DEPARTMENT OF
Managed
Health Care

# Timely Access Report

## Measurement Year 2022

1-888-466-2219

HAVE A PROBLEM WITH YOUR HEALTH PLAN? CONTACT THE DMHC

HealthHelp.ca.gov

Prepared by the Department of Managed Health Care (DMHC)

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# DMHC MISSION, VALUES & GOALS

## MISSION

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

## CORE VALUES

- Integrity
- Leadership
- Commitment to Service

## GOALS

- Educate and assist California's diverse health care consumers
- Cultivate a coordinated and sustainable health care marketplace
- Regulate fairly, efficiently, and effectively
- Foster a culture of excellence throughout the organization

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# Executive Summary

Providing timely access to health care services is not only required under the law, but is also a health plan's fundamental duty to its enrollees. This report summarizes the Measurement Year (MY) 2022 results of the provider appointment availability survey (timely access data) submitted by full service and behavioral health plans (health plans) to the California Department of Managed Health Care (DMHC). The charts within this report display, at the health plan level, the percentage of providers that responded to the survey with an appointment available within the applicable appointment wait time standard. In addition, this report implements changes required by SB 221 (2021) by including average appointment wait times charts, data tables and methodology. The new average appointment wait time charts in this report set forth the mean and median appointment wait time for each provider type, displayed by product.

The standardized provider appointment availability survey methodology (timely access survey methodology) health plans follow to report timely access data to the DMHC has remained the same from MY 2019 to MY 2022. Using the same methodology allows the timely access data to be compared across multiple years. Thus, changes in observed timely access rates may primarily be attributed to the changes in supply and demand for health care services and changes in the delivery of health care, including the impact caused by the COVID-19 pandemic. However, without specific information regarding staffing, appointment demand, or changes in the health care delivery system, the DMHC cannot directly evaluate how these factors impacted timely access rates. The timely access survey methodology provides health plans with the flexibility to record the next available appointment offered by a health plan contracted provider, regardless of whether the appointment was an in-person or a telehealth appointment.[1] Thus, timely access rates in this report account for the increased expansion and adoption of telehealth that occurred during the COVID-19 pandemic.

In MY 2021 and MY 2022, many health plans noted concerns about the impact of COVID-19 on appointment availability and their ability to complete the timely access survey. Although fewer health plans noted the impact of COVID-19 on staffing and appointment demand in the MY 2022 timely access data, the decrease in rates of compliance from pre-pandemic levels may indicate the effects of the COVID-19 pandemic continued to impact access to health care services in MY 2022. While timely access rates improved from 2019 to 2020, health plans previously indicated that this improvement may be due to patients making fewer appointments during the COVID pandemic. This assumption is supported by the fact that, on average, both urgent and non-urgent rates of compliance in 2021 and 2022 fell below rates observed in MY 2019.

Due to the DMHC's oversight and monitoring activities, health plans have continued to make improvements in the quality of data collection and reporting over the last eight years. Starting in MY 2016, the DMHC has required each reporting health plan to use an external vendor to conduct an annual quality assurance review of its timely access data prior to submission the DMHC. In addition, the DMHC has annually reviewed the data submitted by health plans for compliance with the timely access survey methodology and reporting requirements. Where compliance concerns have been

[1] The DMHC expanded the timely access survey methodology to include telehealth providers beginning in MY 2019 and continued this update in each measurement year including the timely access survey methodology used by health plans in MY 2022.

identified, the DMHC requested the health plan to provide a response and a corrective action plan. In prior years, health plan data was excluded from some charts due to data reliability concerns. However, the number of health plans with data quality concerns has decreased over the last three measurement years, and only one health plan reported data that was deemed unreliable and therefore was excluded from one of the urgent appointment charts set forth in this report.[2]

**Key Rate of Compliance Findings for Full Service Health Plans:**

- For non-urgent and urgent appointments combined, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 87% to a low of 56%. (Chart 1)
- For non-urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 94% to a low of 66%. (Chart 5)
- For urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 84% to a low of 46%. (Chart 9)
- Of the providers selected to be surveyed by full service health plans, 54% completed the survey, 27% did not respond to the survey, and 20% were ineligible to participate in the survey.[3, 4]

**Key Rate of Compliance Findings for Behavioral Health Plans:**

- For non-urgent and urgent appointments combined, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 83% to a low of 66%. (Chart 13)
- For non-urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 89% to a low of 77%. (Chart 17)
- For urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 77% to a low of 54%. (Chart 21)
- Of the providers selected to be surveyed by behavioral health plans, 52% completed the survey, 31% did not respond to the survey, and 18% were ineligible to participate in the survey.[5]

In MY 2023, the DMHC will begin holding health plans accountable to meet the minimum urgent and non-urgent rates of compliance set forth in the amended Timely Access Regulation. As part of that effort, the DMHC will require health plans who do not meet the 70% urgent or non-urgent rates of

[2] OptumHealth Behavioral Solutions of California exceeded the five percent sampling error threshold for urgent Medi-Cal products due to a low response rate for the survey. Due to a high number of non-responsive providers and providers who were ineligible to participate in the survey, an insufficient number of providers completed the survey to produce a reliable estimated rate of compliance for that product line. To ensure that the health plan produces reliable timely access data in future reporting, the DMHC will review the health plan's compliance, issue findings, and request a response and a corrective action plan. After this investigation, if the DMHC finds a violation of law, the matter may be referred to the DMHC's Office of Enforcement for further disciplinary action.

[3] 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).

[4] Please note that the figures in the full service health plan responses rates add up to 101% due to rounding.

[5] Please note that the figures in the behavioral health plan responses rates add up to 101% due to rounding.

compliance to submit a corrective action plan when they submit their Timely Access Data to the DMHC in 2024. The DMHC will evaluate health plans' rates of compliance and corrective action plans and may take further disciplinary action against health plans for non-compliance with these new requirements.

To implement new requirements established by SB 221 (2021) and SB 225 (2022), the DMHC incorporated the new 10 business day behavioral health follow-up appointment standard into the MY 2023 timely access survey methodology and will require health plans that do not meet an 80% initial performance target for behavioral health follow-up appointments to submit a corrective action plan. The DMHC will continue to work with stakeholders to implement and refine monitoring requirements set forth in SB 221 and SB 225 and codify these changes into regulation, including evaluation and adjustment of the initial performance target for behavioral health follow-up appointments.

# 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.

# Introduction and Background

Created by consumer-sponsored legislation in 1999, the California Department of Managed Health Care (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 consumers. The DMHC protects the health care rights of 29.7 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. These standards include wait times to access urgent appointments, non-urgent appointments, and behavioral health follow-up appointments.[6] In addition, the standards require coordination of interpreter services with appointments, health plan Member Services availability, and telephone triage or screening services during and after regular business hours. Notably, if an enrollee is offered an appointment within the wait time standards and the enrollee chooses to select a later appointment, the health plan has met the standard. Additionally, a licensed health care professional may determine that a later appointment may be appropriate based on the enrollee's condition if scheduling at a later time will not negatively affect the enrollee's health. To demonstrate performance with the timely access standards, each health plan is required to monitor their networks and submit an annual Timely Access Compliance Report (compliance report) to the DMHC.

To strengthen the DMHC's ability to oversee health plan compliance with the timely access standards, the law was amended by Senate Bill (SB) 964 (2014). SB 964 authorized the DMHC, in consultation with stakeholders, to develop standardized methodologies for measuring compliance with the timely access standards. The goal of using a standardized timely access survey methodology is to obtain comparable data across all reporting health plans. This would improve the DMHC's ability to compare results among health plans and ultimately develop an acceptable rate of compliance for health plans to meet.

The DMHC worked closely with stakeholders to strengthen the timely access requirements and health plan reporting through amendments to the Timely Access Regulation.[7] The amendments to the Timely Access Regulation, which became effective on April 1, 2022, incorporate the mandatory timely access survey methodology, standardize reporting, and require health plans to meet a minimum rate of compliance of 70% for both non-urgent and urgent appointments starting in MY 2023.[8] With these new requirements in the Timely Access Regulation, the DMHC will be able to better hold health

[6] The 10 business day behavioral health follow-up appointment standard became effective July 1, 2022 (Senate Bill 221 221) (2021-2022 Reg. Sess.).
[7] California Code of Regulations, title 28, section 1300.67.2.2.
[8] MY 2023 data will be reported to the DMHC in 2024.

plans accountable for meeting a minimum rate of compliance, and ultimately provide timely access to care to enrollees.

Beginning in MY 2023, health plans will also be required to demonstrate that each network meets the required 70% minimum rate of compliance for both urgent and non-urgent appointments. This will allow the DMHC to review each individual health plan network's ability to deliver timely appointments, ascertain whether each health plan network met the established rate of compliance, and compare performance across all health plans.

Once the 70% rate of compliance is implemented in MY 2023, the DMHC will begin displaying timely access data by health plan network in the annual Timely Access Report, rather than aggregated by health plan.[9] This approach will be more consistent with the way enrollees access health care services from their health plan and will allow for better coordination of timely access and network adequacy reviews, which in turn will lead to better transparency into health plan compliance with the timely access to care standards.

In 2021 and 2022, two bills were enacted to improve timely access to care standards and health plan monitoring. SB 221 (2021) codified existing definitions and wait time standards from the Timely Access Regulation into the Timely Access Statute and added a new appointment wait time standard for behavioral health follow-up appointments of 10 business days.[10] 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 behavioral health follow-up appointments.

Additionally, SB 221 required the DMHC to develop a methodology to determine the average appointment wait time. To implement this new requirement, the DMHC included the average appointment wait time charts, data tables, and methodology in this report.

The DMHC took immediate steps to implement SB 221, including issuing three All Plan Letters requiring health plans to begin implementation and monitoring of the new wait time standard for behavioral health follow-up appointments.[11] The DMHC also incorporated monitoring and reporting requirements for the new standard into the mandatory timely access survey methodology for MY 2023. Further, the DMHC issued an All Plan Letter requiring health plans to meet an initial performance target for behavioral health follow-up appointments. Health plans that do not obtain at least an 80% rate of compliance for behavioral health follow-up appointments in MY 2023, will be required to submit a corrective action plan with their timely access data submission. The DMHC will evaluate health plans' MY 2023 behavioral health follow-up appointment results and may adjust the performance target in future measurement years. The DMHC will continue to work with stakeholders to implement and refine monitoring requirements set forth in SB 221 and SB 225 and codify these changes into regulation.

[9] A network is a discrete set of network providers the health plan has designated to deliver all covered services to enrollees covered by a health plan in a specific service area. (Title 28 CCR section 1300.67.2.2(b)(5).)
[10] 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 enrollee's health.
[11] All Plan Letter (APL) 21-025 – Newly Enacted Statutes Impacting Health Plans (12/20/2021), APL 22-007 – DPN Monitoring and Annual Reporting Changes (3/4/2022), and APL 22-026 – Implementation of Amendments to Timely Access and Network Reporting Statutes and Regulation (11/4/2022).

**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 authorization does not have to be obtained in advance from the health plan. A 96 hour (4 days) wait time standard applies when authorization from the health plan must be obtained prior to the delivery of 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.

Health plans are required to ensure that each of its provider networks has the capacity to offer enrollees appointments within the timely access standards. Health plans must also ensure that appointments meet the clinical appropriateness standard, which requires that services be provided in a timely manner that is appropriate for the nature of the individual enrollee's condition, consistent with good professional practice.

In conjunction with the clinical appropriateness standard, the Timely Access Statute and Regulation allows the wait time for an appointment to be extended if the referring, treating, or triaging licensed health care provider, acting within the scope of the provider's practice (and consistent with professionally recognized standards of practice), determines and notes in the relevant record that a longer wait time will not have a detrimental impact on the health of the enrollee. In addition, preventive care services and periodic follow-up care may be scheduled in advance consistent with professionally recognized standards of practice, in a timeframe determined by the treating health care provider.

Enrollees may access urgently needed services in a variety of ways depending on the delivery model of the health plan, aside from emergency treatment obtained at an emergency room. For example, many health plan enrollees who require urgent care may obtain same-day appointments through their primary care provider or through another doctor within their medical group. Some health plans offer the capability to meet urgent primary care treatment needs by offering advanced access, which is the ongoing availability of primary care services on the same day or the next business day following the day of the enrollee's request. Additionally, some health plans allow enrollees to access urgent care through contracts with dedicated urgent care centers located within the enrollee's local service area. Some methods of meeting enrollee 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 enrollees' urgent care needs that are not delivered via appointments cannot be measured by the timely access survey.

**How the DMHC Monitors Timely Access**

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

- Monitoring enrollee complaints submitted to the DMHC Help Center to identify trends and take appropriate action, including referral to the DMHC 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 enrollees to ensure health plans have an adequate number of providers to offer timely access to care to their enrollees.
- 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

plan determines there are timely access or network adequacy issues based on audits, oversight, or other information such as enrollee grievances that concern timely access to appointments, the DMHC evaluates whether the plan implemented corrective action as required by the plan's written quality assurance process. The DMHC also reviews the health plan's processes for coordinating language assistance services when enrollees obtain health care services, including at the time of a scheduled urgent or non-urgent appointment.

- Taking enforcement action against health plans that violate timely access requirements, which may include requiring a corrective action plan.

Between January 1, 2017, and September 30, 2023, the DMHC has issued 73 access-related deficiencies to health plans through the medical survey process. Of these 73 deficiencies:

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

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

**DISTANCE**

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


**AVAILABILITY**

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

**INTERPRETER**

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

# Timely Access Compliance Report Findings

The timely access survey methodology sets forth the process for an annual assessment of a health plan's ability to offer appointments within the wait time standards. The timely access survey measures health plan contracted providers' next available appointment and does not measure actual enrollee experiences. The charts within this report are created using the timely access data reported by health plans. The charts display the percentage of surveyed providers who indicated they had appointments available within the appointment wait time standards.

The DMHC requires health plans to annually measure capacity for timely appointment by using the mandatory timely access survey methodology and then report the results to the DMHC. The timely access survey uses a randomly selected stratified sample of each provider type within a health plan network in each county. Health plans contact a random sample of health plan contracted providers and query them for their next available appointment. Health plans compare the providers' responses to these surveys against the appointment wait time standards to ascertain the percentage of surveyed providers with an appointment available within the urgent and non-urgent wait time standards. On May 1st of each year, health plans report the results of the timely access survey with other timely access monitoring results to the DMHC.

**Rate of Compliance Charts: Background**

The Rate of Compliance Charts (Charts 1 through 24) below show the percentage of surveyed providers indicating whether an appointment within the timely access standard is available, organized by all products combined (aggregate), Commercial Products, Individual/Family Products, and Medi-Cal Products.[12] Full service and behavioral health plans' timely access data are presented in the Rate of Compliance Charts separately; however, the Rate of Compliance Charts for full service health plans include responses for behavioral health services. It is important to understand the health plan timely access survey results reflect only the time period in which a provider was surveyed, based on the sample size of surveyed providers who responded.

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

[12] Large or small group employer-sponsored health plans are examples of lines of business included in the commercial product. Individual or family health plans purchased privately or through the Covered California Exchange are examples of lines of business included in the Individual/Family Product.

## Rate of Compliance Charts: Sampling Error Rate

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 24) 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.[13] When a health plan fails to meet the 5% threshold, the results of the survey may not be sufficiently reliable to produce generalizable results.[14] Charts 1 through 24 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.

In MY 2022, OptumHealth Behavioral Solutions of California was the only health plan to exceed the five percent sampling error threshold due to a low response rate for providers in this network. The health plan only exceeded the five percent sample error in one measure: urgent appointments for Medi-Cal products. While all health plans are represented in the charts below, the chart for urgent appointments for Medi-Cal products reported by behavioral health plans is excluded from this report. The chart is excluded because OptumHealth Behavioral Solutions of California was the only behavioral health plan of this type to report timely access data for MY 2022 and the sampling error rendered the health plan's urgent appointment results unreliable. The unreliable estimate resulted from a low response rate for the providers in this network. The appointment wait time data for OptumHealth Behavioral Solutions of California's Medi-Cal network is included in the plan-level results in Chart 13, as the number of combined provider responses reported for the Medi-Cal, Commercial and Individual/Family products was sufficient to produce reliable results. Additionally, OptumHealth Behavioral Solutions of California's Medi-Cal network is represented in the full service health plan charts through its plan partner, UnitedHealthcare Community Plan of California, Inc., because the combined number of responses between the OptumHealth providers and the full service health plan providers was sufficient to produce a reliable urgent appointment rate.[15]

## Rate of Compliance Charts: Response Rates

The DMHC evaluates response, non-response, and ineligible rates reported by health plans in the compliance report, which may impact the amount of effort required to obtain a timely appointment and the ability of a health plan to produce a reliable estimated rate of compliance.[16] Although the

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[13] 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 an 90% confidence level, which means that a rate of compliance estimate of 75% with a sampling error of +/- 5% indicates that there is an 90% certainty that the true rate of compliance is between 70% and 80%.

[14] 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.

[15] See Appendix A of this report for further details regarding Optum Health's rates of compliance and sampling error.

[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.

survey response rates may suggest that enrollees could experience difficulties contacting providers to schedule appointments, there are methodological reasons that a health plan may have difficulty obtaining survey appointment information from providers that enrollees are less likely to experience. 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.

There are other factors in the health plan survey process that suggest the surveys are not a direct reflection on the enrollee experience. 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. Furthermore, providers may react differently when contacted by a health plan to complete a survey versus when a patient contacts a provider with a health condition seeking an appointment. Thus, the rate of non-responding and ineligible providers may not represent the enrollee's experience in obtaining a timely appointment.

The tables below list the response, non-response, and ineligible rates for full service and behavioral health plans. These figures are calculated from each individual provider survey attempt. An attempt occurs when a provider has been sent a written survey (e.g., email or fax), a phone call survey has been made or attempted, appointment data has been extracted from the provider's appointment schedule, or the provider has been identified as a verified advanced access primary care provider.[17]

The table below shows that providers in full service health plans had a response rate of 54%. Twenty-seven percent (27%) of the providers selected to be surveyed did not respond. The data indicates that the non-response rate was primarily due to providers failing to respond to the survey within the 15 business days allowed for a response. The remaining 20% of survey attempts were from providers who were ineligible to participate in the survey, most commonly as a result of contact information issues.

| Full Service Health Plans<br>Summary of Survey Response Rates[18] | |
|---|---|
| Completed Survey | 54% |
| Non-Response | |
| Declined to Respond | 5% |
| No Response within Required Timeframe | 22% |
| Ineligible | |
| Ineligible – Contact Information Issue | 8% |
| Ineligible – Provider Not in Plan Network | 2% |
| Ineligible – Provider Retired or Ceasing to Practice | 1% |
| Ineligible – Provider Not in County | 5% |
| Ineligible – Provider Listed Under Incorrect Specialty | 1% |
| Ineligible – Provider Does Not Offer Appointments | 3% |

[17] 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 fail 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.

[18] The figures in the Full Service Health Plan Summary of Survey Response Rates table add up to 101% due to rounding.

The table below lists the response, non-response, and ineligible rates for behavioral health plans. These providers had a survey response rate of 52%, and a non-response rate of 31%. The remaining 18% of the survey attempts were from providers who were ineligible to participate in the survey, most commonly as a result of contact information issues.

| Behavioral Health Plans<br>Summary of Survey Response Rates[19] | |
|---|---|
| Completed Survey | 52% |
| Non-Response | |
| Declined to Respond | 4% |
| No Response within Required Timeframe | 27% |
| Ineligible | |
| Ineligible – Contact Information Issue | 6% |
| Ineligible – Provider Not in Plan Network | 2% |
| Ineligible – Provider Retired or Ceasing to Practice | 1% |
| Ineligible – Provider Not in County | 5% |
| Ineligible – Provider Listed Under Incorrect Specialty | <1% |
| Ineligible – Provider Does Not Offer Appointments | 4% |

**Average Appointment Wait Time Charts: Background**

The Average Appointment Wait Time Charts (Charts 25 through 33) below display full service and behavioral health plans' mean and median appointment wait time for all products combined (aggregate), Commercial Products, Individual/Family Products, and Medi-Cal Products for each provider type. The median and mean appointment wait time is calculated by measuring the wait time from the date of the provider's response to the survey and the next available appointment. Each chart includes the applicable appointment wait time standard to provide insight into the enrollee experience and whether health plan networks are generally able to provide appointments within each applicable appointment wait time standard.

The average (mean) represents the total appointment wait time for the bottom 90 percent of appointment times divided among these appointments. The median appointment wait time represents the wait time where half of all appointments are at or below (i.e., middle point of all reported wait times). The DMHC included the mean to implement the average appointment wait time methodology requirements set forth in Health and Safety Code section 1367.03, sub. (f)(3). The DMHC identified some outlier observations that were skewing the calculation of the mean. In order to produce an average appointment wait time value that more closely reflected the overall enrollee experience, the DMHC eliminated the most extreme wait times and calculated the average based on the 90th percentile wait times for each provider type.[20] The median appointment wait time was also included

[19] The figures in the Behavioral Health Plans Summary of Survey Response Rates table add up to 101% due to rounding.
[20] Excessively long wait times can skew the average appointment wait time results such that the mean does not necessarily represent the expected appointment time available to enrollees. The DMHC observed excessively long wait times for some providers which may result from several factors, including data errors, limited capacity, providers being on leave, or specific provider group scheduling processes. Notably, providers and groups often have other processes to ensure enrollees receive urgent services, such as directing enrollees 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 enrollee experience. To better understand this issue and how urgent care is delivered outside of appointments, the DMHC added a survey question related to other methods providers use to offer enrollees urgent care.

to provide a better understanding of what an enrollee may experience when attempting to obtain an appointment.

Health plan networks must be sufficient to offer enrollees non-urgent appointments with primary care providers and non-physician mental health providers within 10 business days of the request for an appointment. Non-urgent appointments with ancillary providers and specialist physicians, including psychiatrists, must be offered within 15 business days of the request. The mean and median non-urgent appointment wait time is set forth below for each provider type across all health plans for all providers surveyed:

- The primary care provider non-urgent appointment wait time mean is 5 business days and the median is 3 business days. (Chart 25)
- The specialist physician non-urgent appointment wait time mean is 15 business days and the median is 10 business days. (Chart 26)
- The psychiatrist non-urgent appointment wait time mean is 6 business days and the median is 4 business days. (Chart 27)
- The non-physician mental health care provider non-urgent appointment wait time mean is 4 business days and the median is 3 business days. (Chart 28)
- The ancillary service provider non-urgent appointment wait time mean is 4 business days and the median is 3 business days.[21] (Chart 29)

Health plan networks must be sufficient to offer enrollees an appointment within the applicable urgent appointment wait time standard. An urgent appointment must be available within 48 hours (2 days) of the request when no prior authorization is required or 96 hours (4 days) of the request when prior authorization is required of the request. The mean and median urgent appointment wait time is set forth below for each provider type across all health plans for all providers surveyed:

- The primary care provider urgent appointment wait time mean is 82 hours (3.4 days) and the median is 29 hours (1.2 days). (Chart 30)
- The specialist physician urgent appointment wait time mean is 241 hours (10 days) and the median is 98 hours (4.1 days). (Chart 31)
- The psychiatrist urgent appointment wait time mean is 109 hours (4.5 days) and the median is 47 hours (2 days). (Chart 32)
- The non-physician mental health care provider urgent appointment wait time mean is 58 hours (2.4 days) and the median is 46 hours (1.9 days). (Chart 33)

[21] Ancillary services providers provide supportive or diagnostic services. The Timely Access Data measures appointment wait times for ancillary service providers offering appointments for physical therapy and mammography services.

# Full Service Health Plans Rate of Compliance Charts

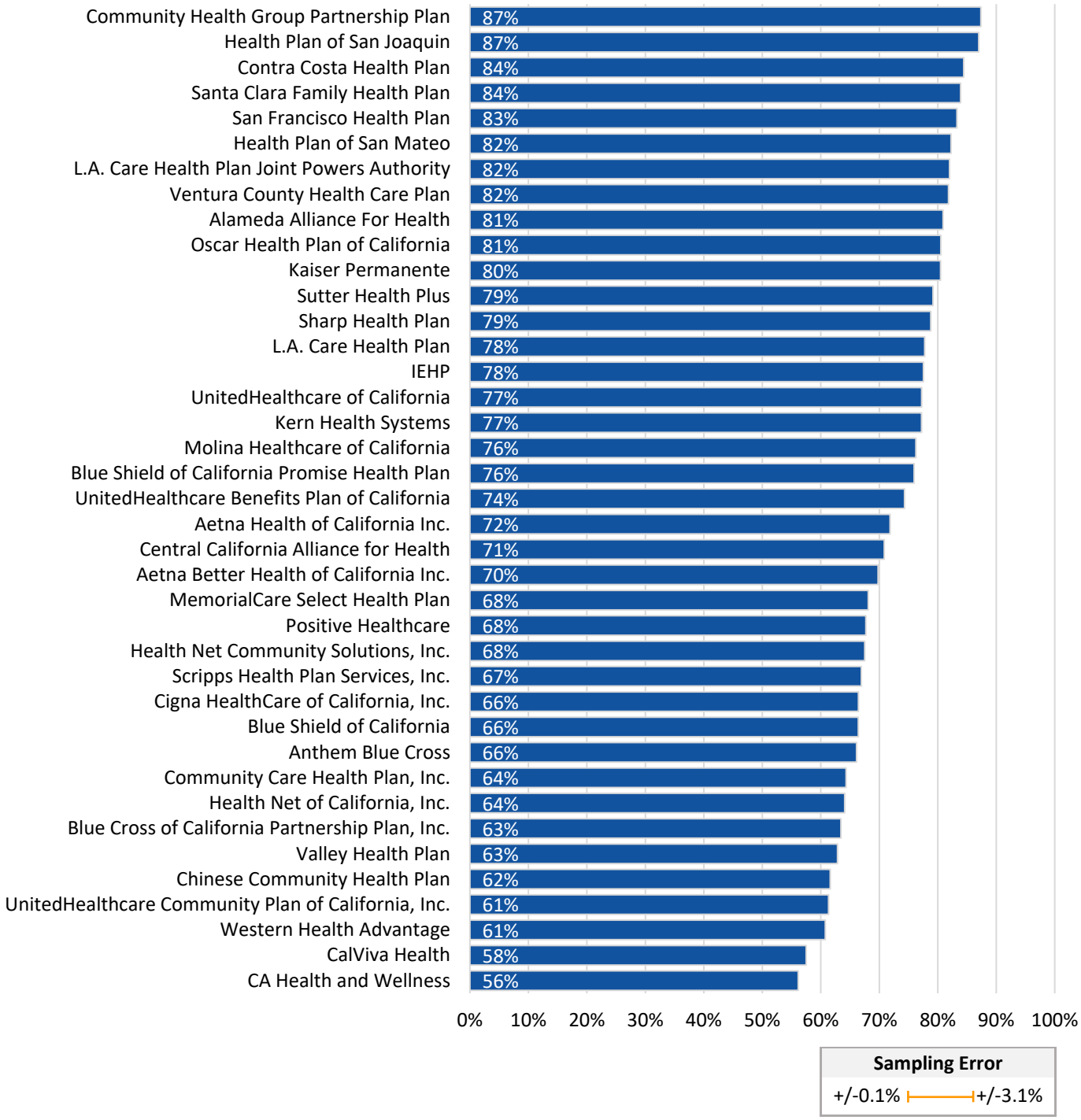
# Urgent and Non-Urgent Appointments

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

## Chart 1

### Full Service Health Plans

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

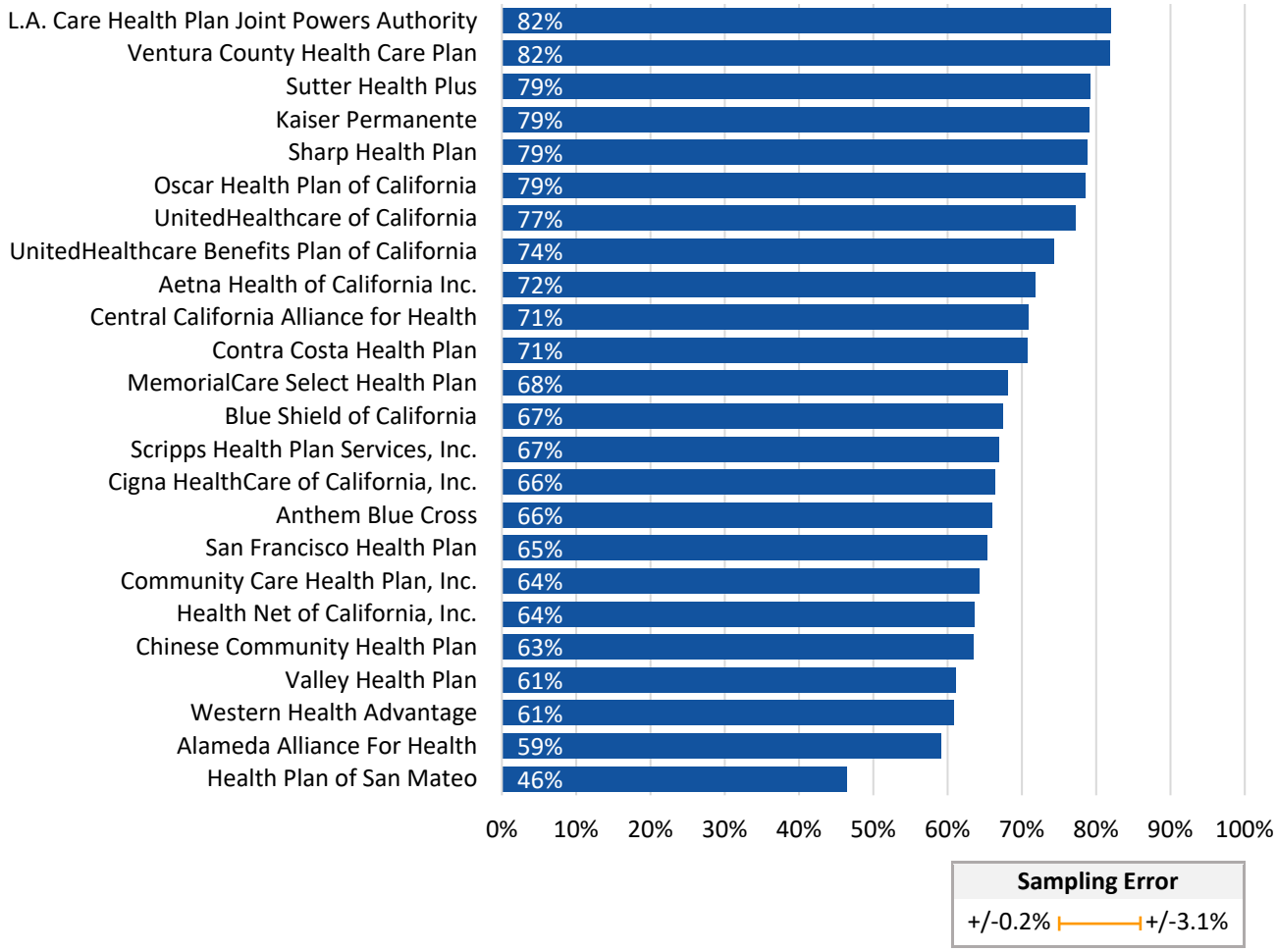


**Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards**

## Chart 2

### Full Service Health Plans – Commercial

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

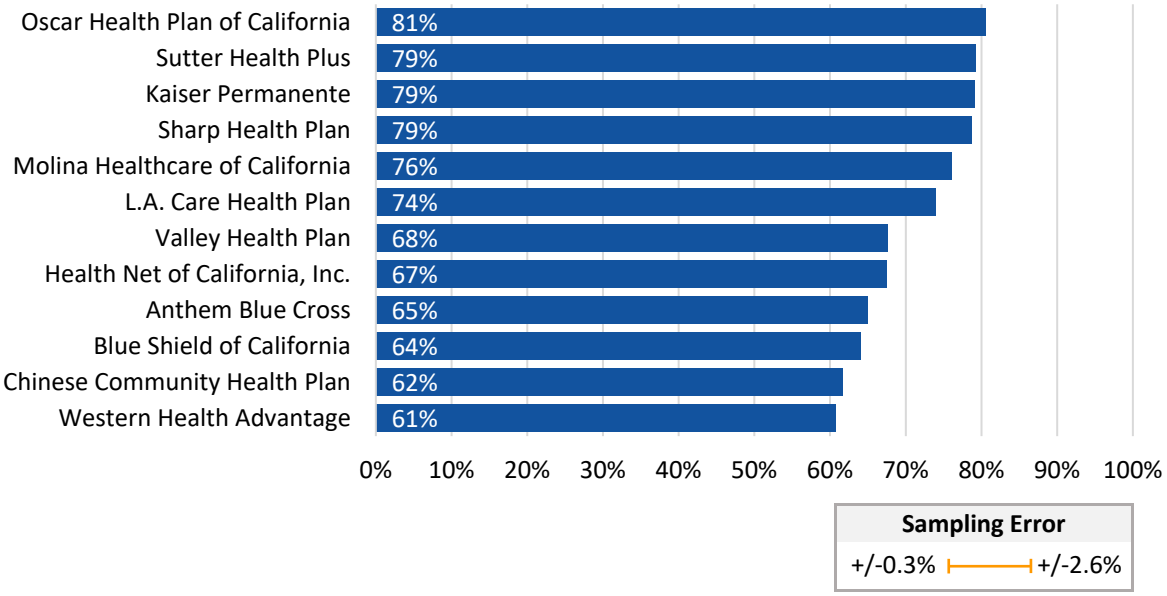


**Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards**

## Chart 3

### Full Service Health Plans – Individual/Family

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

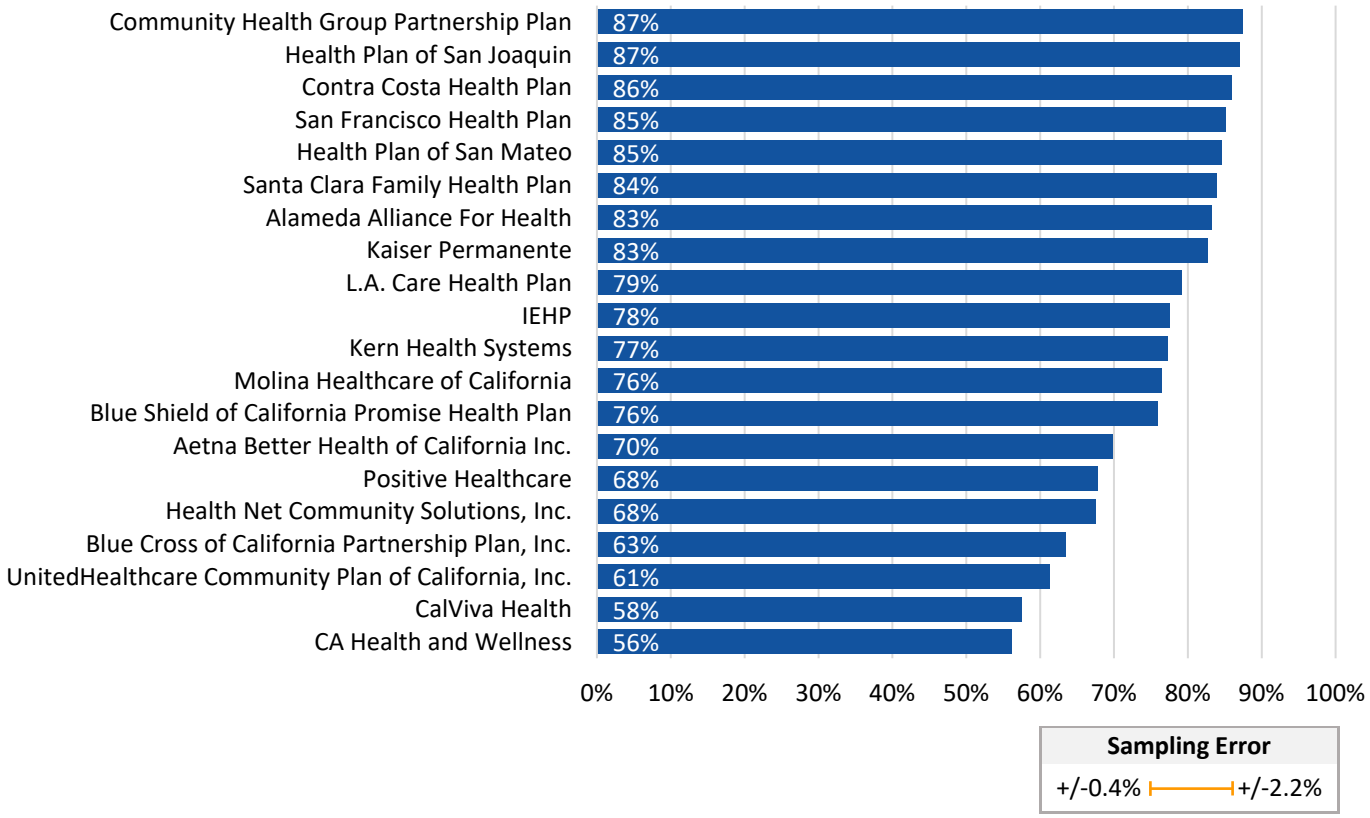


**Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards**

## Chart 4

### Full Service Health Plans – Medi-Cal

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



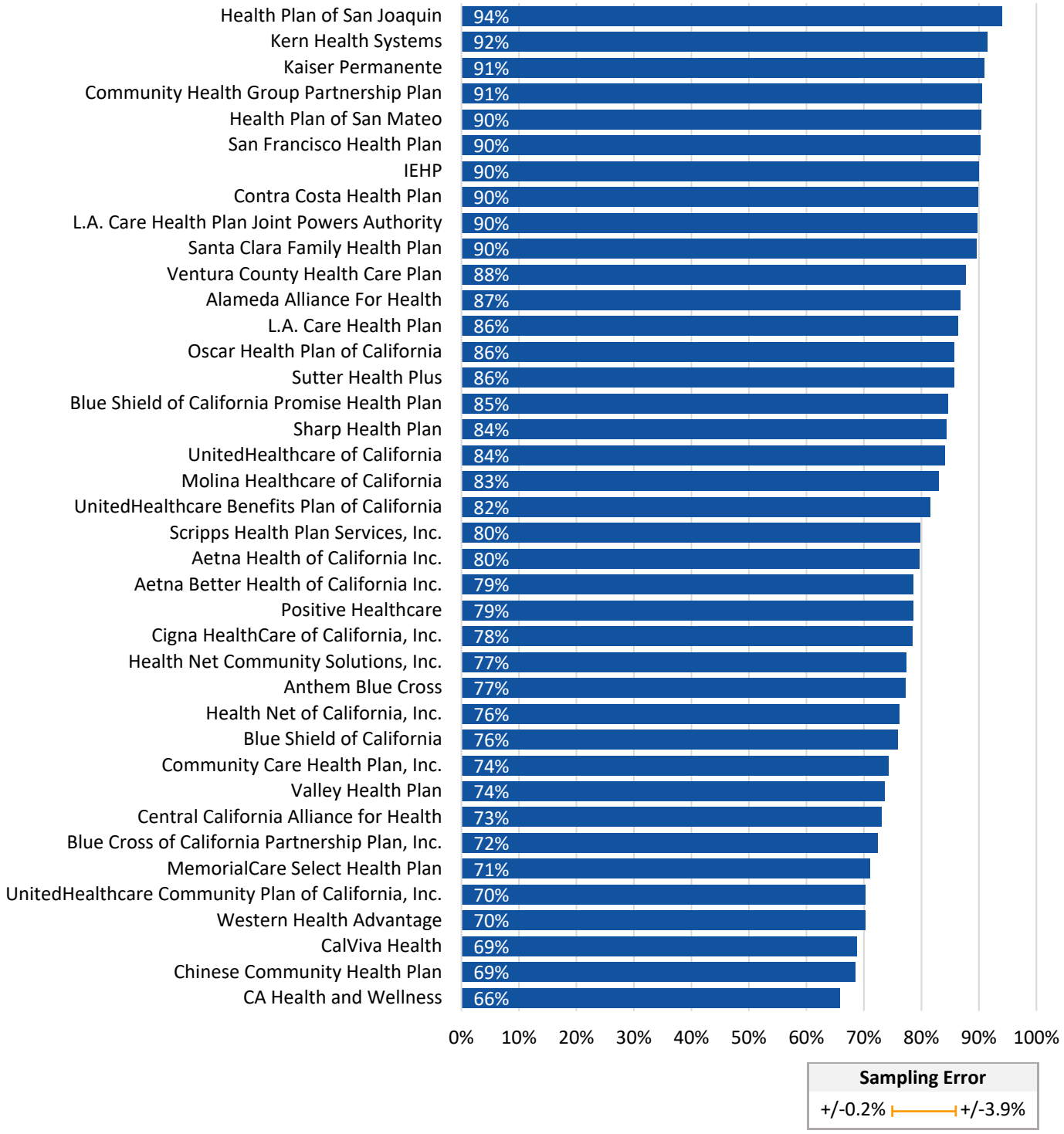
# Non-Urgent Appointments

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

## Chart 5

### Full Service Health Plans

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

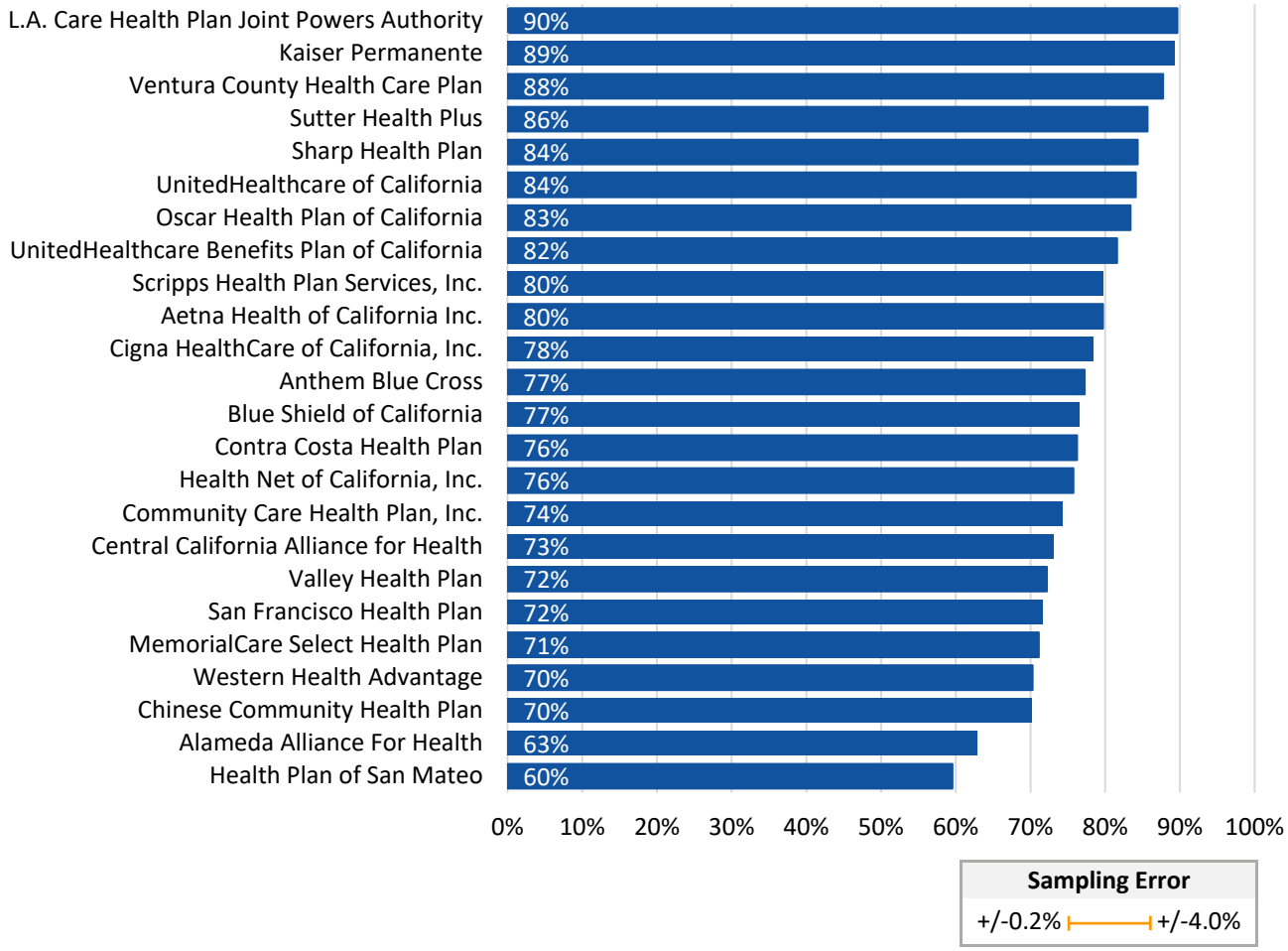


**Percentage of Surveyed Providers Meeting Non-Urgent Appointment Wait Time Standards**

## Chart 6

### Full Service Health Plans – Commercial

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

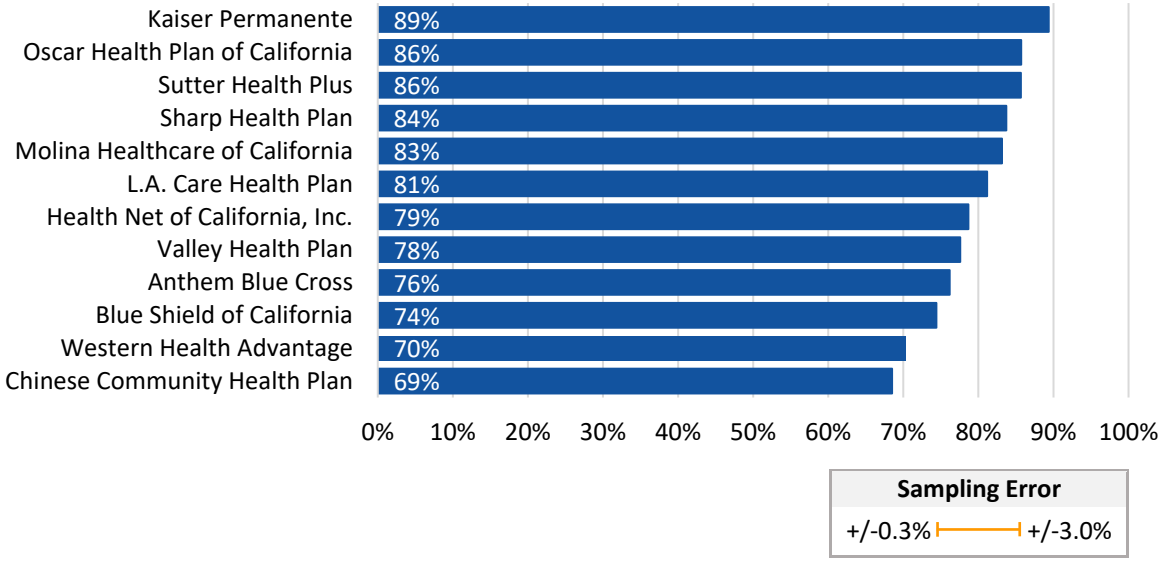


**Percentage of Surveyed Providers Meeting Non-Urgent Appointment Wait Time Standards**

## Chart 7

### Full Service Health Plans – Individual/Family

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

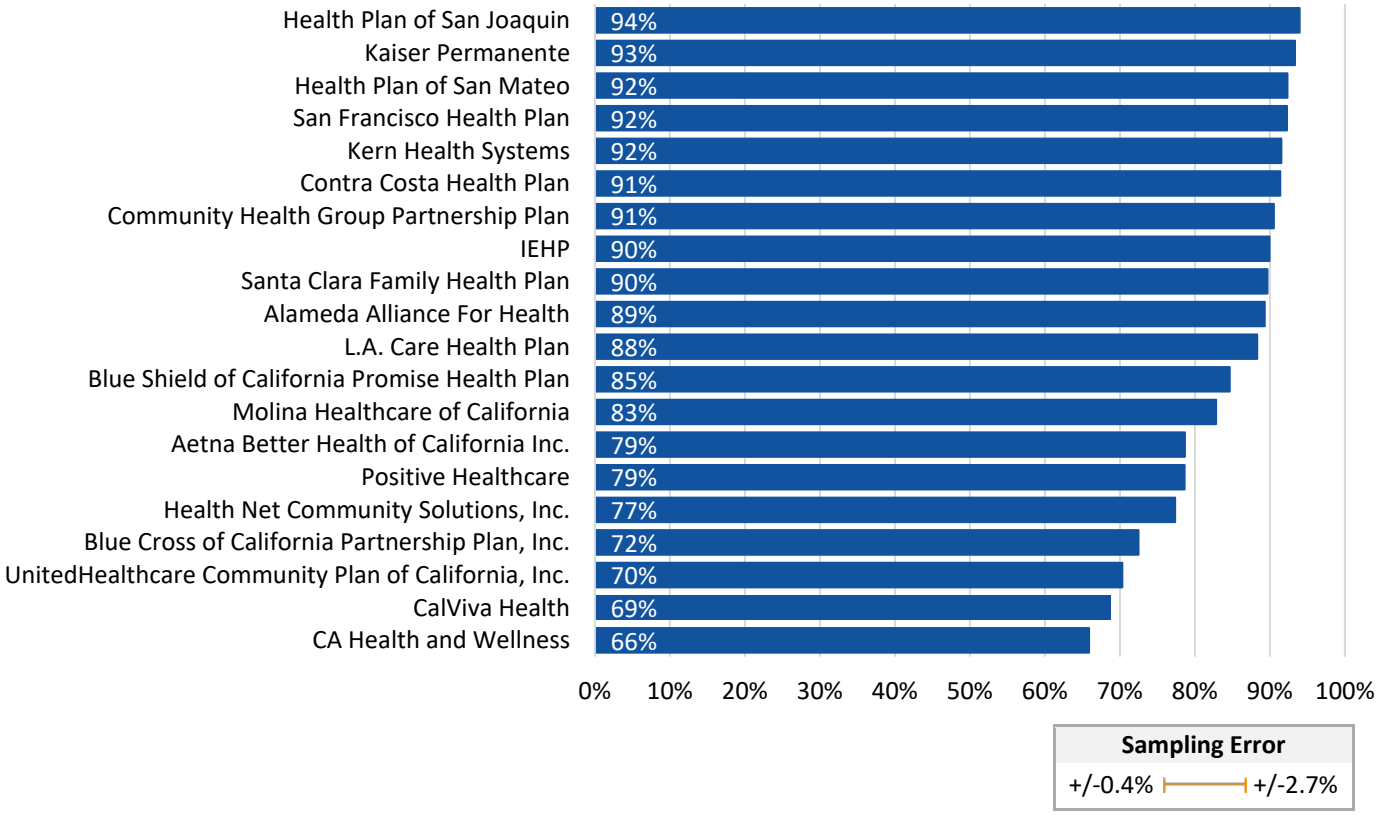


**Percentage of Surveyed Providers Meeting Non-Urgent Appointment Wait Time Standards**

## Chart 8

### Full Service Health Plans – Medi-Cal

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



# Urgent Appointments

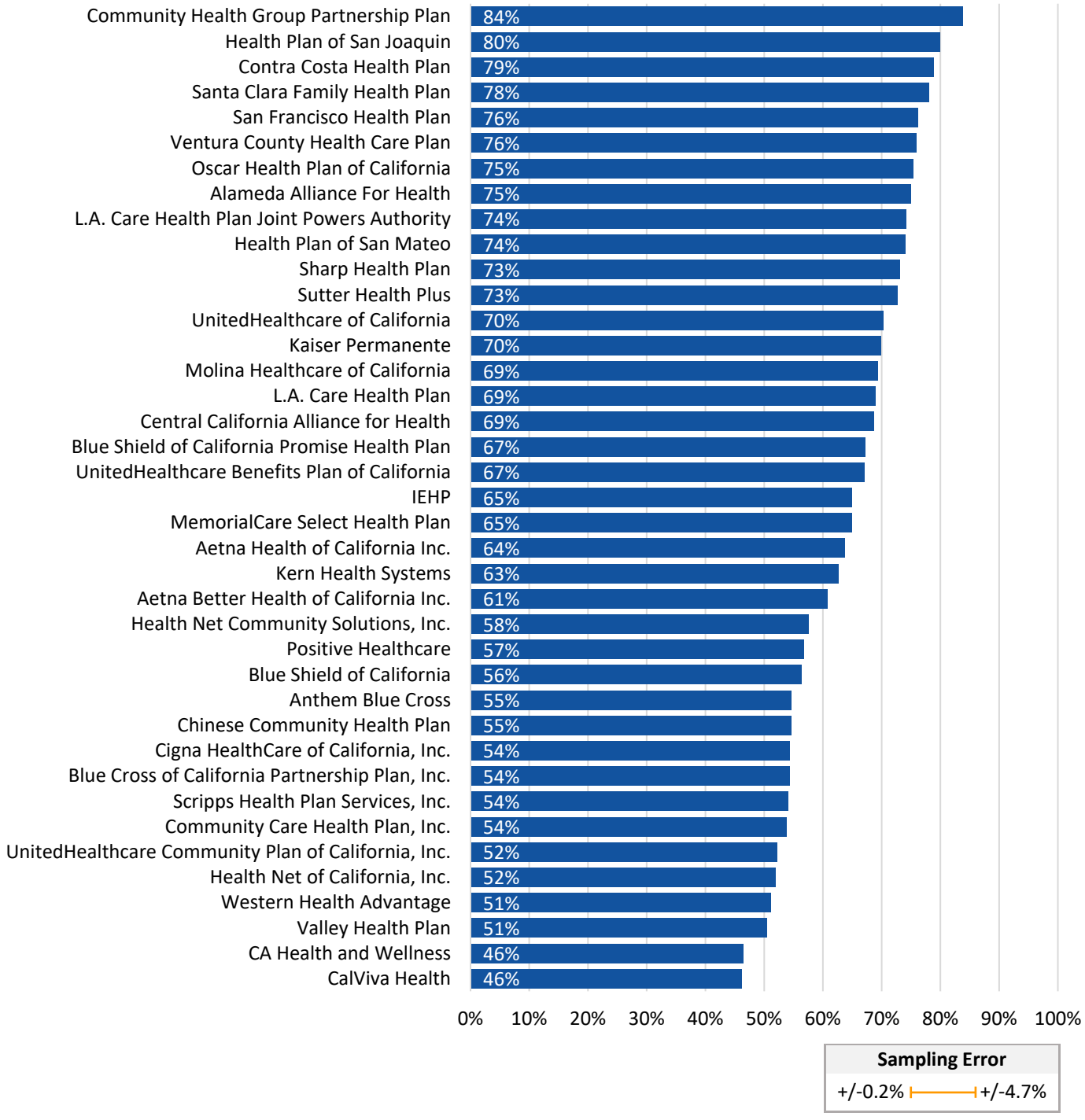
### Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards

As noted earlier in this Timely Access Report, enrollees may access urgently needed services in a variety of different ways depending on the delivery model of the health plan, aside from emergency treatment that may be obtained at an emergency room. These differing methods of meeting enrollee urgent care needs are not measured under the timely access survey methodology and are not displayed in this Timely Access Report.

## Chart 9

### Full Service Health Plans

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

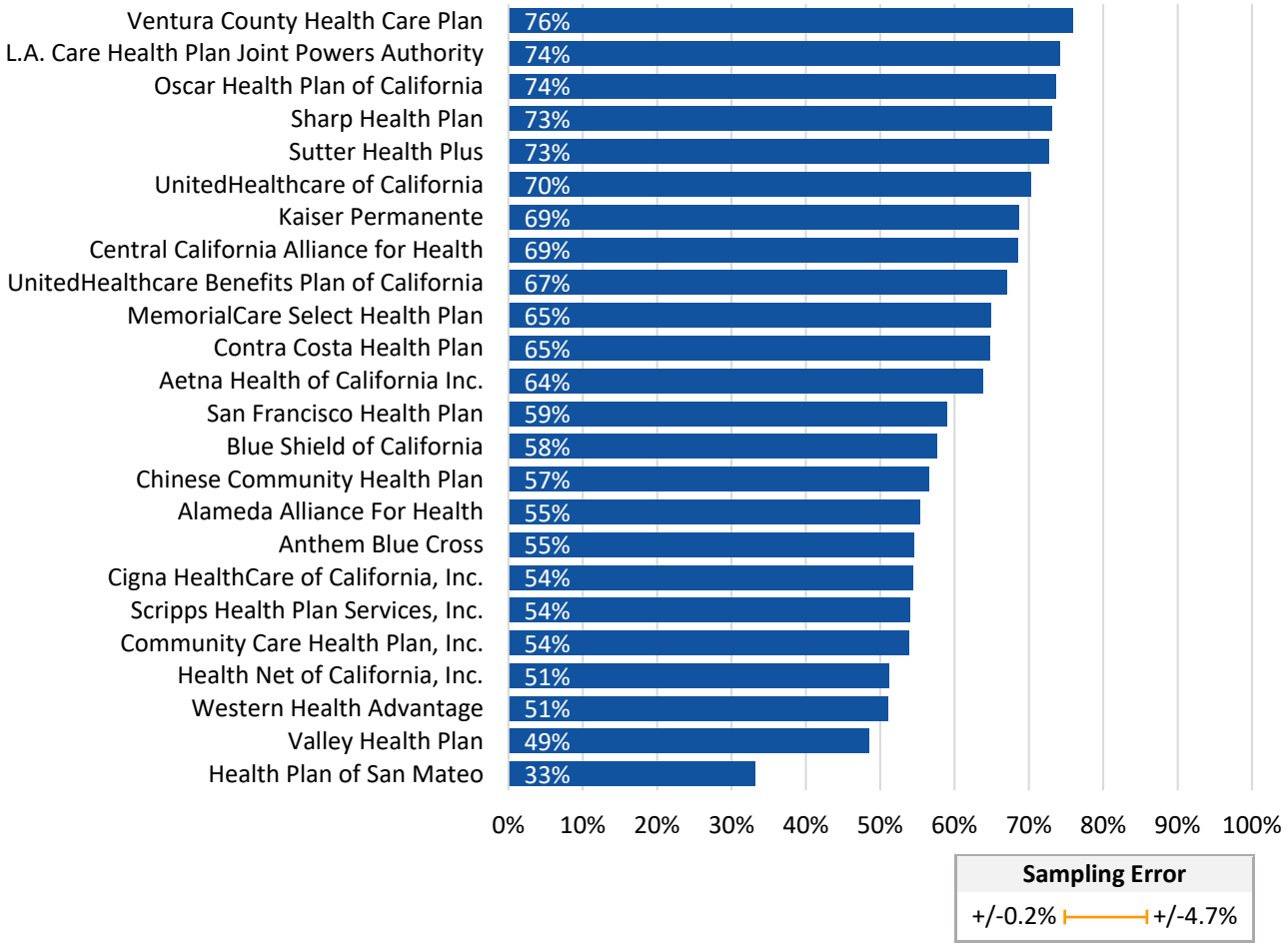


**Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards**

## Chart 10

### Full Service Health Plans – Commercial

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

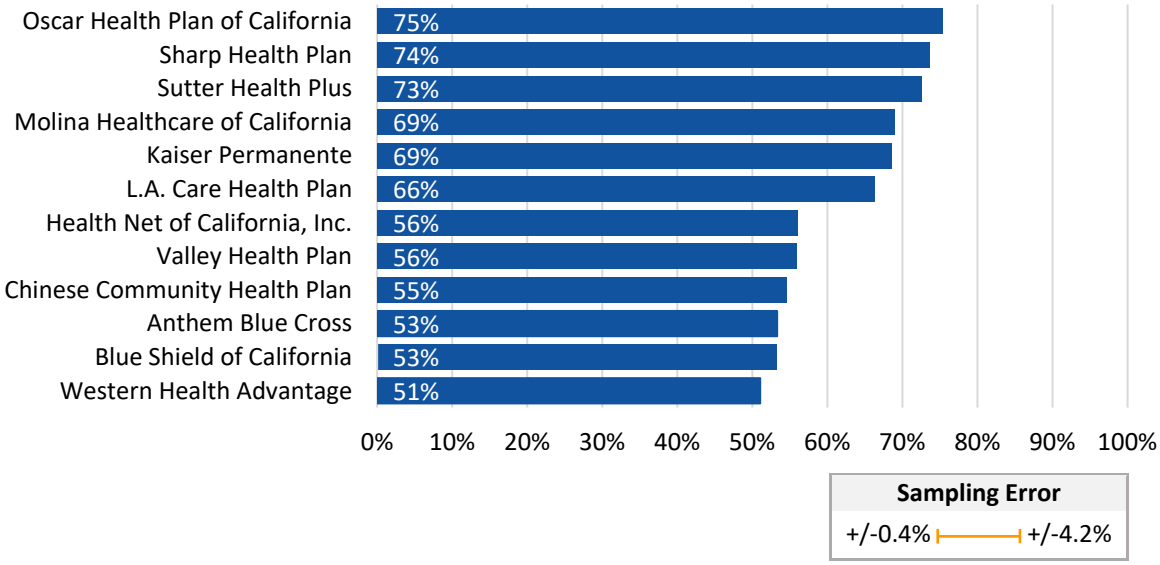


**Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards**

## Chart 11

### Full Service Health Plans – Individual/Family

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

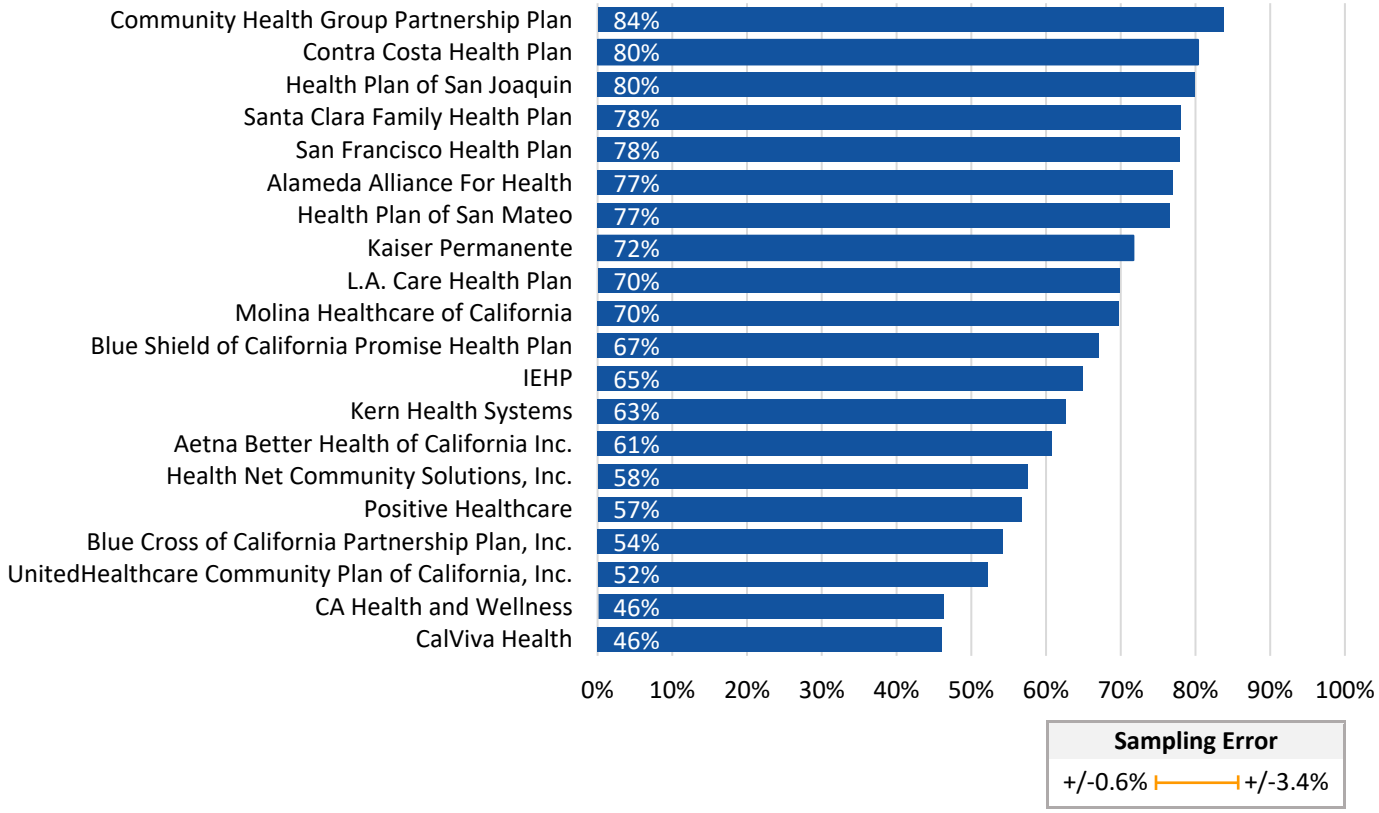


**Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards**

## Chart 12

### Full Service Health Plans – Medi-Cal

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



# Behavioral Health Plans
# Rate of Compliance Charts

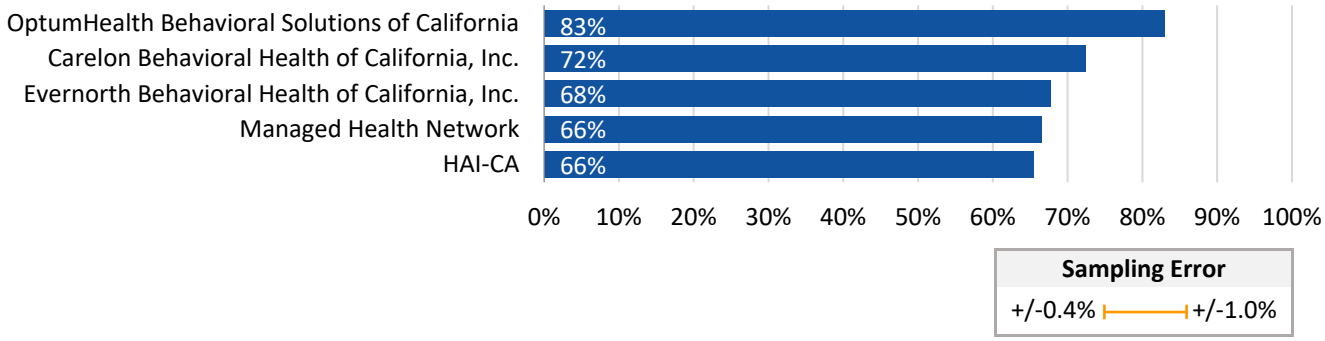
# Urgent and Non-Urgent Appointments

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

## Chart 13

### Behavioral Health Plans

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

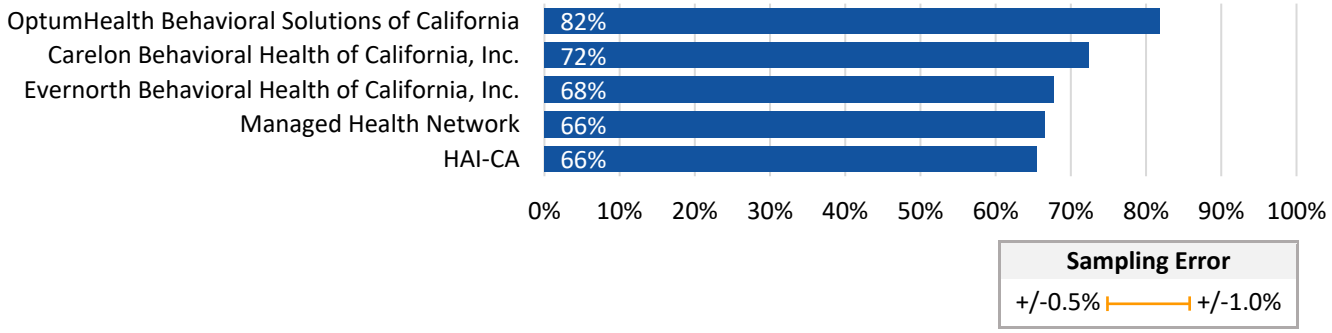


**Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards**

## Chart 14

### Behavioral Health Plans – Commercial

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

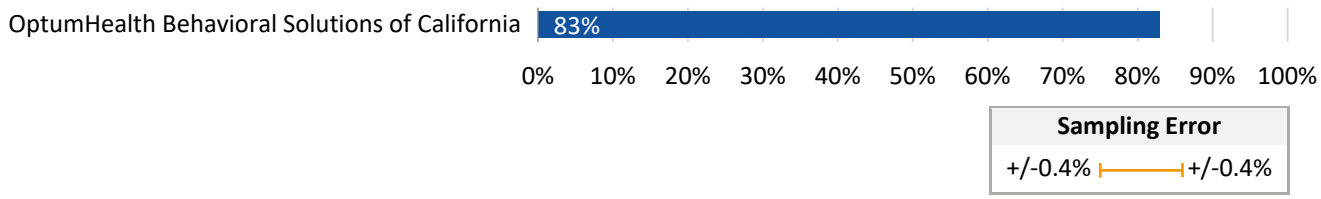


**Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards**

## Chart 15

### Behavioral Health Plans – Individual/Family

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

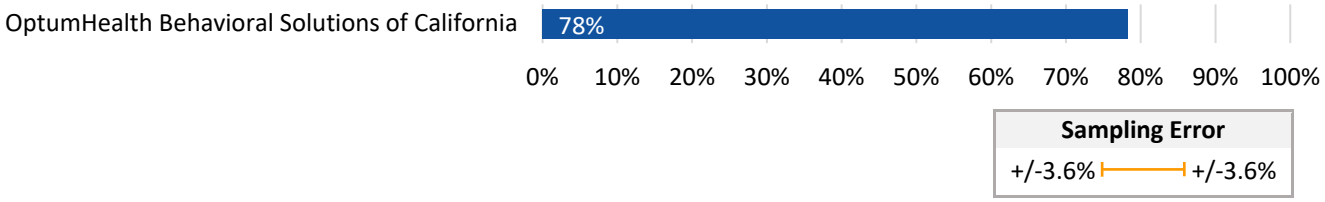


**Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards**

## Chart 16

### Behavioral Health Plans – Medi-Cal

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



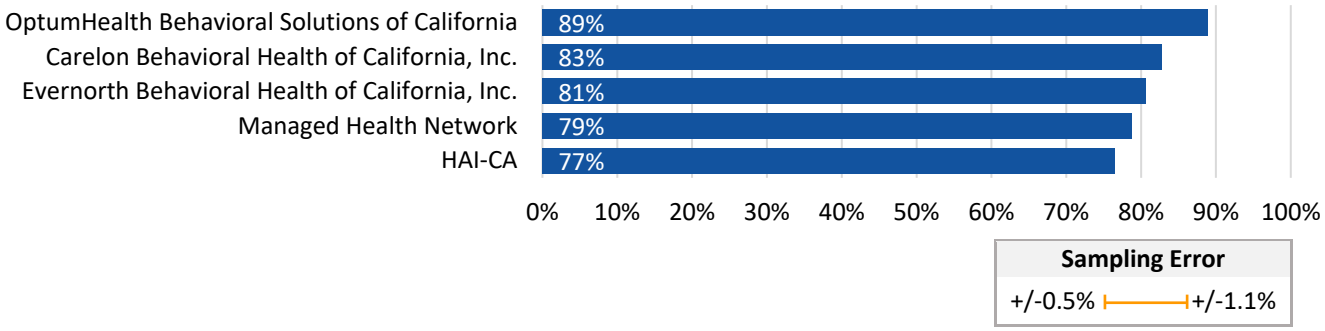
# Non-Urgent Appointments

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

## Chart 17

### Behavioral Health Plans

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

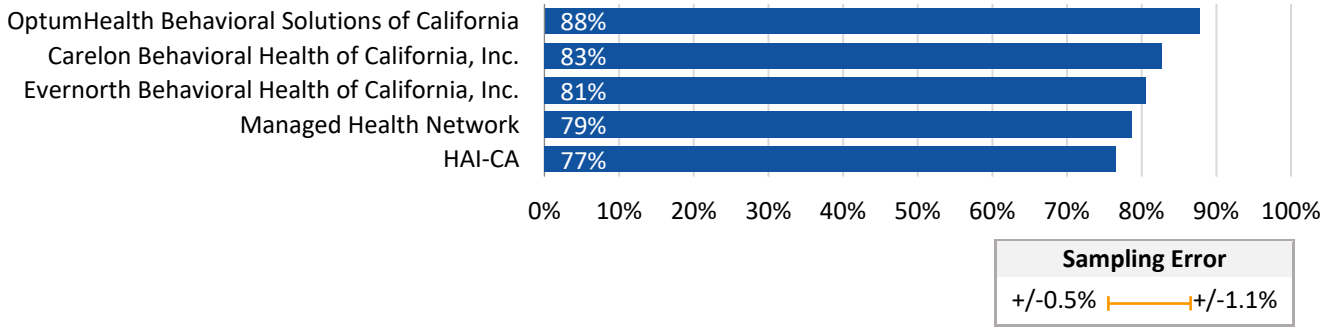


**Percentage of Surveyed Providers Meeting Non-Urgent Appointment Wait Time Standards**

## Chart 18

### Behavioral Health Plans – Commercial

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

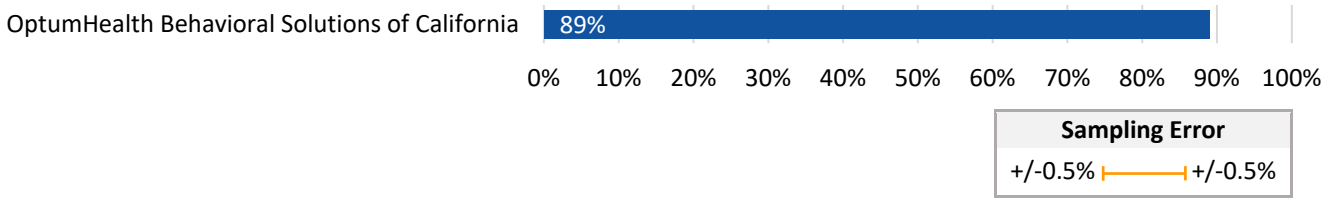


**Percentage of Surveyed Providers Meeting Non-Urgent Appointment Wait Time Standards**

## Chart 19

### Behavioral Health Plans – Individual/Family

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

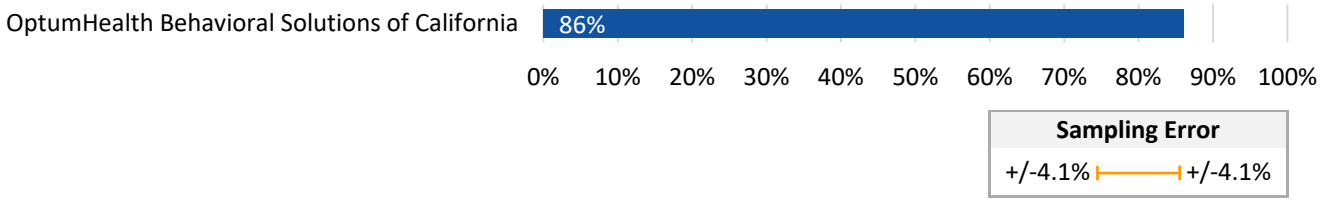


**Percentage of Surveyed Providers Meeting Non-Urgent Appointment Wait Time Standards**

## Chart 20

### Behavioral Health Plans – Medi-Cal

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



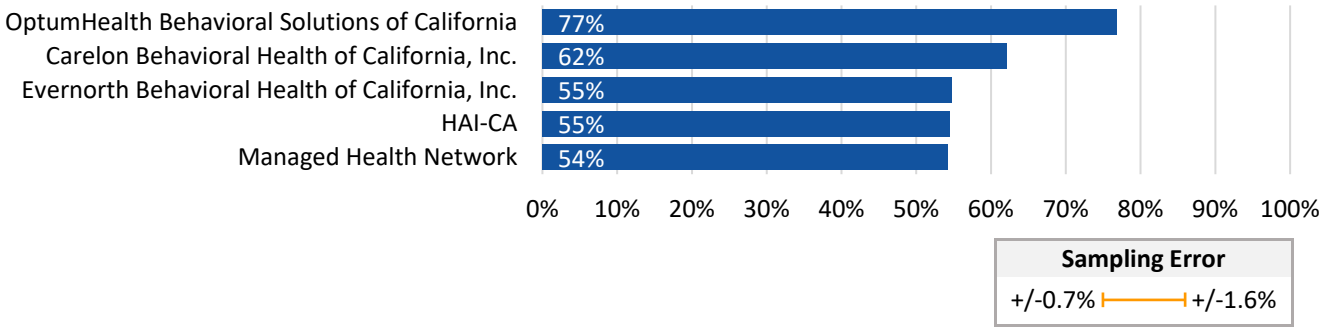
# Urgent Appointments

**Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards**

## Chart 21

### Behavioral Health Plans

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

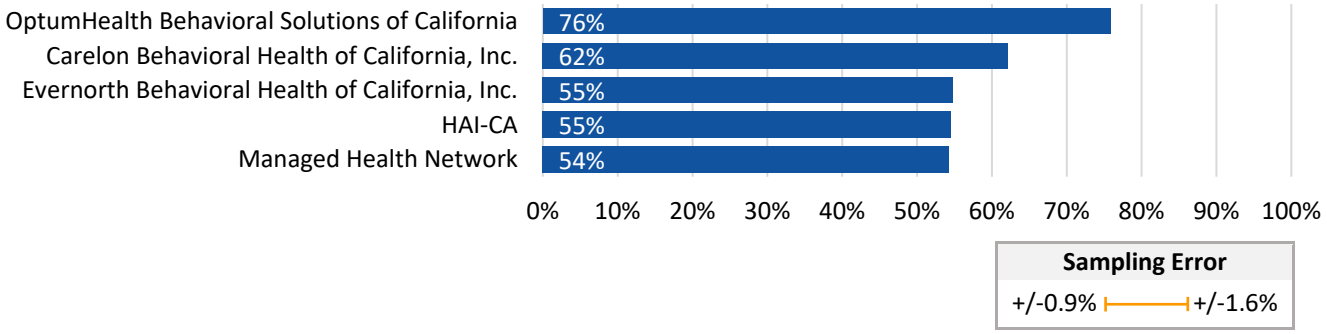


**Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards**

## Chart 22

### Behavioral Health Plans – Commercial

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

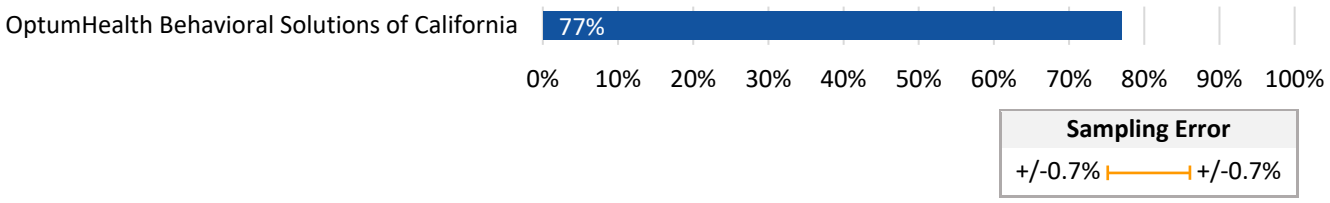


**Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards**

## Chart 23

### Behavioral Health Plans – Individual/Family

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



**Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards**

## Chart 24

### Behavioral Health Plans – Medi-Cal

Due to a sampling error greater than five percent, the DMHC is unable to display results for the one applicable Medi-Cal behavioral health plan, OptumHealth Behavioral Solutions of California. Appendix A contains a detailed explanation of the data discrepancies.

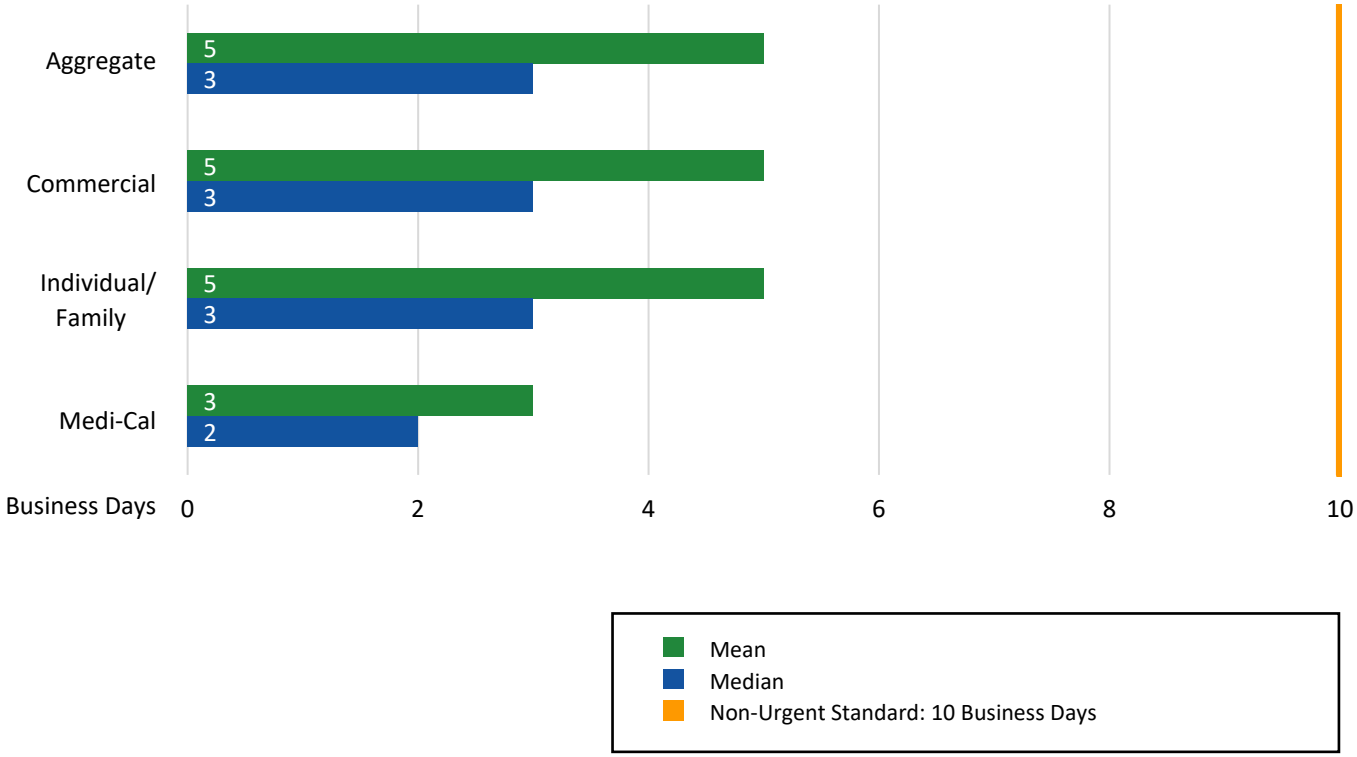
# Full Service and Behavioral Health Plans Average Appointment Wait Time Charts

# Non-Urgent Appointments

## Chart 25

### Primary Care Providers – Average Appointment Wait Time

This chart presents full service health plans' mean and median appointment wait times for primary care provider non-urgent appointments associated with Commercial, Individual/Family, and Medi-Cal products.

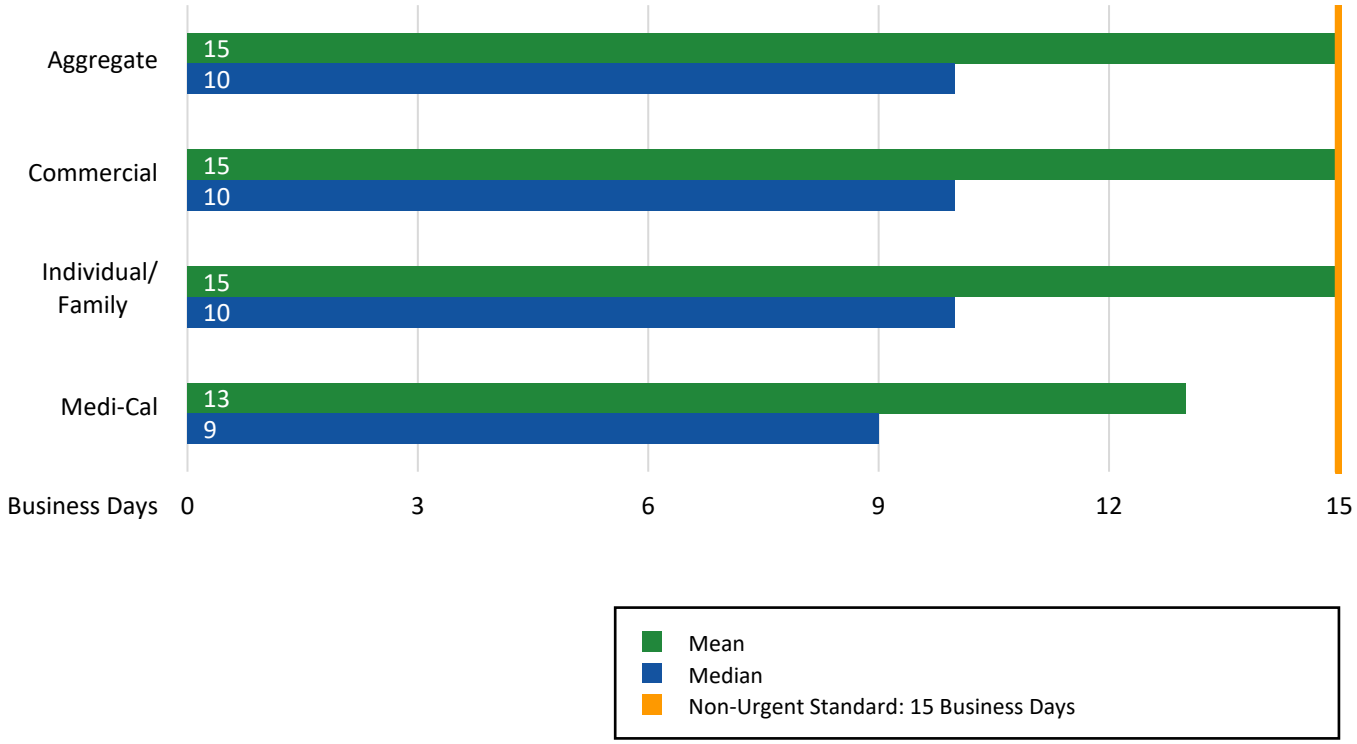


# Non-Urgent Appointments

## Chart 26

### Specialist Physicians – Average Appointment Wait Time

This chart presents full service health plans' mean and median appointment wait times for specialist physician non-urgent appointments associated with Commercial, Individual/Family, and Medi-Cal products.

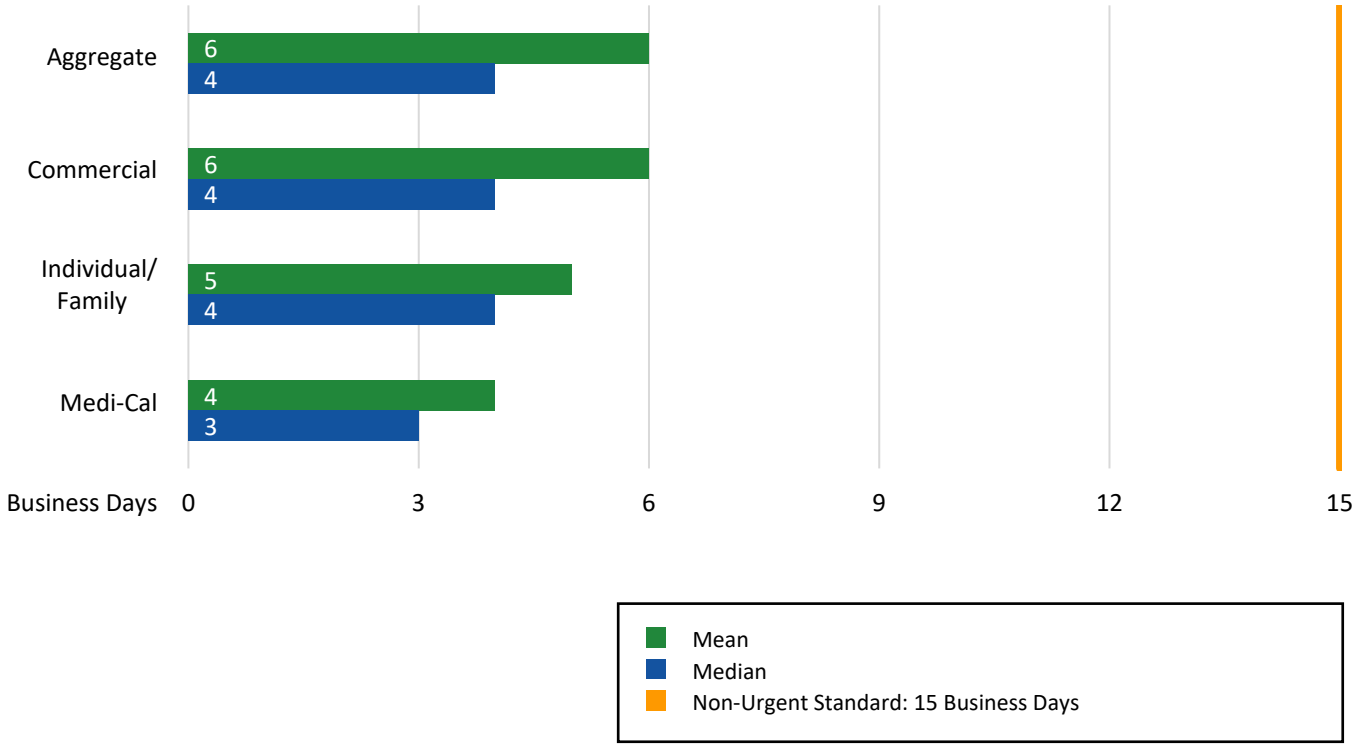


# Non-Urgent Appointments

## Chart 27

### Psychiatrists – Average Appointment Wait Time

This chart presents full service and behavioral health plans' mean and median appointment wait times for psychiatrist non-urgent appointments associated with Commercial, Individual/Family, and Medi-Cal products.

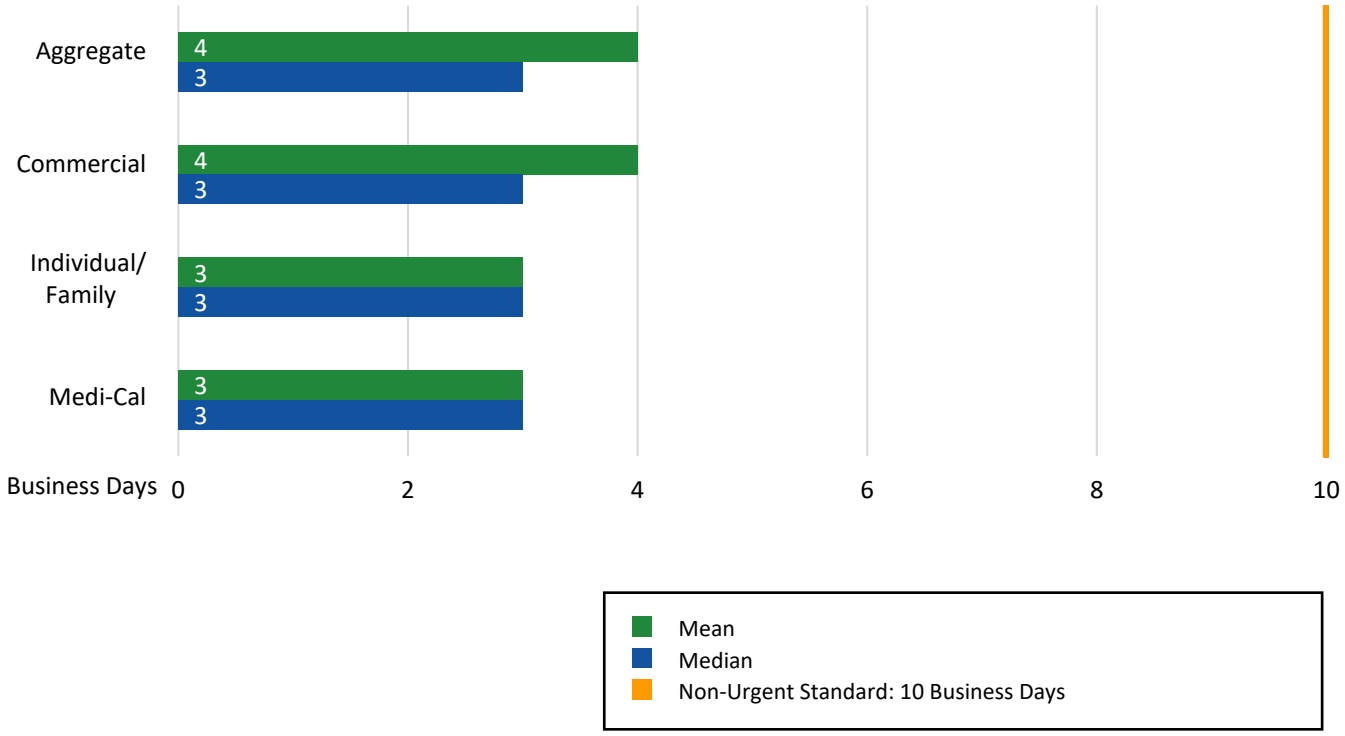


# Non-Urgent Appointments

## Chart 28

### Non-Physician Mental Health Providers – Average Appointment Wait Time

This chart presents full service and behavioral health plans' mean and median appointment wait times for non-physician mental health provider non-urgent appointments associated with Commercial, Individual/Family, and Medi-Cal products.



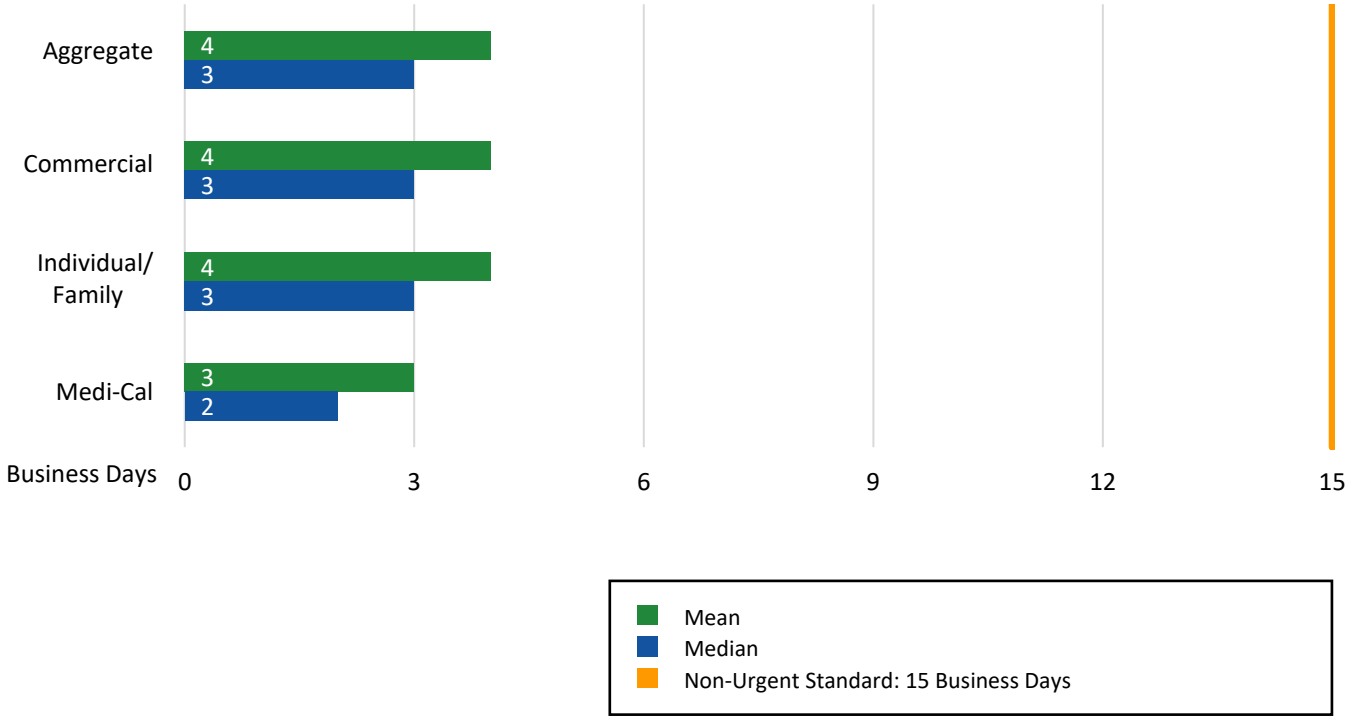
# Non-Urgent Appointments

**Average Appointment Wait Time Across All Product Types**

## Chart 29

### Ancillary Providers – Average Appointment Wait Time

This chart presents full service health plans' mean and median appointment wait times for ancillary provider non-urgent appointments associated with Commercial, Individual/Family, and Medi-Cal products.

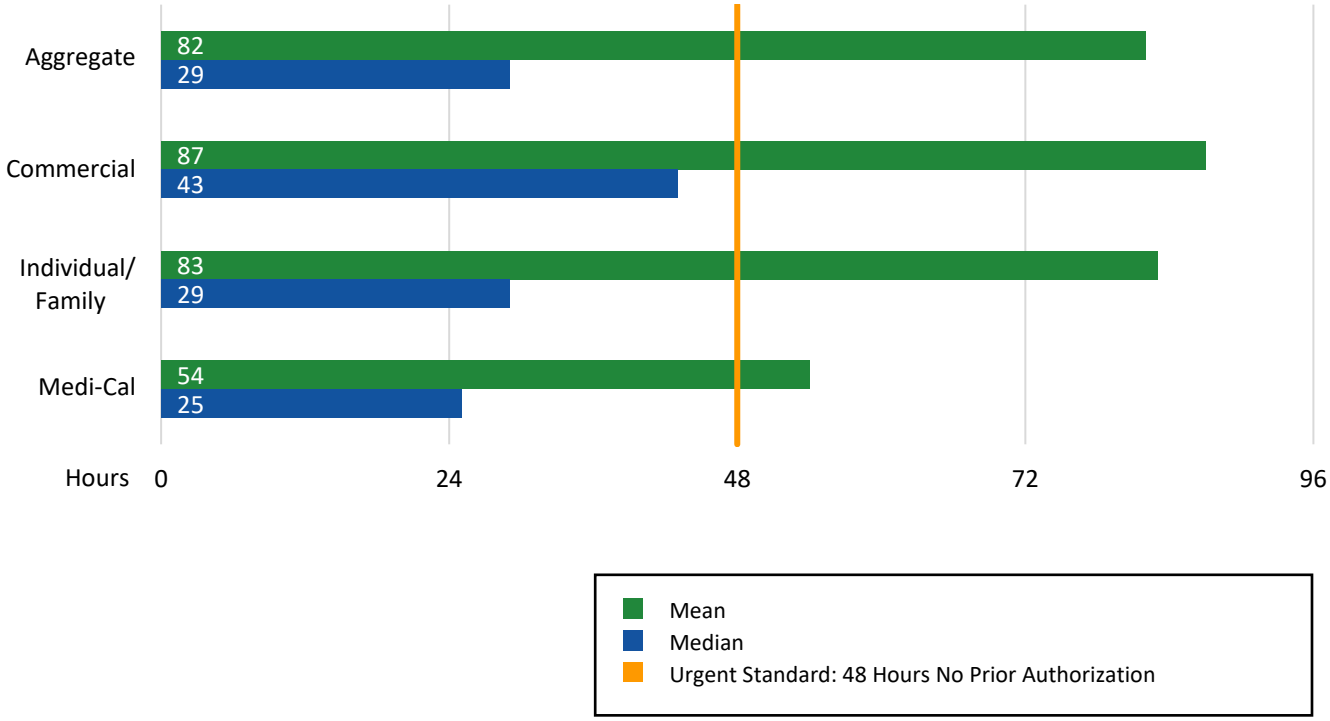


# Urgent Appointments

## Chart 30

### Primary Care Providers – Average Appointment Wait Time

This chart presents full service health plans' mean and median appointment wait times for primary care provider urgent appointments associated with Commercial, Individual/Family, and Medi-Cal products.

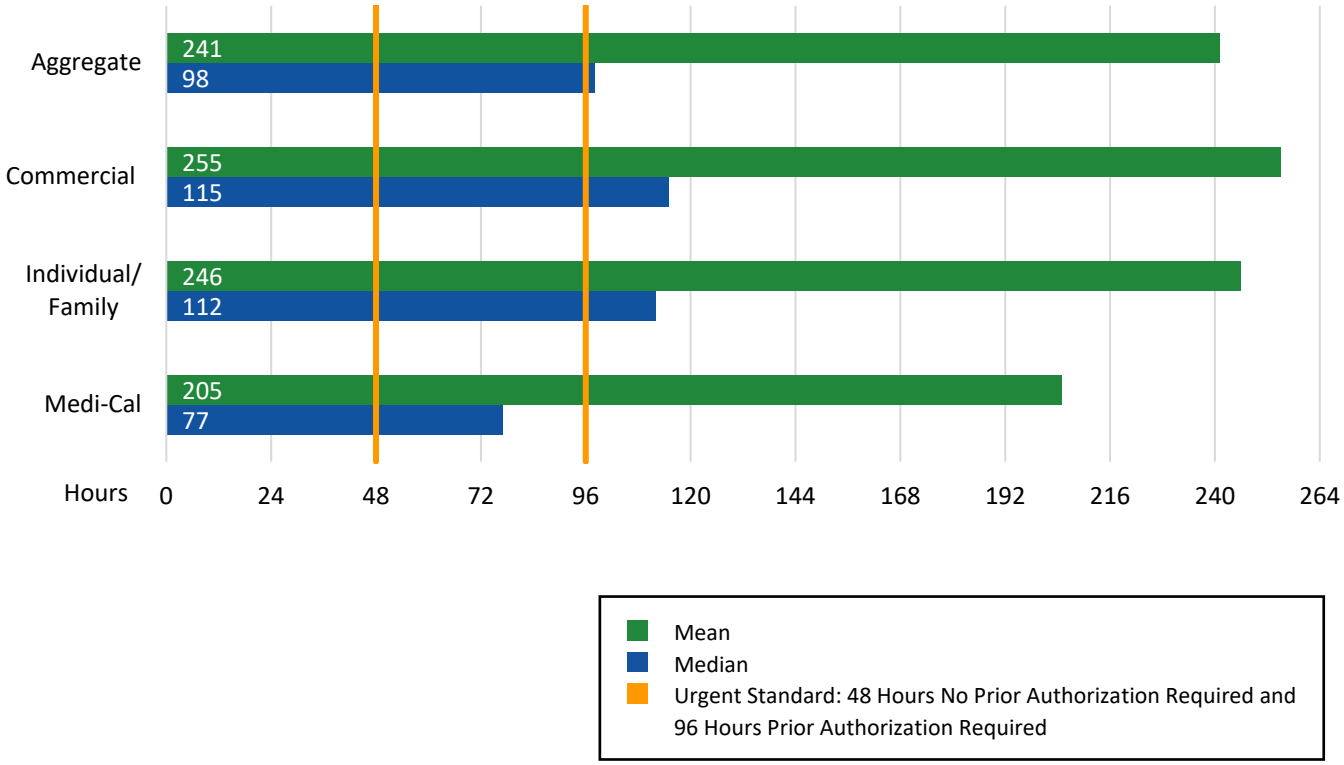


# Urgent Appointments

## Chart 31

### Specialist Physicians – Average Appointment Wait Time

This chart presents full service and behavioral health plans' mean and median appointment wait times for specialist physician urgent appointments associated with Commercial, Individual/Family, and Medi-Cal products.

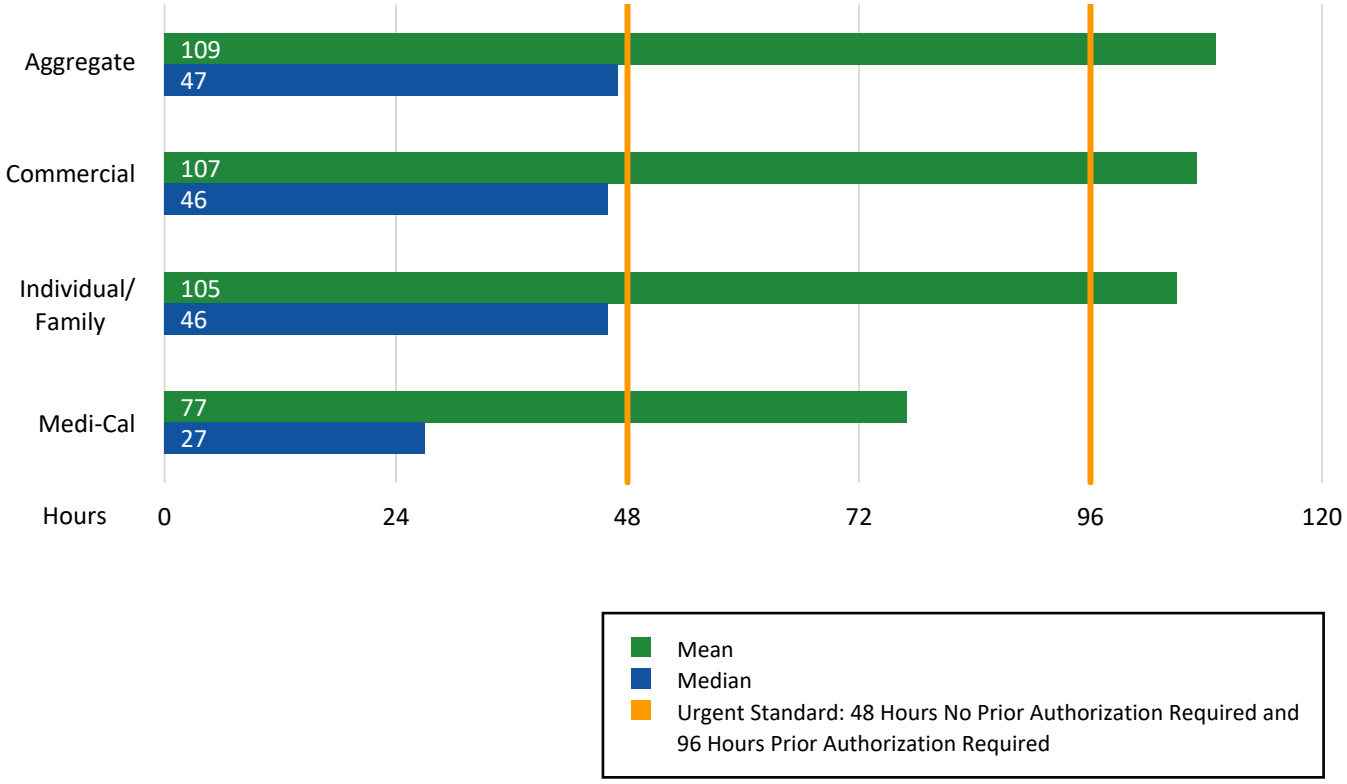


# Urgent Appointments

## Chart 32

### Psychiatrists – Average Appointment Wait Time

This chart presents full service and behavioral health plans' mean and median appointment wait times for psychiatrist urgent appointments associated with Commercial, Individual/Family, and Medi-Cal products.

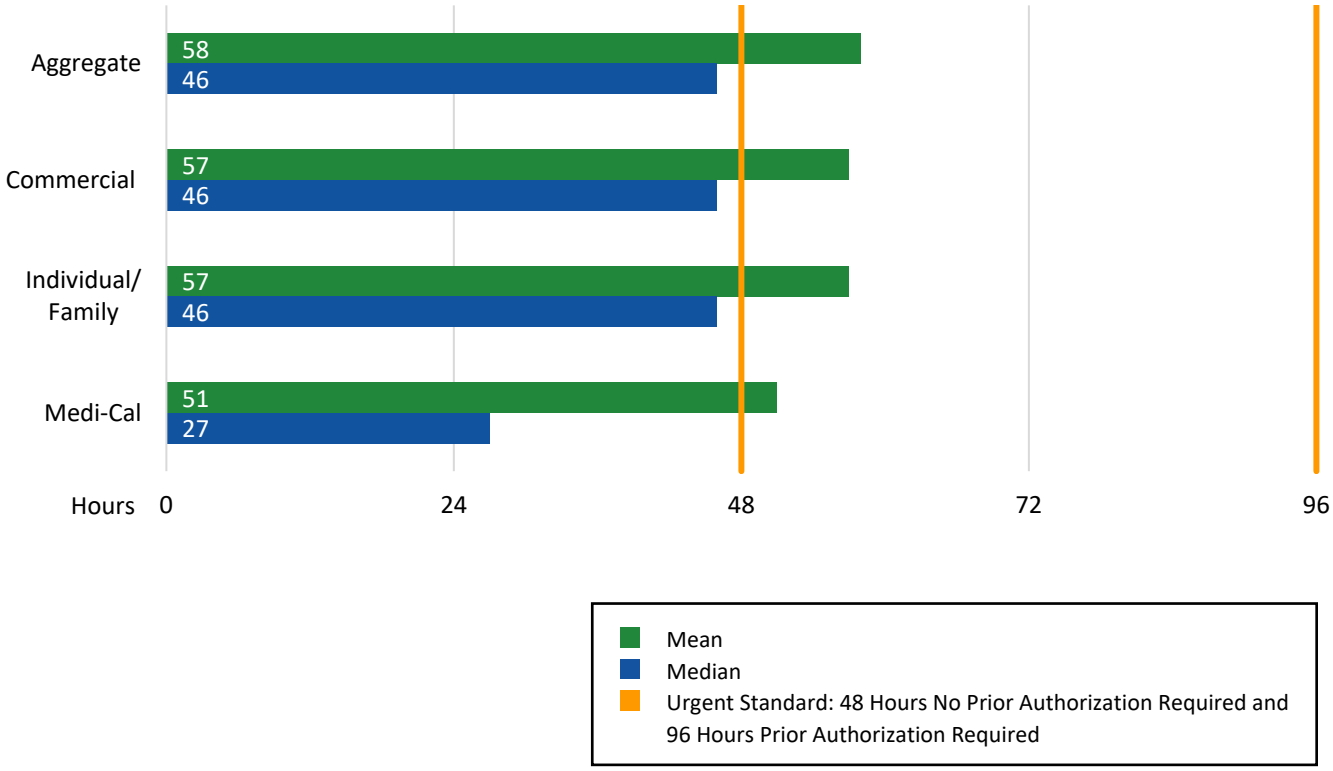


# Urgent Appointments

## Chart 33

### Non-Physician Mental Health Providers – Average Appointment Wait Time

This chart presents full service and behavioral health plans' mean and median appointment wait times for non-physician mental health provider urgent appointments with Commercial, Individual/Family, and Medi-Cal products.



# Next Steps

As we look forward, the DMHC continues to focus on ensuring health plan enrollees can access appropriate health care services within the timely access standards. Health plans have already started collecting data for MY 2023 using the updated timely access survey methodology that includes an evaluation of follow-up appointments for behavioral health providers. The DMHC has worked closely with stakeholders, including consumer advocates, health plans, and provider organizations to develop and update the standardized timely access survey methodology and rate of compliance incorporated in the amended Timely Access Regulation.[22] Under the amended regulation, the DMHC will hold health plans accountable for meeting the minimum rate of compliance of 70% for both non-urgent and urgent appointments starting in MY 2023, which will be reported to the DMHC in 2024. In addition, the DMHC will require health plans that do not achieve an 80% initial performance target for behavioral health follow-up appointments to submit a corrective action plan to the DMHC in 2024.

The DMHC will also continue to work, in consultation with stakeholders, to enhance health plan accountability and data quality. Beginning in 2024, a health plan will be required to submit a corrective action plan to the DMHC where a network is reported with a 5% or greater sampling error for urgent and non-urgent appointments or where a health plan's data identifies 20% or more of its providers in a network as ineligible to participate in the survey.

With the enactment of the amendments to the Timely Access Statute and Regulation in 2022 and 2023, over the next year the DMHC will take steps to implement the following actions:

- The DMHC will continue to require health plans to collect and report timely access data by health plan network and work to develop network-level data in the Timely Access Report, rather than displaying the data aggregated by health plan.
- The DMHC will require health plans to take corrective actions if they fail to meet the minimum rates of compliance of 70% for both non-urgent and urgent appointments. The DMHC may take enforcement action against health plans who are unable to come into compliance with these standards, where appropriate.
- The DMHC will require health plans that do not achieve an 80% initial performance target for behavioral health follow-up appointments to submit a corrective action plan to the DMHC in 2024. Further, the DMHC will seek stakeholder input as it continues to evaluate this threshold for purposes of enacting a permanent compliance standard for behavioral health follow-up appointments into the Timely Access Regulation.
- The DMHC will continue to study and refine implementation of the SB 221 and SB 225 reporting requirements into the standardized timely access survey methodology, including reporting the average appointment wait time for each class of appointments, capturing compliance data related to the behavioral health follow-up appointment wait time standard, and developing performance targets for behavioral health follow-up appointments.
- The DMHC will continue to work, in consultation with stakeholders, to enhance health plan accountability and data quality. This will be accomplished by the DMHC's evaluation of the

[22] The DMHC update 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.

impact of ineligible and non-responding providers on the rates of compliance and through implementation of two new data quality standards in the timely access survey methodology.

- The DMHC will continue to work with health plans and statisticians to ensure data accuracy in the timely access reporting. This includes continuing to require health plans to utilize an external vendor to perform a quality assurance review of the health plans' data prior to submission of the timely access data and quality assurance report to the DMHC.
- The DMHC added a survey question related to other methods providers use to offer enrollees urgent care in the MY 2024 timely access survey methodology. The results of this survey will help the DMHC to better understand how urgent care is delivered outside of appointments when an appointment is not available within the urgent appointment standards. The DMHC will evaluate the results when the data is reported in 2025.
- The DMHC will continue to conduct annual reviews of timely access data by health plan and provide feedback related to compliance concerns to each plan. The DMHC will also provide the health plan with an opportunity to respond and submit corrective action plans to improve reliability, comparability, and accuracy of the data where findings of non-compliance are identified.
- The DMHC will monitor the effectiveness of previously submitted corrective action plans. Further, the DMHC may refer health plans that violate statutory or regulatory reporting requirements to the DMHC's Office of Enforcement for further action.
- The DMHC will continue to work with and provide timely access data to the Center for Data Insights and Innovation (CDII) for incorporation into the Quality of Care Report Card.
- The DMHC will continue to report health plan results for both the 48 hour and 96 hour urgent appointment wait time standards in the applicable Average Appointment Wait Time Charts set forth in this report.
- The DMHC will continue to include the proportion of providers excluded from health plan survey results in the Timely Access Report, including the reasons for excluding those providers, and how such exclusions may affect the survey's conclusions about access to care.

# Conclusion

One of the DMHC's top priorities is to ensure health plan enrollees 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 also continue to work with and collaborate with stakeholders, including health plans, providers, and consumer advocates, to fully implement the amended Timely Access Regulation and more recent legislation.

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

# Appendices

# Appendix A: Timely Access Data Discrepancies & Analysis

The charts in this report include timely access data for primary care physicians, primary care non-physician medical practitioners, specialist physicians, non-physician mental health providers, and ancillary providers for both urgent and non-urgent appointments.[23] The charts included in this report identify the percentage of appointments in which a provider indicated an appointment was available within the applicable wait time standards (Rate of Compliance Charts) and the mean and median appointment wait times (Average Appointment Wait Time Charts).

## Data – Timely Access Survey Methodology

The timely access rates reported to the DMHC were calculated by health plans through survey responses from providers that were contracted with health plans. Health plans are required by the timely access survey methodology to create contact lists at the beginning of the measurement year and use the contact list to draw samples or censuses of networks to be surveyed from June through December of the measurement year. The multimodal surveys are conducted by health plans through a written survey (e.g., email or fax), a phone call survey, appointment data extracted from the provider's appointment schedule, or where 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. 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 change jobs 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, under the timely access survey methodology health plans may not remove or add providers following the creation of the contact list.

The survey identifies whether the first available appointment with a provider fell within the wait time standards. 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 health plan survey errors.

## Overall Rate of Compliance

The overall timely access rate of compliance is first computed by the DMHC-contracted statistician at the county network-level. The numerator for the overall rate is the sum of the number of providers who responded to the survey with an urgent appointment within wait time standards and the number of providers who responded to the survey with a non-urgent appointment within the wait time standards. The denominator for the rate is the sum of the number of providers who answered the survey for urgent appointments and the number of providers who answered the survey for non-urgent

[23] Specialist physicians consist of cardiologists, endocrinologists, gastroenterologists, and adult and child psychiatrists. Ancillary providers consist of service centers (facilities or entities) providing mammography and physical therapy appointments. Non-physician mental health care providers consist of Licensed Professional Clinical Counselors, Psychologists (Ph.D.-level), Marriage and Family Therapists, Licensed Marriage and Family Therapists, Master of Social Work, and Licensed Clinical Social Workers.

appointments. The calculated county network overall rate is then used to calculate a weighted mean at the health plan-level, which is described below.

## Health Plan-Level Rates of Compliance

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

## Sampling Error

Each Rate of Compliance chart includes an estimate of timely access rates of compliance and provides the range in sampling errors for the presented rates. The sampling error indicates, with 90% certainty, the range where the actual rate might fall given the sample size and estimated rate.[24] Sampling errors were calculated by the DMHC-contracted statistician using a finite population correction. The variability in sampling errors resulted from variation in rates, the size of health plan networks and the degree to which target sample sizes were achieved. 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 5%, as these results are deemed unreliable.

In MY 2022, OptumHealth Behavioral Solutions of California was the only health plan to exceed the five percent sampling error. This health plan exceeded the five percent threshold for urgent Medi-Cal products and is the only behavioral health plan that reported a Medi-Cal product in MY 2022. While all health plans are represented in the charts below, the chart for urgent care appointments for Medi-Cal products for behavioral health plans is excluded from this report.

The health plan's unreliable estimate resulted from a low response rate for the providers in this network. Over half of providers selected to be surveyed failed to respond, and nearly 20% were ineligible to participate in the survey. Furthermore, several of the providers who completed the survey indicated that the urgent appointment question was not applicable as the provider did not offer urgent appointments. These issues led to an insufficient sample size to produce a reliable estimated of rate of compliance for urgent appointments for the plan's Medi-Cal product. However, the appointment wait time data for OptumHealth Behavioral Solutions of California's Medi-Cal network is included in the plan-level results in Chart 13, as the sample of combined provider responses reported for the Medi-Cal, Commercial and Individual/Family products was sufficient to produce reliable results. Additionally, OptumHealth Behavioral Solutions of California's Medi-Cal network is represented in Full Service Health Plan charts through its Plan partner, UnitedHealthcare Community Plan of California, Inc.,

[24] 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.

because the number of responses between the OptumHealth providers and the full service health plan providers was sufficient to produce a reliable urgent appointment rate.

### Behavioral Health Plan(s) Excluded from Chart(s) Due to High Sampling Error

| Chart Number | Health Plan Name | Measurement Type | Survey Product | MY 2022 Rate of Compliance | MY 2022 Sampling Error |
|---|---|---|---|---|---|
| Chart 24 | OptumHealth Behavioral Solutions of California | Urgent | Medi-Cal | 70% | 6% |

## Average Appointment Wait Times Methodology

The industry average (mean and median) appointment wait times are calculated by the DMHC-contracted statistician for urgent and non-urgent appointments by each provider type. Provider appointment wait times are calculated using the health plan reported Raw Survey Data. The DMHC measures the wait time between the time and date of the survey administration to the next available appointment for a provider, excluding weekends and holidays for non-urgent appointments. When the Raw Survey Data has duplicate survey responses for a provider associated with multiple networks, a single observation for each individual provider appointment is used from the Raw Survey Data; providers surveyed multiple times will have multiple appointments used for the average appointment wait time calculations. For example, if a provider's survey response is reported in the data three times with the same date and time for the survey initiation and next available appointment (representing a single survey response applied across multiple networks), only one of those instances are used to calculate the average appointment wait time. If the provider's survey response was reported in the data three times, but the survey initiation date or next available appointment date and times are distinct in those three entries, then all three responses are used to calculate the average appointment wait time. Where a provider was surveyed multiple times, the provider's appointment wait time is weighted so that the provider's wait time represents the average of those appointment wait times.

The mean appointment wait time is calculated as the sum of appointment wait times that are at or below the 90$^{th}$ percentile time divided by the number of appointments that are at or below the 90$^{th}$ percentile appointment time. The DMHC identified some outlier observations that were skewing the calculation of the mean. In order to produce an average appointment wait time value that more closely reflected the overall enrollee experience, the DMHC eliminated the most extreme wait times and calculated the average based on the bottom 90th percentile wait times for each provider type.[25] The median appointment wait time is the 50$^{th}$ percentile appointment wait time of all appointments, and reflects the wait time where half of the appointments are at or below. The median calculation does not exclude excessively long appointment wait times (or outliers). The average appointment wait time charts present urgent appointment times in hours and non-urgent appointment times in business days.

[25] 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 enrollees receive urgent services, such as directing enrollees 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 enrollee 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.

## Survey and Data Issues

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. This process identified numerous data issues and potential discrepancies. In addition to the external vendor analysis, the DMHC conducts other data validation checks that may be addressed with the health plan to ensure the reliability and accuracy of the data. The DMHC conducts further investigation into issues or potential discrepancies identified during its review. As part of this investigation, the DMHC requests health plans provide an explanation for the discrepancy or engage in corrective action, where appropriate, to ensure that any discrepancies are corrected in future reporting years.

Erroneous compliance calculations:

- The DMHC independently verified health plan rates of compliance against each 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.[26] These errors mostly produced negligible differences between the health plan rates reported in results and raw data. Only one health plan, San Francisco Health Authority, appeared to have errors that lead to discrepancies just above one percentage point for urgent appointment rates for two of their networks. The remaining errors led to discrepancies between the sources that were less than a percentage point. All charts use the rates of compliance calculated using the health plan's reported results data.

- Some health plans did not account for a holiday when determining whether an appointment fell within the 10 or 15 business day appointment wait time standard. The timely access survey methodology requires health plans to exclude specified holidays in the calculation of the number of days until the next available non-urgent appointment. The holiday omission error led to health plans identifying some appointments as non-compliant when the appointment was compliant with the wait time standard. Although eight health plans had this error, it accounted for a small share of appointments and did not have a substantive impact on rates.

De-duplication errors:

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

Omission of results for certain networks:

- Health Net of California, Inc. failed to report survey results for its Canopy network in 2021 and 2022. If this network has substantively different timely access rates compared to its other networks that were reported to the DMHC, then results presented in the charts for this health plan may not accurately represent rates for the health plan. However, because Health Net of California, Inc. has

[26] Health plans are required to calculate the DMHC 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.

several networks, and there is substantial overlap in providers across their networks, it is unlikely that this omission biases the results presented in this Timely Access Report.

- Holman Professional Counseling Centers failed to report timely access data for its commercial network by the required submission deadline. As a result, Holman Professional Counseling Centers' timely access data was unable to be validated and is not included in the charts or the data accompanying this this report. The health plan submitted results data outside of the DMHC required submission process that indicated an urgent appointment rate of compliance of 74% and a non-urgent appointment rate of 83%. These figures have not been validated against the raw data, nor has there been an assessment of the statistical reliability of these results due to the health plan's late submission and its failure to achieve target sample sizes for its psychiatrists and non-physician mental health providers in most network counties.

Target Sample Size:

- Target sample sizes 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. Failure to achieve the target sample size occurred mainly in counties with a small number of providers, which necessitates a survey of all or nearly all providers to produce reliable county-level results. Aggregating results to the health plan-level largely overcomes these issues by increasing the total sample size.

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

The table below sets forth the health plans' legal name and trade name or DBA.

## 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 | |
| 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 Managed Medical Care Commission | Central California Alliance for Health |
| Scripps Health Plan Services, Inc. | |
| Sharp Health Plan | |
| Sutter Health Plan | Sutter Health Plus |
| UHC of California | UnitedHealthcare of California |
| UnitedHealthcare Benefits Plan of California | |
| UnitedHealthcare Community Plan of California, Inc. | |
| Western Health Advantage | |

## Behavioral Health Plans

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

# Appendix C: Health Plans Rate of Compliance Summary

The rates of compliance in the summary of full service and behavioral health plans below are included in the charts within this Timely Access Report. An asterisk (*) indicates that the health plan did not report timely access data for this product. “Excluded” indicates that the health plan exceeded the 5% sampling error threshold and was excluded from one or more charts.

## Full Service Health Plans

| Health Plan Name | Aggregate | | | Commercial | | | Individual/Family | | | Medi Cal | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Urgent/ Non Urgent | Urgent | Non Urgent | Urgent/ Non Urgent | Urgent | Non Urgent | Urgent/ Non Urgent | Urgent | Non Urgent | Urgent/ Non Urgent | Urgent | Non Urgent |
| Aetna Better Health of California Inc. | 70% | 61% | 79% | * | * | * | * | * | * | 70% | 61% | 79% |
| Aetna Health of California Inc. | 72% | 64% | 80% | 72% | 64% | 80% | * | * | * | * | * | * |
| Alameda Alliance For Health | 81% | 75% | 87% | 59% | 55% | 63% | * | * | * | 83% | 77% | 89% |
| Anthem Blue Cross | 66% | 55% | 77% | 66% | 55% | 77% | 65% | 53% | 76% | * | * | * |
| Blue Cross of California Partnership Plan, Inc. | 63% | 54% | 72% | * | * | * | * | * | * | 63% | 54% | 72% |
| Blue Shield of California | 66% | 56% | 76% | 67% | 58% | 77% | 64% | 53% | 74% | * | * | * |
| Blue Shield of California Promise Health Plan | 76% | 67% | 85% | * | * | * | * | * | * | 76% | 67% | 85% |
| CA Health and Wellness | 56% | 46% | 66% | * | * | * | * | * | * | 56% | 46% | 66% |
| CalViva Health | 58% | 46% | 69% | * | * | * | * | * | * | 58% | 46% | 69% |
| Central California Alliance for Health | 71% | 69% | 73% | 71% | 69% | 73% | * | * | * | * | * | * |
| Chinese Community Health Plan | 62% | 55% | 69% | 63% | 57% | 70% | 62% | 55% | 69% | * | * | * |
| Cigna HealthCare of California, Inc. | 66% | 54% | 78% | 66% | 54% | 78% | * | * | * | * | * | * |
| Community Care Health Plan, Inc. | 64% | 54% | 74% | 64% | 54% | 74% | * | * | * | * | * | * |
| Community Health Group Partnership Plan | 87% | 84% | 91% | * | * | * | * | * | * | 87% | 84% | 91% |
| Contra Costa Health Plan | 84% | 79% | 90% | 71% | 65% | 76% | * | * | * | 86% | 80% | 91% |
| Health Net Community Solutions, Inc. | 68% | 58% | 77% | * | * | * | * | * | * | 68% | 58% | 77% |
| Health Net of California, Inc. | 64% | 52% | 76% | 64% | 51% | 76% | 67% | 56% | 79% | * | * | * |
| Health Plan of San Joaquin | 87% | 80% | 94% | * | * | * | * | * | * | 87% | 80% | 94% |
| Health Plan of San Mateo | 82% | 74% | 90% | 46% | 33% | 60% | * | * | * | 85% | 77% | 92% |
| IEHP | 78% | 65% | 90% | * | * | * | * | * | * | 78% | 65% | 90% |
| Kaiser Permanente | 80% | 70% | 91% | 79% | 69% | 89% | 79% | 69% | 89% | 83% | 72% | 93% |
| Kern Health Systems | 77% | 63% | 92% | * | * | * | * | * | * | 77% | 63% | 92% |
| L.A. Care Health Plan | 78% | 69% | 86% | * | * | * | 74% | 66% | 81% | 79% | 70% | 88% |
| L.A. Care Health Plan Joint Powers Authority | 82% | 74% | 90% | 82% | 74% | 90% | * | * | * | * | * | * |
| MemorialCare Select Health Plan | 68% | 65% | 71% | 68% | 65% | 71% | * | * | * | * | * | * |
| Molina Healthcare of California | 76% | 69% | 83% | * | * | * | 76% | 69% | 83% | 76% | 70% | 83% |
| Oscar Health Plan of California | 81% | 75% | 86% | 79% | 74% | 83% | 81% | 75% | 86% | * | * | * |
| Positive Healthcare | 68% | 57% | 79% | * | * | * | * | * | * | 68% | 57% | 79% |
| San Francisco Health Plan | 83% | 76% | 90% | 65% | 59% | 72% | * | * | * | 85% | 78% | 92% |
| Santa Clara Family Health Plan | 84% | 78% | 90% | * | * | * | * | * | * | 84% | 78% | 90% |
| Scripps Health Plan Services, Inc. | 67% | 54% | 80% | 67% | 54% | 80% | * | * | * | * | * | * |
| Sharp Health Plan | 79% | 73% | 84% | 79% | 73% | 84% | 79% | 74% | 84% | * | * | * |
| Sutter Health Plus | 79% | 73% | 86% | 79% | 73% | 86% | 79% | 73% | 86% | * | * | * |
| UnitedHealthcare Benefits Plan of California | 74% | 67% | 82% | 74% | 67% | 82% | * | * | * | * | * | * |
| UnitedHealthcare Community Plan of California, Inc. | 61% | 52% | 70% | * | * | * | * | * | * | 61% | 52% | 70% |
| UnitedHealthcare of California | 77% | 70% | 84% | 77% | 70% | 84% | * | * | * | * | * | * |
| Valley Health Plan | 63% | 51% | 74% | 61% | 49% | 72% | 68% | 56% | 78% | * | * | * |
| Ventura County Health Care Plan | 82% | 76% | 88% | 82% | 76% | 88% | * | * | * | * | * | * |
| Western Health Advantage | 61% | 51% | 70% | 61% | 51% | 70% | 61% | 51% | 70% | * | * | * |

## Behavioral Health Plans

| Health Plan Name | Aggregate | | | Commercial | | | Individual/Family | | | Medi Cal | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Urgent/ Non Urgent | Urgent | Non Urgent | Urgent/ Non Urgent | Urgent | Non Urgent | Urgent/ Non Urgent | Urgent | Non Urgent | Urgent/ Non Urgent | Urgent | Non Urgent |
| Carelon Behavioral Health of California, Inc. | 72% | 62% | 83% | 72% | 62% | 83% | * | * | * | * | * | * |
| Evernorth Behavioral Health of California, Inc. | 68% | 55% | 81% | 68% | 55% | 81% | * | * | * | * | * | * |
| HAI-CA | 66% | 55% | 77% | 66% | 55% | 77% | * | * | * | * | * | * |
| Managed Health Network | 66% | 54% | 79% | 66% | 54% | 79% | * | * | * | * | * | * |
| OptumHealth Behavioral Solutions of California | 83% | 77% | 89% | 82% | 76% | 88% | 83% | 77% | 89% | 78% | Excluded | 86% |

# Appendix D: Average Appointment Wait Times by Product

The Average Appointment Wait Time tables below sets forth urgent and non-urgent mean and median appointment wait time by Commercial, Individual/Family, Medi-Cal products and all health plan reported products aggregated for full service and behavioral health plans combined. Urgent appointment wait times are measured in hours and non-urgent appointment wait times are measured in business days. Urgent and non-urgent appointment wait time standards are set forth in the table below for reference. For additional information on the calculation of mean and median see Appendix A.

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

| Provider Type | Non Urgent Appointment Wait Time Standard | Aggregate | | Commercial | | Individual/Family | | Medi Cal | |
|---|---|---|---|---|---|---|---|---|---|
| | | Mean | Median | Mean | Median | Mean | Median | Mean | Median |
| Primary Care Provider | 10 Business Days | 5 | 3 | 5 | 3 | 5 | 3 | 3 | 2 |
| Specialist Physician | 15 Business Days | 15 | 10 | 15 | 10 | 15 | 10 | 13 | 9 |
| Psychiatrist | 15 Business Days | 6 | 4 | 6 | 4 | 5 | 4 | 4 | 3 |
| Non-Physician Mental Health Care Provider | 10 Business Days | 4 | 3 | 4 | 3 | 3 | 3 | 3 | 3 |
| Ancillary Service Provider | 15 Business Days | 4 | 3 | 4 | 3 | 4 | 3 | 3 | 2 |

## Full Service and Behavioral Health Plans
## Average Urgent Appointment Wait Times by Hours

| Provider Type | Urgent Appointment Wait Time Standard+ | Aggregate | | Commercial | | Individual/Family | | Medi Cal | |
|---|---|---|---|---|---|---|---|---|---|
| | | Mean | Median | Mean | Median | Mean | Median | Mean | Median |
| Primary Care Provider | 48 hours | 82 | 29 | 87 | 43 | 83 | 29 | 54 | 25 |
| Specialist Physician | 48 hours<br>96 hours | 241 | 98 | 255 | 115 | 246 | 112 | 205 | 77 |
| Psychiatrist | 48 hours<br>96 hours | 109 | 47 | 107 | 46 | 105 | 46 | 77 | 27 |
| Non-Physician Mental Health Care Provider | 48 hours<br>96 hours | 58 | 46 | 57 | 46 | 57 | 46 | 51 | 27 |

+ If no prior authorization is required by the health plan, an urgent appointment must be offered to the enrollee within 48 hours of the request for the appointment. If prior authorization is required by the health plan, an urgent appointment must be offered to the enrollee within 96 hours of the request for the appointment.

# Appendix E: Average Appointment Wait Times by Health Plan

The Average Appointment Wait Time tables below set forth each health plan's urgent and non-urgent mean and median appointment wait time aggregated by all health plan reported products. Urgent appointment wait times are measured in hours and non-urgent appointment wait times are measured in business days. Urgent and non-urgent appointment wait time standards are set forth in the table below for reference. An asterisk (*) indicates that the health plan did not report timely access data for this provider type. 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 Day Standard Mean \| Median | Specialist Physician 15 Business Day Standard Mean \| Median | Psychiatrist 15 Business Day Standard Mean \| Median | NPMH 10 Business Day Standard Mean \| Median | Ancillary 15 Business Day Standard Mean \| Median |
|---|---|---|---|---|---|
| Aetna Better Health of California Inc. | 3 \| 3 | 15 \| 8 | 12 \| 7 | 4 \| 3 | 25 \| 7 |
| Aetna Health of California Inc. | 4 \| 3 | 14 \| 9 | 7 \| 6 | 4 \| 3 | 4 \| 2 |
| Alameda Alliance For Health | 2 \| 2 | 10 \| 4 | 2 \| 1 | 1 \| 1 | 1 \| 1 |
| Anthem Blue Cross | 6 \| 4 | 18 \| 14 | 8 \| 6 | 4 \| 3 | 4 \| 3 |
| Blue Cross of California Partnership Plan, Inc. | 4 \| 3 | 21 \| 16 | 8 \| 6 | 4 \| 3 | 3 \| 2 |
| Blue Shield of California | 5 \| 2 | 19 \| 14 | 9 \| 8 | 5 \| 4 | 4 \| 3 |
| Blue Shield of California Promise Health Plan | 3 \| 1 | 16 \| 12 | 6 \| 4 | 4 \| 3 | 4 \| 2 |
| CA Health and Wellness | 9 \| 6 | 26 \| 22 | 12 \| 11 | 4 \| 3 | 6 \| 4 |
| CalViva Health | 6 \| 3 | 22 \| 20 | 18 \| 21 | 6 \| 5 | 6 \| 6 |
| Central California Alliance for Health | 1 \| 1 | 34 \| 12 | 6 \| 5 | 4 \| 3 | 7 \| 4 |
| Chinese Community Health Plan | 3 \| 2 | 23 \| 18 | 4 \| 4 | 3 \| 1 | 17 \| 21 |
| Cigna HealthCare of California, Inc. | 5 \| 3 | 21 \| 16 | 10 \| 7 | 4 \| 3 | 5 \| 4 |
| Community Care Health Plan, Inc. | 4 \| 3 | 34 \| 34 | 8 \| 2 | 7 \| 5 | 3 \| 1 |
| Community Health Group Partnership Plan | 1 \| 1 | 9 \| 10 | 7 \| 7 | 5 \| 7 | 6 \| 5 |
| Contra Costa Health Plan | 2 \| 1 | 5 \| 3 | 2 \| 1 | 2 \| 1 | 5 \| 1 |
| Health Net Community Solutions, Inc. | 4 \| 3 | 16 \| 11 | 10 \| 8 | 4 \| 3 | 4 \| 2 |
| Health Net of California, Inc. | 5 \| 4 | 19 \| 15 | 10 \| 7 | 4 \| 3 | 4 \| 3 |
| Health Plan of San Joaquin | 2 \| 1 | 2 \| 1 | 2 \| 1 | 1 \| 1 | 1 \| 1 |
| Health Plan of San Mateo | 2 \| 2 | 14 \| 4 | 1 \| 1 | 1 \| 1 | 1 \| 1 |
| IEHP | 3 \| 3 | 6 \| 5 | 3 \| 2 | 3 \| 2 | 2 \| 1 |
| Kaiser Permanente | 2 \| 2 | 3 \| 2 | 2 \| 1 | 2 \| 2 | 1 \| 1 |
| Kern Health Systems | 3 \| 3 | 4 \| 3 | 2 \| 2 | 2 \| 2 | 1 \| 1 |
| L.A. Care Health Plan | 3 \| 2 | 14 \| 10 | 4 \| 3 | 3 \| 3 | 3 \| 2 |
| L.A. Care Health Plan Joint Powers Authority | 1 \| 1 | 6 \| 6 | 5 \| 4 | 3 \| 3 | 4 \| 2 |
| MemorialCare Select Health Plan | 6 \| 3 | 14 \| 11 | 7 \| 3 | 6 \| 5 | 3 \| 2 |
| Molina Healthcare of California | 4 \| 3 | 11 \| 9 | 7 \| 4 | 4 \| 4 | 3 \| 2 |
| Oscar Health Plan of California | 10 \| 5 | 18 \| 15 | 6 \| 5 | 3 \| 3 | 6 \| 2 |
| Positive Healthcare | 21 \| 8 | 17 \| 14 | 7 \| 5 | 4 \| 4 | 13 \| 5 |
| San Francisco Health Plan | 2 \| 1 | 6 \| 2 | 2 \| 1 | 1 \| 1 | 2 \| 1 |
| Santa Clara Family Health Plan | 2 \| 2 | 5 \| 3 | 2 \| 1 | 1 \| 1 | 2 \| 1 |
| Scripps Health Plan Services, Inc. | 7 \| 4 | 21 \| 18 | 10 \| 7 | 4 \| 3 | 5 \| 4 |
| Sharp Health Plan | 2 \| 2 | 10 \| 7 | 2 \| 1 | 1 \| 1 | 3 \| 2 |
| Sutter Health Plus | 8 \| 6 | 29 \| 28 | 6 \| 5 | 3 \| 3 | 7 \| 6 |
| UnitedHealthcare Benefits Plan of California | 6 \| 4 | 18 \| 14 | 6 \| 5 | 3 \| 3 | 5 \| 3 |
| UnitedHealthcare Community Plan of California, Inc. | 6 \| 4 | 25 \| 19 | 6 \| 5 | 4 \| 3 | 2 \| 1 |
| UnitedHealthcare of California | 5 \| 3 | 18 \| 15 | 6 \| 5 | 3 \| 3 | 5 \| 3 |
| Valley Health Plan | 11 \| 7 | 18 \| 16 | 3 \| 1 | 2 \| 1 | 3 \| 3 |
| Ventura County Health Care Plan | 3 \| 2 | 9 \| 3 | 6 \| 5 | 3 \| 3 | 4 \| 4 |
| Western Health Advantage | 4 \| 1 | 15 \| 12 | 12 \| 10 | 6 \| 4 | 11 \| 9 |

# Behavioral Health Plans
## Average Non-Urgent Appointment Wait Time

| Health Plan Name | PCP 10 Business Day Standard | Specialist Physician 15 Business Day Standard | Psychiatrist 15 Business Day Standard | NPMH 10 Business Day Standard | Ancillary 15 Business Day Standard |
|---|---|---|---|---|---|
| | Mean \| Median | Mean \| Median | Mean \| Median | Mean \| Median | Mean \| Median |
| Carelon Behavioral Health of California, Inc. | * | * | 9 \| 6 | 4 \| 3 | * |
| Evernorth Behavioral Health of California, Inc. | * | * | 10 \| 7 | 4 \| 3 | * |
| HAI-CA | * | * | 9 \| 8 | 5 \| 4 | * |
| Managed Health Network | * | * | 10 \| 7 | 4 \| 3 | * |
| OptumHealth Behavioral Solutions of California | * | * | 6 \| 5 | 3 \| 3 | * |

## Full Service Health Plans
## Average Urgent Appointment Wait Time

| Health Plan Name | PCP 48 Hour Standard+ Mean \| Median | Specialist Physician 48 Hour or 96 Hour Standards+ Mean \| Median | Psychiatrist 48 Hour or 96 Hour Standards+ Mean \| Median | NPMH 48 Hour or 96 Hour Standards+ Mean \| Median |
|---|---|---|---|---|
| Aetna Better Health of California Inc. | 40 \| 22 | 187 \| 45 | 356 \| 218 | 90 \| 48 |
| Aetna Health of California Inc. | 35 \| 22 | 163 \| 76 | 131 \| 93 | 65 \| 51 |
| Alameda Alliance For Health | 15 \| 8 | 110 \| 48 | 25 \| 22 | 16 \| 18 |
| Anthem Blue Cross | 99 \| 44 | 315 \| 164 | 203 \| 125 | 87 \| 67 |
| Blue Cross of California Partnership Plan, Inc. | 55 \| 24 | 401 \| 190 | 194 \| 119 | 101 \| 51 |
| Blue Shield of California | 112 \| 47 | 332 \| 165 | 255 \| 168 | 101 \| 68 |
| Blue Shield of California Promise Health Plan | 60 \| 23 | 177 \| 112 | 108 \| 53 | 69 \| 43 |
| CA Health and Wellness | 172 \| 75 | 598 \| 333 | 345 \| 274 | 82 \| 56 |
| CalViva Health | 107 \| 49 | 337 \| 191 | 487 \| 478 | 156 \| 100 |
| Central California Alliance for Health | 18 \| 18 | 109 \| 119 | 30 \| 28 | 45 \| 25 |
| Chinese Community Health Plan | 27 \| 19 | 415 \| 169 | 147 \| 147 | 54 \| 3 |
| Cigna HealthCare of California, Inc. | 84 \| 28 | 373 \| 168 | 257 \| 165 | 98 \| 70 |
| Community Care Health Plan, Inc. | 49 \| 22 | 668 \| 259 | 179 \| 50 | 217 \| 174 |
| Community Health Group Partnership Plan | 74 \| 50 | 115 \| 74 | 103 \| 49 | 51 \| 27 |
| Contra Costa Health Plan | 13 \| 6 | 65 \| 28 | 23 \| 22 | 18 \| 18 |
| Health Net Community Solutions, Inc. | 60 \| 24 | 227 \| 117 | 236 \| 141 | 75 \| 48 |
| Health Net of California, Inc. | 86 \| 45 | 326 \| 169 | 259 \| 166 | 99 \| 68 |
| Health Plan of San Joaquin | 13 \| 6 | 43 \| 23 | 15 \| 20 | 18 \| 18 |
| Health Plan of San Mateo | 19 \| 19 | 410 \| 72 | 16 \| 21 | 16 \| 16 |
| IEHP | 62 \| 47 | 44 \| 24 | 37 \| 23 | 46 \| 32 |
| Kaiser Permanente | 36 \| 25 | 34 \| 22 | 23 \| 22 | 42 \| 25 |
| Kern Health Systems | 71 \| 48 | 30 \| 21 | 28 \| 22 | 49 \| 45 |
| L.A. Care Health Plan | 49 \| 29 | 145 \| 71 | 67 \| 26 | 57 \| 44 |
| L.A. Care Health Plan Joint Powers Authority | 29 \| 23 | 68 \| 52 | 88 \| 25 | 53 \| 32 |
| MemorialCare Select Health Plan | 44 \| 22 | 156 \| 53 | 127 \| 96 | 78 \| 36 |
| Molina Healthcare of California | 29 \| 20 | 109 \| 68 | 107 \| 42 | 48 \| 28 |
| Oscar Health Plan of California | 92 \| 26 | 237 \| 66 | 91 \| 68 | 46 \| 50 |
| Positive Healthcare | 36 \| 37 | 228 \| 123 | 150 \| 71 | 75 \| 47 |
| San Francisco Health Plan | 14 \| 6 | 119 \| 31 | 36 \| 23 | 16 \| 19 |
| Santa Clara Family Health Plan | 14 \| 6 | 85 \| 44 | 22 \| 22 | 17 \| 18 |
| Scripps Health Plan Services, Inc. | 133 \| 68 | 436 \| 215 | 257 \| 165 | 98 \| 70 |
| Sharp Health Plan | 31 \| 23 | 99 \| 67 | 23 \| 19 | 15 \| 8 |
| Sutter Health Plus | 184 \| 119 | 663 \| 436 | 103 \| 72 | 46 \| 49 |
| UnitedHealthcare Benefits Plan of California | 96 \| 42 | 312 \| 166 | 103 \| 72 | 46 \| 49 |
| UnitedHealthcare Community Plan of California, Inc. | 134 \| 50 | 458 \| 166 | 66 \| 33 | 62 \| 27 |
| UnitedHealthcare of California | 75 \| 26 | 296 \| 149 | 103 \| 72 | 46 \| 49 |
| Valley Health Plan | 57 \| 29 | 282 \| 193 | 140 \| 30 | 66 \| 25 |
| Ventura County Health Care Plan | 12 \| 20 | 71 \| 52 | 103 \| 72 | 46 \| 49 |
| Western Health Advantage | 68 \| 25 | 226 \| 119 | 344 \| 296 | 124 \| 72 |

## Behavioral Health Plans
## Average Urgent Appointment Wait Time

| Health Plan Name | PCP 48 Hour Standard+ Mean \| Median | Specialist Physician 48 Hour or 96 Hour Standards+ Mean \| Median | Psychiatrist 48 Hour or 96 Hour Standards+ Mean \| Median | NPMH 48 Hour or 96 Hour Standards+ Mean \| Median |
|---|---|---|---|---|
| Carelon Behavioral Health of California, Inc. | * | * | 220 \| 121 | 68 \| 45 |
| Evernorth Behavioral Health of California, Inc. | * | * | 257 \| 165 | 98 \| 70 |
| HAI-CA | * | * | 255 \| 168 | 101 \| 68 |
| Managed Health Network | * | * | 262 \| 167 | 99 \| 68 |
| OptumHealth Behavioral Solutions of California | * | * | 97 \| 71 | 46 \| 49 |

+ If no prior authorization is required by the health plan, an urgent appointment must be offered to the enrollee within 48 hours of the request for the appointment. If prior authorization is required by the health plan, an urgent appointment must be offered to the enrollee within 96 hours of the request for the appointment.