent	Medi Cal NPMH Follow Up
Aetna Health of California Inc.	87%	70%	92%	87%	70%	92%	90%	72%	92%	*	*	*
Alameda Alliance For Health	60%	51%	88%	60%	50%	88%	*	*	*	61%	52%	88%
Anthem Blue Cross	81%	65%	91%	80%	65%	91%	80%	64%	91%	*	*	*
Balance by CCHP	53%	47%	43%	56%	48%	39%	53%	47%	43%	*	*	*
Blue Cross of California Partnership Plan, Inc.	71%	59%	90%	*	*	*	*	*	*	71%	59%	90%
Blue Shield of California	81%	67%	87%	82%	68%	87%	78%	63%	87%	*	*	*
Blue Shield of California Promise Health Plan	81%	74%	88%	*	*	*	*	*	*	81%	74%	88%
CalViva Health	80%	69%	94%	*	*	*	*	*	*	80%	69%	94%
Central California Alliance for Health	67%	84%	93%	67%	84%	93%	*	*	*	*	*	*
Cigna HealthCare of California, Inc.	82%	67%	86%	82%	67%	86%	*	*	*	*	*	*
Community Care Health Plan, Inc.	78%	67%	91%	78%	67%	91%	*	*	*	*	*	*
Community Health Group Partnership Plan	79%	87%	90%	*	*	*	*	*	*	79%	87%	90%
Community Health Plan of Imperial Valley	77%	69%	93%	*	*	*	*	*	*	77%	69%	93%
Contra Costa Health Plan	84%	71%	91%	83%	70%	91%	*	*	*	84%	71%	91%
Health Net Community Solutions, Inc.	81%	70%	90%	*	*	*	*	*	*	81%	70%	90%
Health Net of California, Inc.	82%	68%	92%	82%	68%	92%	86%	73%	93%	*	*	*

Full Service Health Plans Rates of Compliance (Continued)

Health Plan Name	All Products Non Urgent	All Products Urgent	All Products NPMH Follow Up	Commercial Non Urgent	Commercial Urgent	Commercial NPMH Follow Up	Individual/ Family Non Urgent	Individual/ Family Urgent	Individual/ Family NPMH Follow Up	Medi Cal Non Urgent	Medi Cal Urgent	Medi Cal NPMH Follow Up
Health Plan of San Joaquin	76%	78%	93%	*	*	*	*	*	*	76%	78%	93%
Health Plan of San Mateo	53%	27%	49%	44%	22%	Omitted	*	*	*	59%	31%	Omitted
IEHP	85%	77%	94%	*	*	*	84%	75%	94%	86%	78%	94%
Kaiser Permanente	92%	74%	93%	93%	71%	94%	93%	71%	94%	91%	78%	90%
Kern Health Systems	76%	74%	98%	*	*	*	*	*	*	76%	74%	98%
L.A. Care Health Plan	82%	69%	86%	*	*	*	82%	69%	87%	81%	68%	85%
L.A. Care Health Plan Joint Powers Authority	90%	70%	88%	90%	70%	88%	*	*	*	*	*	*
MemorialCare Select Health Plan	78%	75%	100%	78%	75%	100%	*	*	*	*	*	*
Molina Healthcare of California	78%	67%	85%	*	*	*	79%	68%	86%	77%	66%	83%
Positive Healthcare	67%	63%	92%	*	*	*	*	*	*	67%	63%	92%
San Francisco Health Plan	77%	66%	90%	83%	74%	88%	*	*	*	75%	63%	91%
Santa Clara Family Health Plan	64%	53%	86%	*	*	*	*	*	*	64%	53%	86%
Scripps Health Plan Services, Inc.	81%	65%	84%	81%	65%	84%	*	*	*	*	*	*
Sharp Health Plan	86%	73%	89%	86%	73%	89%	87%	73%	89%	*	*	*
Sutter Health Plan	87%	63%	96%	87%	63%	96%	87%	63%	96%	*	*	*
UnitedHealthcare Benefits Plan of California	86%	67%	96%	86%	67%	96%	*	*	*	*	*	*
UnitedHealthcare of California	89%	70%	96%	89%	70%	96%	*	*	*	*	*	*
Valley Health Plan	68%	58%	86%	66%	56%	85%	72%	62%	89%	*	*	*
Ventura County Health Care Plan	95%	74%	96%	95%	74%	96%	*	*	*	*	*	*
Western Health Advantage	86%	67%	92%	86%	67%	92%	86%	67%	92%	*	*	*

Behavioral Health Plans Rates of Compliance

Health Plan Name	All Products Non Urgent	All Products Urgent	All Products NPMH Follow Up	Commercial Non Urgent	Commercial Urgent	Commercial NPMH Follow Up	Individual/ Family Non Urgent	Individual/ Family Urgent	Individual/ Family NPMH Follow Up	Medi Cal Non Urgent	Medi Cal Urgent	Medi Cal NPMH Follow Up
Holman Professional Counseling Centers	90%	76%	91%	90%	76%	91%	*	*	*	*	*	*
OptumHealth Behavioral Solutions of California	95%	71%	96%	95%	71%	96%	95%	71%	96%	*	*	*

Appendix D: Average Appointment Wait Times by Health Plan

The Average Appointment Wait Time tables below include 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. 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. 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) Mean	PCP (10 Business Days) Median	Specialist Physician (15 Business Days)	Specialist Physician (15 Business Days)	Psychiatrist (15 Business Days) Mean	Psychiatrist (15 Business Days) Median	NPMH (10 Business Days) Mean	NPMH (10 Business Days) Median	NPMH Follow Up (10 Business Days) Mean	NPMH Follow Up (10 Business Days) Median	Ancillary (15 Business Days) Mean	Ancillary (15 Business Days) Median
Aetna Health of California Inc.	3	2	14	9	6	3	3	2	4	4	5	3
Alameda Alliance For Health	7	4	20	15	2	1	3	2	4	5	5	1
Anthem Blue Cross	5	3	14	9	4	3	3	2	4	5	4	3
Balance by CCHP	2	1	21	17	16	18	14	18	13	18	14	8
Blue Cross of California Partnership Plan, Inc.	3	2	16	10	7	5	3	3	4	5	2	2
Blue Shield of California	3	1	15	10	5	4	3	3	4	5	5	4
Blue Shield of California Promise Health Plan	1	1	19	13	2	1	3	3	4	5	4	3
CalViva Health	3	2	13	9	7	4	3	2	4	5	5	5
Central California Alliance for Health	5	4	23	18	2	1	3	3	4	5	6	3
Cigna HealthCare of California, Inc.	4	3	14	9	5	3	3	3	4	5	4	3
Community Care Health Plan, Inc.	3	2	17	12	17	10	3	3	5	5	2	2
Community Health Group Partnership Plan	1	1	10	6	5	2	3	2	5	6	5	5
Community Health Plan of Imperial Valley	3	2	14	8	5	3	2	2	6	5	4	2

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

Health Plan Name	PCP (10 Business Days) Mean	PCP (10 Business Days) Median	Specialist Physician (15 Business Days) Mean	Specialist Physician (15 Business Days) Median	Psychiatrist (15 Business Days) Mean	Psychiatrist (15 Business Days) Median	NPMH (10 Business Days) Mean	NPMH (10 Business Days) Median	NPMH Follow Up (10 Business Days) Mean	NPMH Follow Up (10 Business Days) Median	Ancillary (15 Business Days) Mean	Ancillary (15 Business Days) Median
Contra Costa Health Plan	2	1	9	7	5	5	3	2	4	5	5	1
Health Net Community Solutions, Inc.	3	3	12	8	4	3	3	3	4	5	2	1
Health Net of California, Inc.	4	3	13	8	5	4	3	2	4	5	3	2
Health Plan of San Joaquin	6	3	11	4	7	8	3	3	4	5	4	3
Health Plan of San Mateo	6	4	28	25	14	9	7	4	8	5	Omitted	5
IEHP	3	3	11	9	4	3	2	2	5	5	4	3
Kaiser Permanente	2	2	4	4	2	2	2	3	5	5	2	1
Kern Health Systems	2	2	14	8	7	4	2	1	3	3	3	4
L.A. Care Health Plan	3	2	15	11	2	2	4	3	5	5	7	3
L.A. Care Health Plan Joint Powers Authority	1	1	11	9	2	2	4	4	5	5	7	6
MemorialCare Select Health Plan	3	2	11	6	Omitted	10	1	1	5	5	2	1
Molina Healthcare of California	4	3	13	9	6	5	3	2	5	5	2	1
Positive Healthcare	19	15	13	10	2	2	2	3	4	5	1	1
San Francisco Health Plan	6	4	16	11	4	3	2	2	3	5	1	1
Santa Clara Family Health Plan	5	3	26	21	7	3	5	3	3	4	17	7
Scripps Health Plan Services, Inc.	3	2	17	12	4	3	4	3	5	5	3	2
Sharp Health Plan	3	3	8	6	4	4	3	3	4	5	2	1
Sutter Health Plan	6	4	22	17	5	5	2	2	2	2	13	15
UnitedHealthcare Benefits Plan of California	5	3	12	8	5	4	2	2	3	2	3	2
UnitedHealthcare of California	3	3	13	9	5	4	2	2	3	2	3	2
Valley Health Plan	5	2	20	15	6	3	5	3	3	4	17	7
Ventura County Health Care Plan	6	4	15	12	4	4	2	2	3	2	1	1
Western Health Advantage	1	1	16	11	6	7	3	2	3	3	6	4

Behavioral Health Plans
Average Non-Urgent Appointment Wait Time

Health Plan Name	PCP (10 Business Days) Mean	PCP (10 Business Days) Median	Specialist Physician (15 Business Days) Mean	Specialist Physician (15 Business Days) Median	Psychiatrist (15 Business Days) Mean	Psychiatrist (15 Business Days) Median	NPMH (10 Business Days) Mean	NPMH (10 Business Days) Median	NPMH Follow Up (10 Business Days) Mean	NPMH Follow Up (10 Business Days) Mean	Ancillary (15 Business Days) Mean	Ancillary (15 Business Days) Median
Holman Professional Counseling Centers	NA	NA	NA	NA	5	3	3	3	4	5	NA	NA
OptumHealth Behavioral Solutions of California	NA	NA	NA	NA	5	4	2	2	3	2	NA	NA

Full Service Health Plans
Average Urgent Appointment Wait Time

Health Plan Name	PCP (48 Hours) Mean	PCP (48 Hours) Median	Specialist Physician (48 or 96 Hours) Mean	Specialist Physician (48 or 96 Hours) Median	Psychiatrist (48 or 96 Hours) Mean	Psychiatrist (48 or 96 Hours) Median	NPMH (48 or 96 Hours) Mean	NPMH (48 or 96 Hours) Median
Aetna Health of California Inc.	33	21	143	72	111	30	47	38
Alameda Alliance For Health	90	30	229	123	32	21	33	25
Anthem Blue Cross	69	24	225	89	92	48	53	45
Balance by CCHP	90	42	250	120	445	625	420	625
Blue Cross of California Partnership Plan, Inc.	28	20	284	120	131	64	42	26
Blue Shield of California	60	24	263	114	118	68	53	42
Blue Shield of California Promise Health Plan	23	20	342	96	37	2	42	23
CalViva Health	23	16	145	72	71	73	35	25
Central California Alliance for Health	21	22	33	25	8	1	20	21
Cigna HealthCare of California, Inc.	38	22	219	86	119	70	60	49
Community Care Health Plan, Inc.	24	18	183	68	Omitted	127	55	30
Community Health Group Partnership Plan	22	26	19	2	58	24	36	24
Community Health Plan of Imperial Valley	21	21	171	47	19	23	27	23
Contra Costa Health Plan	25	23	114	47	34	23	39	27
Health Net Community Solutions, Inc.	30	20	120	66	48	25	38	24
Health Net of California, Inc.	44	23	195	71	129	71	45	28
Health Plan of San Joaquin	29	20	55	26	9	4	27	23
Health Plan of San Mateo	171	116	781	499	521	335	163	46
IEHP	23	19	87	53	53	26	28	23
Kaiser Permanente	20	23	21	21	31	23	49	49
Kern Health Systems	13	5	111	43	107	41	25	22
L.A. Care Health Plan	34	22	201	74	33	23	53	31
L.A. Care Health Plan Joint Powers Authority	26	20	87	71	24	22	59	31
MemorialCare Select Health Plan	19	20	63	29	69	94	26	21
Molina Healthcare of California	30	21	93	63	91	47	47	24
Positive Healthcare	Omitted	21	138	65	24	18	36	23

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

Health Plan Name	PCP (48 Hours) Mean	PCP (48 Hours) Median	Specialist Physician (48 or 96 Hours) Mean	Specialist Physician (48 or 96 Hours) Median	Psychiatrist (48 or 96 Hours) Mean	Psychiatrist (48 or 96 Hours) Median	NPMH (48 or 96 Hours) Mean	NPMH (48 or 96 Hours) Median
San Francisco Health Plan	55	16	301	164	82	25	32	24
Santa Clara Family Health Plan	81	45	445	237	73	46	41	23
Scripps Health Plan Services, Inc.	37	24	148	72	96	73	66	65
Sharp Health Plan	33	23	60	30	74	46	40	28
Sutter Health Plan	97	68	200	124	120	64	53	32
UnitedHealthcare Benefits Plan of California	52	23	164	50	97	50	47	30
UnitedHealthcare of California	32	22	181	65	88	49	46	30
Valley Health Plan	73	43	262	162	66	45	40	23
Ventura County Health Care Plan	61	25	135	51	69	48	47	32
Western Health Advantage	53	25	153	94	156	119	115	32

Behavioral Health Plans
Average Urgent Appointment Wait Time

Health Plan Name	PCP (48 Hours) Mean	PCP (48 Hour0073) Median	Specialist Physician (48 or 96 Hours) Mean	Specialist Physician (48 or 96 Hours) Median	Psychiatrist (48 or 96 Hours) Mean	Psychiatrist (48 or 96 Hours) Median	NPMH (48 or 96 Hours) Mean	NPMH (48 or 96 Hours) Median
Holman Professional Counseling Centers	NA	NA	NA	NA	115	44	40	25
OptumHealth Behavioral Solutions of California	NA	NA	NA	NA	90	48	46	30

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.