DEPARTMENT OF
Managed
Healthcare

Timely Access Report

Measurement Year 2016

1-888-466-2219

HAVE A PROBLEM WITH YOUR HEALTH PLAN? CONTACT THE DMHC

HealthHelp.ca.gov

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DMHC MISSION, VALUES & GOALS

MISSION

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

CORE VALUES

- Integrity
- Leadership
- Commitment to Service

GOALS

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

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Executive Summary

Providing timely access to health care services is a health plan's fundamental duty to its enrollees. For Measurement Year 2016, the DMHC required the health plans to hire external vendors to validate the health plans' Timely Access Data and conduct a quality assurance review of their Timely Access Compliance Reports prior to submitting them to the DMHC. The external vendors also prepared a Validation Report for each plan that outlined the results of the vendor's data validation and quality assurance review. The vendors found some data errors or issues with the 2016 data that health plans were unable to correct. Consequently, there is still work to be done to further improve the health plans' data to allow the DMHC to assess how well health plans are complying with the appointment wait time standards.

This report summarizes the data the plans submitted in 2017 that measure provider appointment wait times for calendar year 2016. The charts show provider responses to appointment availability requests.

Some of the key findings related to surveyed providers are:

- The percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 95% to a low of 32% (Chart 1).
- For urgent appointments, the percentage of appointments available within the wait time standards for all surveyed providers ranged from 94% to 18% (Chart 2).
- For non-urgent appointments, the percentage of appointments available within the wait time standards for all surveyed providers ranged from 97% to 36% (Chart 3).
- PCP appointments meeting the wait time standards, for both urgent and non-urgent care, ranged from 95% to 44% (Chart 4), while appointments with specialists available within the wait time standards ranged from 96% to 21% (Chart 5).
- For behavioral health plans, surveyed providers reported appointment availability across all provider types within the wait time standards for both urgent and non-urgent appointments ranged from 72% to 67% (Chart 6). For urgent appointments, the range was 59% to 53% (Chart 7), and for non-urgent appointments the range was 83% to 72% (Chart 8).
- For both urgent and non-urgent appointments, surveyed behavioral health specialist providers (psychiatrist and child and adolescent psychiatrist) reported a range of appointment availability from 46% to 22% (Chart 9).

For audited providers, which don't rely on sampling, Kaiser Permanente reported the following:

- The percentage of audited providers meeting appointment wait time standards across all provider types and appointment types (urgent and non-urgent) was 83% (Chart 10).
- The percentage of audited providers meeting urgent appointment standards was 80% and 82% for non-urgent appointments (Charts 11 and 12).
- Audited appointment wait time standards across both urgent and non-urgent appointments was 95% for PCPs and 82% for specialists (Chart 13).

Ensuring health plans provide timely access to health care services is a high priority for the DMHC. Health plans still have work to do to improve the accuracy and completeness of their Timely Access Compliance Data. For example, health plans should ensure that the sample size of providers is large enough to allow for more disaggregated reporting than is contained in this report (e.g., reporting on non-physician mental health provider urgent and non-urgent appointments, or specialist urgent and non-urgent appointments) and still remain within the 5% sampling error.

The DMHC will work with the health plans, providers and consumer advocates to continue to refine the provider survey methodology and develop an acceptable rate of compliance for provider appointment wait times. Mandatory methodologies for measuring compliance with the timely access standards will be included in the regulations to be promulgated by January 1, 2020.

Introduction and Background

The DMHC regulates health plans under the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended (Knox-Keene Act). The Knox-Keene Act requires health plans to make all services readily available at reasonable times to each enrollee consistent with good professional practice and within the timely access standards.

Pursuant to statute[1], the DMHC promulgated regulations related to timely access to services which became effective on January 17, 2010. The Timely Access Regulations require that health plans meet a set of standards which include specific time frames under which enrollees must be able to access care. These standards include access to urgent and non-urgent care appointments, as well as the availability of telephone triage or screening services during and after regular business hours. To show compliance with the timely access standards, health plans submit annual compliance reports to the DMHC.

Appointment Type	Time frame
Urgent Care (Prior authorization not required by health plan)	48 hours
Urgent Care (prior authorization required by health plan)	96 hours
Non-Urgent Doctor Appointment (primary care physician)	10 business days
Non-Urgent Doctor Appointment (specialty physician)	15 business days
Non-Urgent Mental Health Appointment (non-physician[1])	10 business days
Non-Urgent Appointment (ancillary provider[2])	15 business days

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

[2] Examples of non-urgent appointment for ancillary services include lab work or diagnostic testing, such as mammogram or MRI, and treatment of an illness or injury such as physical therapy.

For several years following the promulgation of the Timely Access Regulations, annual compliance reports submitted by health plans contained a wide variety of methods to gauge appointment times. These included provider telephone surveys, secret shoppers and practice management software audits. These non-standardized methods, and the varying results, made it impossible for the DMHC to compare appointment availability across health plans.

To strengthen the DMHC's ability to oversee health plan compliance and compare data, Health and Safety Code Section 1367.03 was amended in 2014 by SB 964 (Hernandez, Chapter 573, Statutes of 2014). SB 964 authorized the DMHC, in consultation with stakeholders, to develop standardized methodologies for measuring compliance with timely access standards. Upon submission of accurate and comparable data from health plans, the DMHC would be able to compare results among health plans and develop an acceptable rate of compliance.

Immediately following passage of SB 964, the DMHC adopted an initial standardized methodology, which required health plans to conduct a telephone survey of providers to assess the time frame for the next available appointment. Timely Access Compliance Reports submitted by California health plans during the first four years of the process (2011-2015) were not useful in determining individual health plan compliance

1 HSC 1367.03, enacted in 2002, directed the DMHC to adopt standards regarding timely access to services through regulations.

or comparing plans across the industry, due to variation in the techniques or methods used by different health plans when gathering data and measuring compliance. For 2015 and subsequent years, the DMHC created a mandatory methodology that all health plans are required to follow when gathering data, measuring compliance and submitting annual reports.

Due to the burden on health plans and providers to conduct the surveys, the DMHC had intended to move away from telephone surveys and instead develop a standardized audit methodology that assessed compliance by determining the interval between an enrollee's request for an appointment and the actual date of the appointment. The DMHC believed using an audit process that avoided telephone surveys would increase both the accuracy and cost-effectiveness of monitoring compliance.

However, the DMHC has not been able to proceed with a standardized audit methodology because the data needed to move to the audit methodology is not currently captured by all providers.

While the standardized audit methodology was being explored, the DMHC continued to allow health plans to choose to use telephone surveys or an audit to determine compliance with the appointment wait time standards for 2015[2]. All reporting health plans used the survey methodology, except for Kaiser Permanente. However, many health plans failed to follow the standardized telephone survey methodology and submitted survey results to the DMHC with pervasive errors. The DMHC's 2015 Timely Access Report concluded that, due to the many data errors, the DMHC was unable to compare health plan data or determine whether health plans were actually meeting the timely access standards.

Following the release of the 2015 report in February 2017, the DMHC met with health plans, provider organizations, and consumer advocates to discuss the steps health plans were required to immediately take to ensure accurate reporting of future Timely Access Data. The DMHC required the health plans to retain data validators to review and authenticate Timely Access Data before submitting their 2016 and 2017 compliance reports to the DMHC.

As a result of the significant efforts undertaken by the DMHC and the health plans, the data submitted in 2017 for calendar year 2016 had far fewer errors than the 2015 data. The DMHC was able to create charts that compare appointment availability across health plans and behavioral health plans for calendar year 2016.

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

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

Health plans are required to provide (or arrange for) telephone triage or screening services on a 24/7 basis. Patients can get help to determine how urgent their condition is, including a return call within a reasonable timeframe, not to exceed 30 minutes.

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

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

2 The DMHC allowed two types of standardized methodologies to be followed: telephone survey and audit. Of the health plans reporting, only Kaiser Permanente utilized both the telephone survey and audit methodologies.

Timely Access Compliance Report Findings

The charts that follow illustrate the health plan survey results and the percentage of appointments available[3] within the appointment wait time standards. Kaiser Permanente's survey and audit results are reported separately because the survey and audit methodologies are distinct.

Health plans that used the survey methodology contacted a random sample of providers in their network and asked for the next available appointment. The providers' responses to these survey questions were then compared against the appointment wait time standards and submitted to the DMHC as part of the health plan's Timely Access Annual Report. The percentages reflected in the survey charts indicate the percentage of appointments that meet the appointment wait time standards; they do not necessarily reflect an enrollee's experience and whether the enrollee could actually obtain an appointment within the appointment time frames.

Kaiser Permanente, the one health plan that used the audit methodology, audited its scheduling records to identify the time elapsed between the date of the request for the appointment and the date the appointment occurred. Kaiser Permanente used an audit methodology for its integrated system providers, and the survey methodology for its external providers. Kaiser Permanente's data is discussed in the audit data section of this report. The percentages included in the audit charts reflect the percentage of audited appointments within the wait time standards.

The DMHC is working to establish an acceptable rate of compliance with the appointment wait time standards. The DMHC is also working with statisticians to quantify how the percentage of surveyed providers with an appointment availability within the wait time standards translates into a reliable estimate of an enrollee's ability to obtain timely appointments.

The charts in this report were compiled using information reported by health plans. To ensure the reliability of the data, this report displays data with sampling errors of 5% or less. Some charts combine information for more than one provider type or appointment wait time standard in order to remain at or below the 5% sampling error. For example, psychiatrists were combined with the specialist providers. By doing so, this allows for a high level understanding of the data.

If a selected provider did not respond to the survey, the health plan considered the provider's next available appointment to be outside of the appointment wait time standards. In some cases, the survey results were adjusted by the DMHC's statisticians to remove data inconsistencies to allow the DMHC to compare survey results across health plans. For more information related to the data, please see Appendix A.

3 The provider appointment availability survey measures only a provider's next available appointment and does not take into account whether a provider has multiple appointments available within the appointment wait time standards. For example, the survey result would not differentiate between a provider with one timely appointment and a provider with 10 timely appointments.

Health Plan Survey Data

The survey data charts show provider responses to appointment availability requests. For example, if a health plan's survey results show 72 percent, this means that 2016 Timely Access Data reported by the health plan indicated that 72 percent of the time, a provider responded during the survey that an appointment was available within the appointment wait time standards.

This data does not mean that 72 percent of all providers within the plan's network maintain appointment availability within the appointment wait time standards. It is important to understand that the health plan survey results reflect only a point in time based on the providers surveyed.

One health plan, Kaiser Permanente, utilized both the audit methodology for its integrated providers and the survey methodology for its external providers. Kaiser Permanente's survey results are included in charts 1-5 and its audit results are shown separately in charts 10-13.

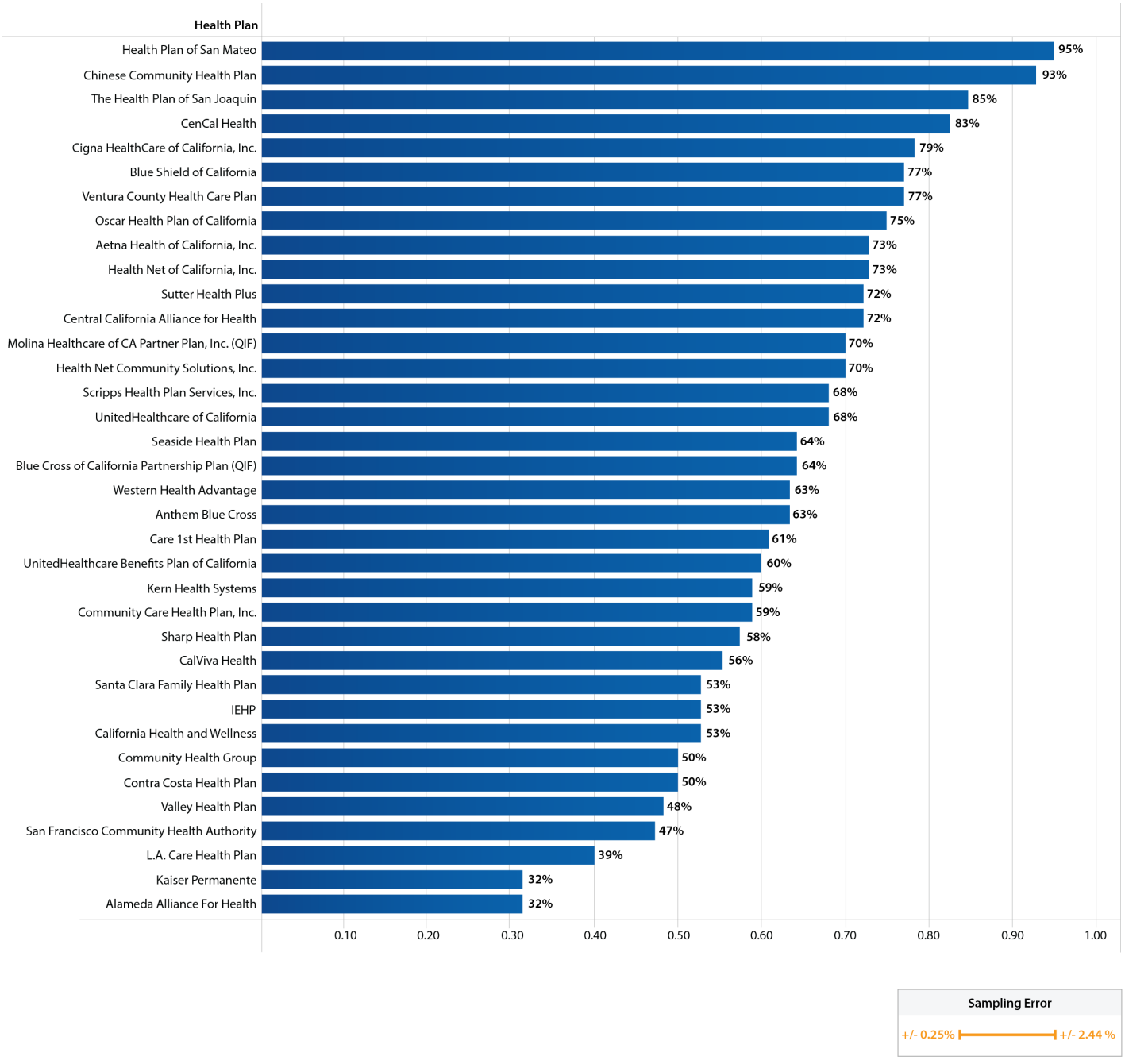
Two behavioral health plans, Value Behavioral Health of CA and Holman Professional Counseling Centers conducted the telephone survey outside of the measurement year. Because the data from these two behavioral health plans was collected outside of the measurement year, it is not usable and therefore is not reflected in any of the behavioral health plan survey results.

Full Service Health Plans Survey Data

Chart 1

Full Service Health Plans
Percentage of Surveyed Providers Meeting Appointment Wait Time Standards

Chart 1 combines health plans' survey results across all provider types (primary care, specialty, non-physician mental health, and ancillary), and across both appointment types (urgent and non-urgent)[4].

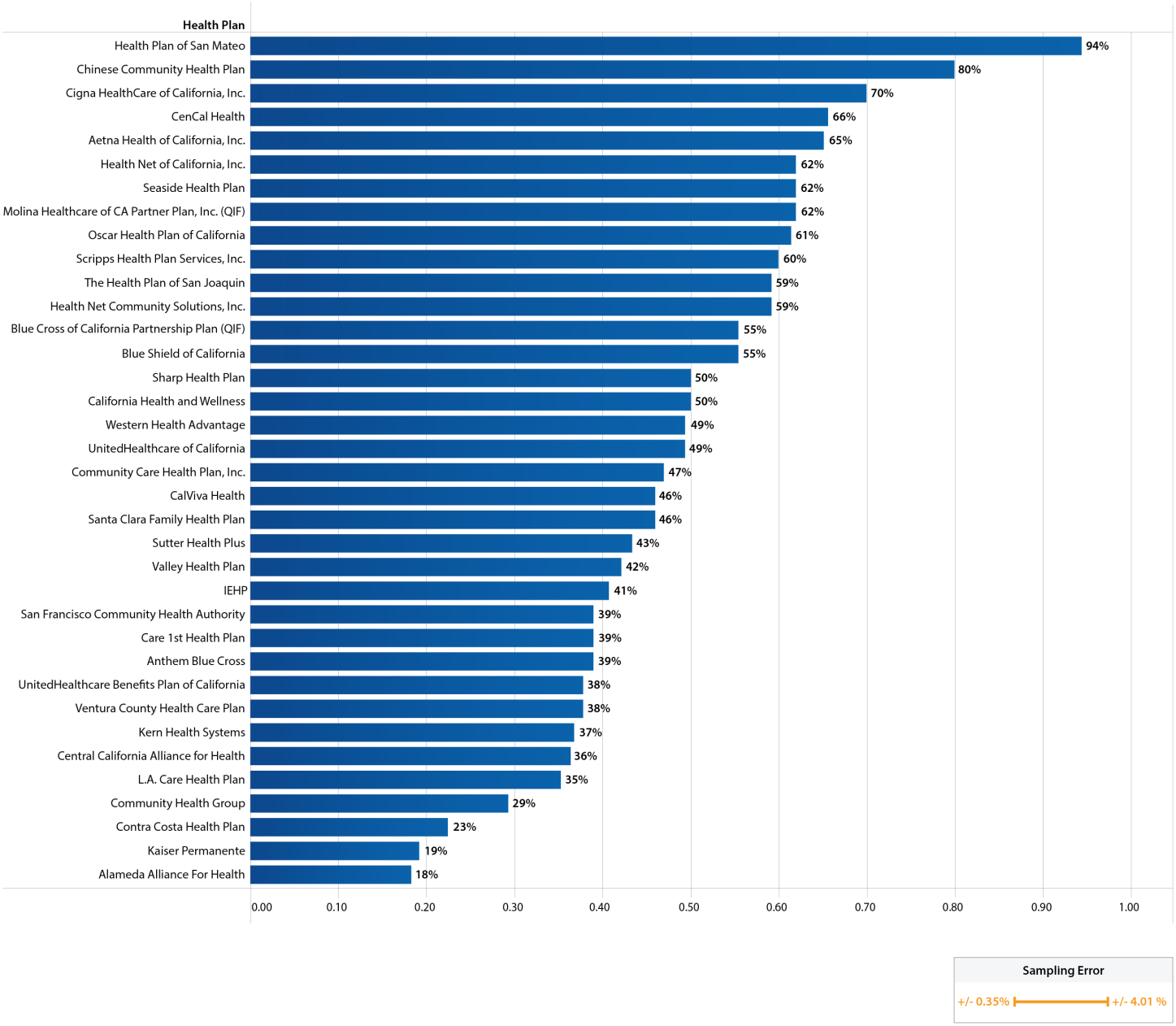


4 Kaiser Permanente used the audit methodology for its integrated providers and the survey methodology for its external providers. Kaiser Permanente's audit data is shown separately in charts 10-13. For information on data excluded from this chart, please see Appendix A.

Chart 2

Full Service Health Plans
Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards

Chart 2 combines health plans' survey results across all provider types (primary care, specialty, non-physician mental health, and ancillary) for urgent appointments[5].



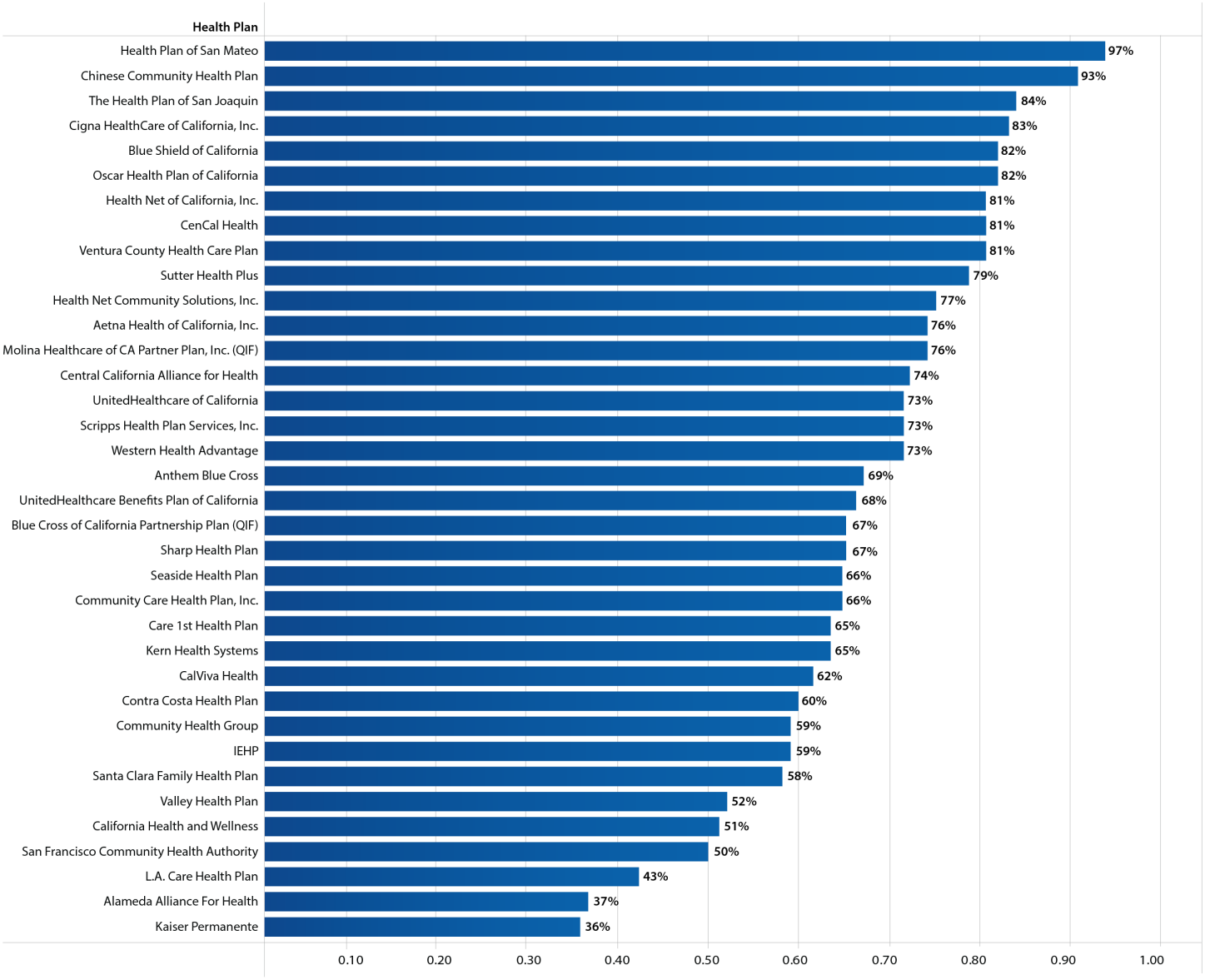
5 Kaiser Permanente used the audit methodology for its integrated providers and the survey methodology for its external providers. Kaiser Permanente's audit data is shown separately in charts 10-13. For information on data excluded from this chart, please see Appendix A.

Chart 3

Full Service Health Plans

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

Chart 3 combines health plans' survey results across all provider types (primary care, specialty, non-physician mental health, and ancillary) for non-urgent appointments[6].



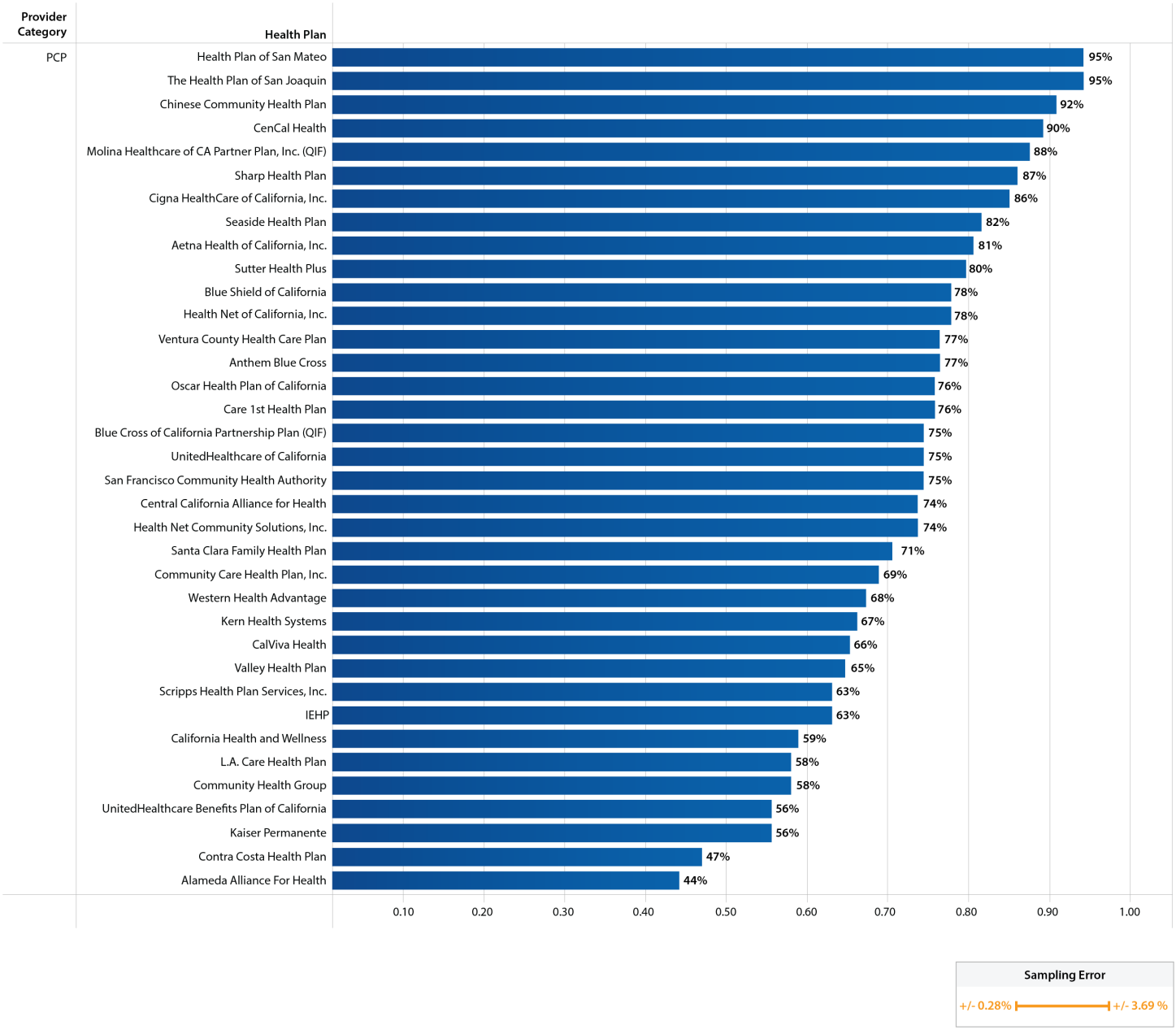
6 Kaiser Permanente used the audit methodology for its integrated providers and the survey methodology for its external providers. Kaiser Permanente's audit data is shown separately in charts 10-13. For information on data excluded from this chart, please see Appendix A.

Chart 4

Full Service Health Plans

Percentage of Surveyed Primary Care Providers Meeting Appointment Wait Time Standards

Chart 4 combines health plans' survey results for PCPs, across both appointment types (urgent and non-urgent)[7].



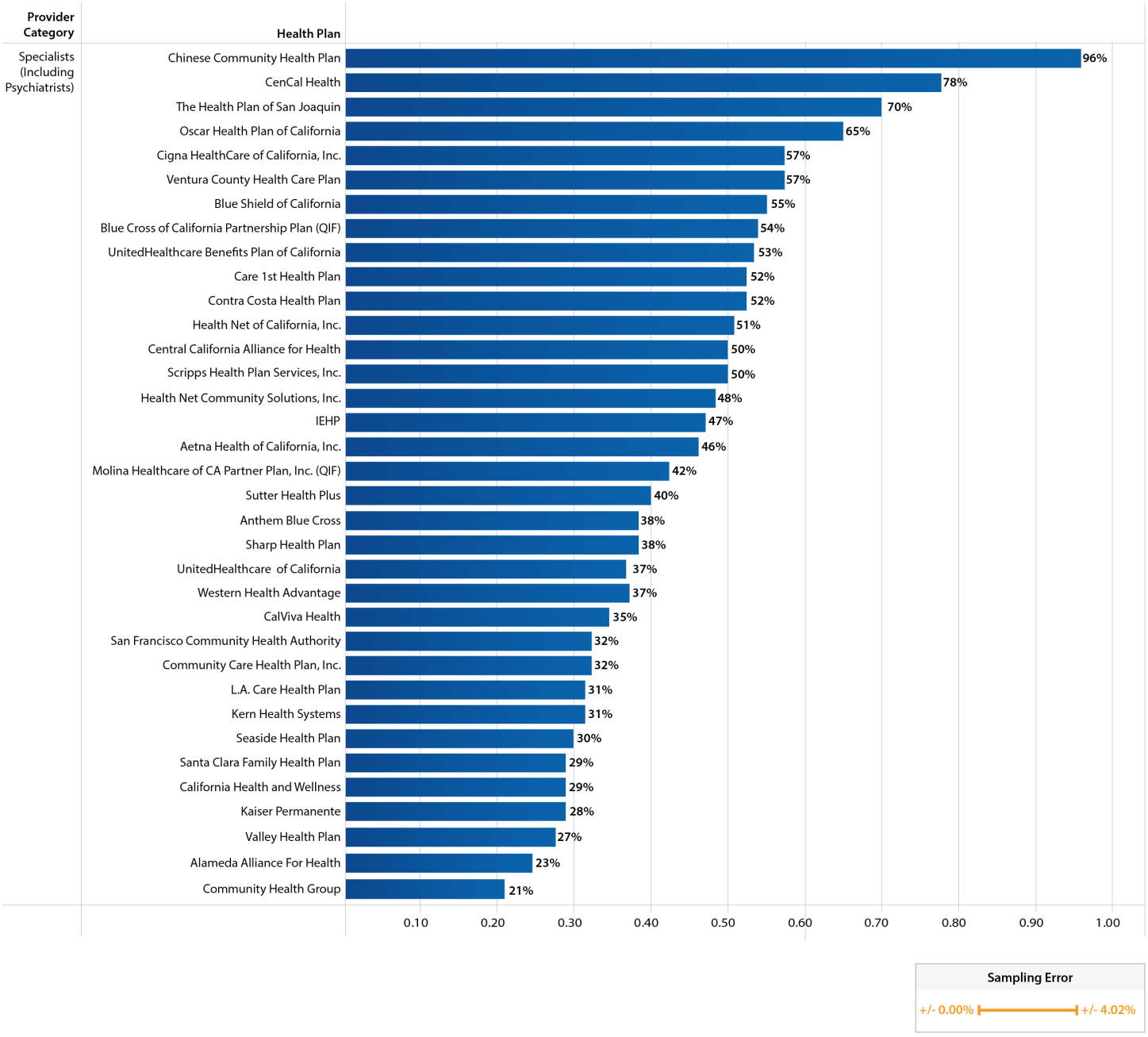
7 Kaiser Permanente used the audit methodology for its integrated providers and the survey methodology for its external providers. Kaiser Permanente's audit data is shown separately in charts 10-13.

Chart 5

Full Service Health Plans

Percentage of Surveyed Specialist Providers Meeting Appointment Wait Time Standards

Chart 5 combines health plans' survey results for specialists (allergist, cardiologist, dermatologist, psychiatrist, and child and adolescent psychiatrist), across both appointment types (urgent and non-urgent)[8].



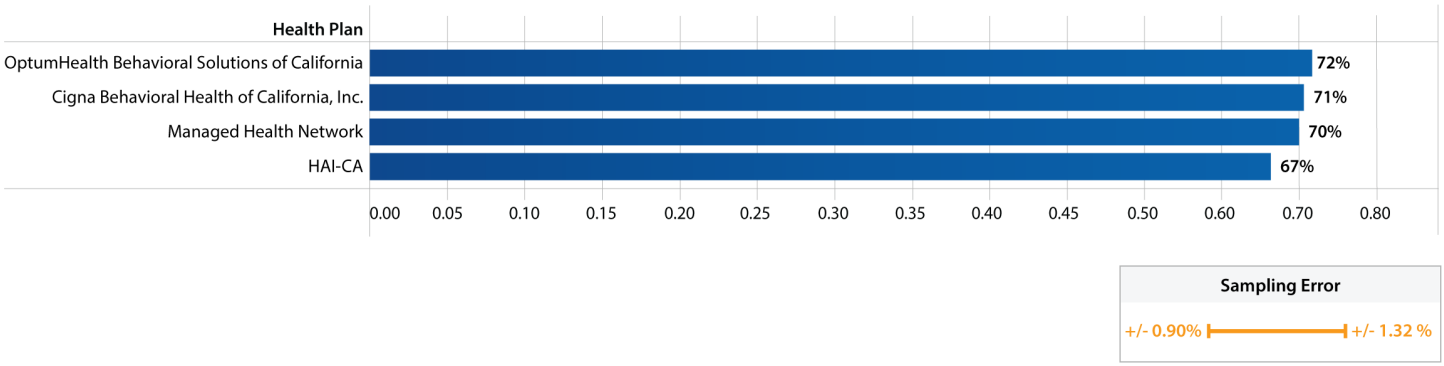
8 This chart shows data from 35 full service health plans. One health plan (Health Plan of San Mateo) is not displayed. For additional information on data excluded from this chart, please see Appendix A. Kaiser Permanente used the audit methodology for its integrated providers and the survey methodology for its external providers. Kaiser Permanente's audit data is shown separately in charts 10-13.

Behavioral Health Plans Survey Data

Chart 6

Behavioral Health Plans
Percentage of Surveyed Providers Meeting Appointment Wait Time Standards

Chart 6 combines health plans' survey results across all behavioral health provider types (specialist[9] and non-physician mental health), and across both appointment types (urgent and non-urgent)[10].



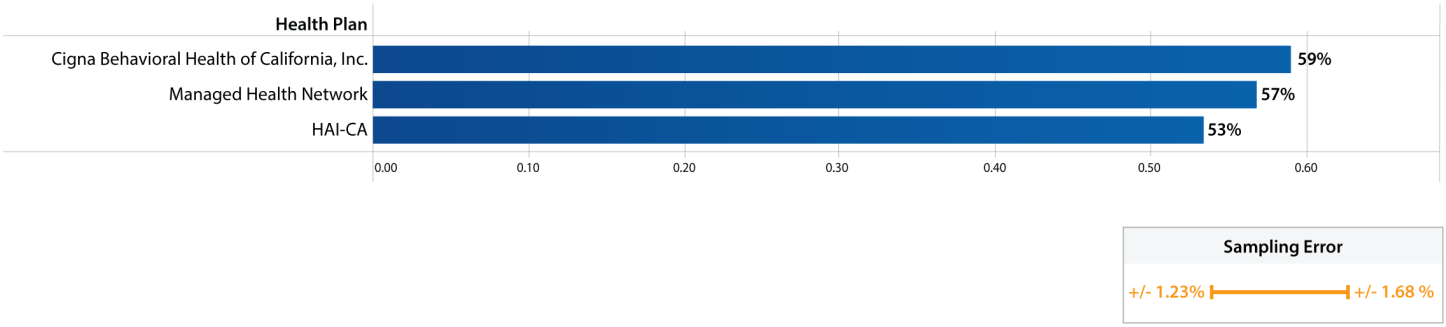
9 Specialists in behavioral health plans consist of psychiatrist and child and adolescent psychiatrist. Behavioral health plans do not report data for the remaining specialist types (allergist, cardiologist, and dermatologist).

10 This chart shows data from four behavioral health plans. Two behavioral health plans (Holman Professional Counseling Centers and Value Behavioral Health of CA) are not displayed. For additional information on data excluded from this chart, please see Appendix A.

Chart 7

Behavioral Health Plans
Percentage of Surveyed Providers Meeting Urgent Appointment Wait Time Standards

Chart 7 combines health plans' survey results across all behavioral health provider types (specialist and non-physician mental health) for urgent appointments[11].



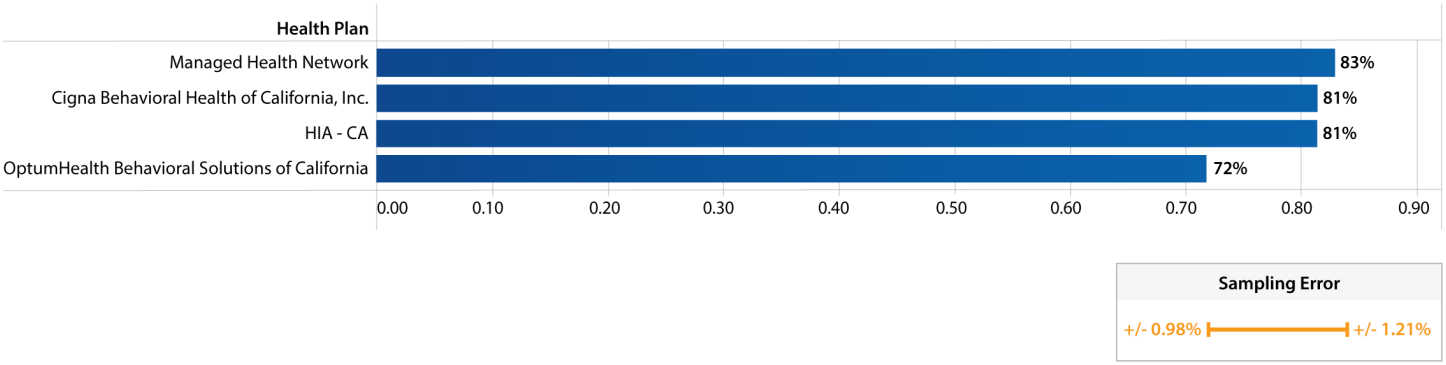
11 This chart shows data from three behavioral health plans. Three behavioral health plans (OptumHealth Behavioral Solutions of California, Holman Professional Counseling Centers and Value Behavioral Health of CA) are not displayed. For additional information on data excluded from this chart, please see Appendix A.

Chart 8

Behavioral Health Plans

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

Chart 8 combines health plans' survey results across all behavioral health provider types (specialist and non-physician mental health) for non-urgent appointments[12].

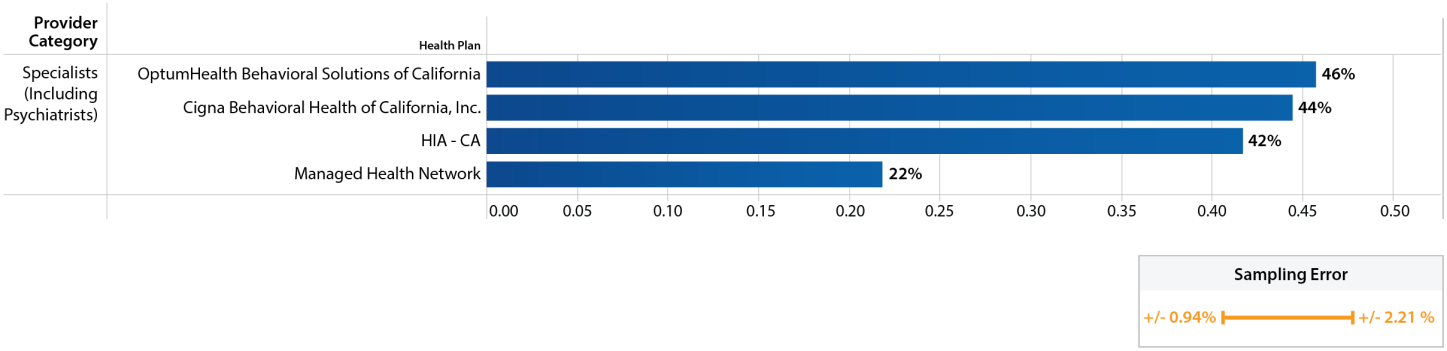


12 This chart shows data from four behavioral health plans. Two behavioral health plans (Holman Professional Counseling Centers and Value Behavioral Health of CA) are not displayed. For additional information on data excluded from this chart, please see Appendix A.

Chart 9

Behavioral Health Plans
Percentage of Surveyed Specialist Providers Meeting Appointment Wait Time Standards

Chart 9 combines behavioral plans' survey results for specialists (psychiatrist and child and adolescent psychiatrist), across both appointment types (urgent and non-urgent)[13].



13 This chart shows data from four behavioral health plans. Two behavioral health plans (Holman Professional Counseling Centers and Value Behavioral Health of CA) are not displayed. For additional information on data excluded from this chart, please see Appendix A.

Health Plan Audit Data

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

Full Service Health Plans Audit Data

Chart 10

Full Service Plan
Percentage of Audited Providers Meeting Appointment Wait Time Standards

Chart 10 combines the health plan's audit results across all provider types (primary care, specialty, non-physician mental health, and ancillary), and across both appointment types (urgent and non-urgent).

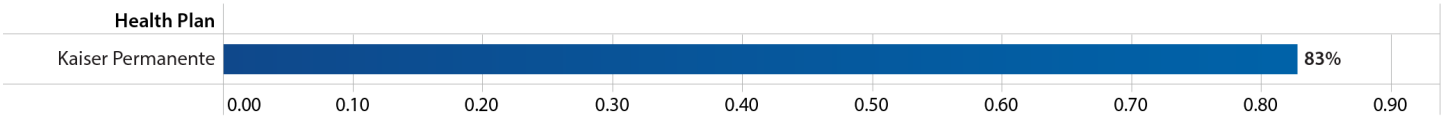


Chart 11

Full Service Plan
Percentage of Audited Providers Meeting Urgent Appointment Wait Time Standards

Chart 11 combines the health plan's audit results across all provider types (primary care, specialty, non-physician mental health, and ancillary) for urgent appointments.

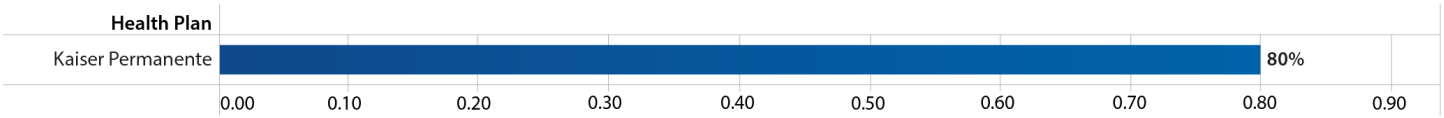


Chart 12

Full Service Plan

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

Chart 12 combines the health plan's audit results across all provider types (primary care, specialty, non-physician mental health, and ancillary) for non-urgent appointments.

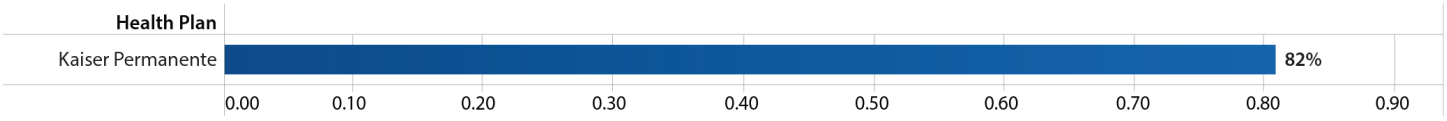
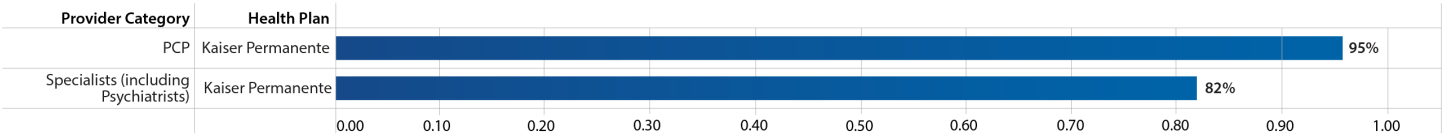


Chart 13

Full Service Plan

Percentage of Audited Specialists and Primary Care Providers Meeting Appointment Wait Time Standards

Chart 13 combines the health plan's audit results for PCP and specialist provider types across both appointment types (urgent and non-urgent).



Next Steps

Providing timely access to health care services is a health plan's fundamental duty to its enrollees. To further improve health plan compliance with timely access standards, the DMHC will:

- Require health plans to utilize an external vendor for 2018 to perform a quality assurance review of the health plans data prior to submission to the DMHC.
- Release the 2018 mandatory methodology and reporting templates in the first quarter of 2018.
- Continue to refine its mandatory provider survey methodology to achieve greater data accuracy while also providing health plans with flexibility to gather data and minimize the reporting burden on providers.
- Continue working with health plans, providers and consumer advocates to develop a standardized reporting template to increase the comparability of data, reduce the resources necessary to standardize data, and allow for better analytics and comparisons of health plans' Timely Access Data.
- Continue to work with, and provide Timely Access Compliance Data to, the Office of the Patient Advocate (OPA) for incorporation into the OPA Quality of Care Report Card.
- Work with health plans, providers and consumer advocates to develop an acceptable rate of compliance that health plans must meet for provider appointment wait times. The DMHC acknowledges this will likely be a multi-year effort as 2016 is the first year the DMHC has been able to report any standardized data and compare the data across plans.

Conclusion

While the data for 2016 are significantly better than the data for 2015, the health plans still have to improve the accuracy and completeness of their Timely Access Compliance Data. For example, health plans should ensure that the sample size of providers is large enough to allow for more disaggregated reporting than is contained in this report (e.g., reporting non-physician mental health provider urgent and non-urgent appointments, or specialist urgent and non-urgent appointments) and still remain within the 5% sampling error.

The charts published in this year's report represent a large step forward in providing comparable data to the public and other interested parties. The DMHC will work with the health plans, providers and consumer advocates to further increase the usability of the Timely Access Data to develop an acceptable rate of compliance.

Know Your Health Care Rights: Timely Access to Care

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

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

DMHC Help Center:

The DMHC Help Center has provided assistance to over 2 million consumers to resolve problems with their health plans. As part of this assistance, the DMHC Help Center has assisted many people that have experienced difficulty obtaining a timely appointment with a provider.

Appendices

Appendix A: Timely Access Compliance Data Discrepancies & Analysis

The charts in this report include data for primary care providers (PCPs), specialists, ancillary providers, and mental health providers[14] for both urgent and non-urgent appointments. The data is presented separately for survey data and audit data. The majority of charts included in this report identify the percentage of appointments in which a provider indicated appointment availability within the wait-time standards set forth in the Knox-Keene Act (survey methodology). Other charts identify the percentage of booked appointments[15] in which the records indicated appointment availability within the wait time standards (audit methodology).

A number of data discrepancies identified in plan reports for 2016 affected the DMHC's analysis of the data. Those errors, including a description as to whether the analysis excluded, noted, or otherwise re-weighted the data in connection with the analysis, are discussed in this Appendix.

Data – Survey Methodology

The timely access rates were calculated from survey responses from provider groups and individual providers that contracted with health plans in 2016. The surveys identified whether the first available appointment with a provider fell within the timely access standards. Providers may have been surveyed multiple times if they contracted with more than one health plan. A provider could also be surveyed multiple times within a health plan, if the provider practiced in multiple locations or was associated with multiple provider groups.

Data – Audit Methodology

Kaiser Permanente utilized the audit methodology for its integrated network of providers and the telephone survey methodology for the health plan's external network of providers. In this report, Kaiser Permanente's audit data is discussed separately because the differences between the survey methodology (appointment availability checks) and the audit methodology (compliance calculations for appointments that occurred in the past) make the data non-comparable.

The audit methodology measures appointments from the date of the request to the date the appointment was scheduled or the date on which the appointment actually occurred. Sampling errors are not applicable to the audit methodology. However, the audit methodology utilized the same weighting principles (described below) as the survey data.

Overall Rate

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

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14 Specialists consist of allergists, dermatologists, cardiologists, and adult and child psychiatrists. Ancillary providers consist of MRI, mammography, and physical therapist providers. Mental health providers consist of non-physician mental health providers.

15 The provider appointment availability survey measures only a provider's next available appointment and does not take into account whether a provider has multiple appointments available within the appointment wait time standards. For example, the survey result would not differentiate between a provider with one timely appointment and a provider with 10 timely appointments.

Each chart includes the timely access rates and provides the "sampling error," or the range within which the analysis is 95 percent certain the actual rate falls given the sample size[16]. Sampling errors were calculated using a finite population correction. The variability in sampling errors resulted from the varying size in health plan networks as well as the degree to which target sample sizes were achieved.

Urgent Appointments

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

Non-Urgent Appointments

For non-urgent care appointments, the analysis created a weighted mean of the timely access rate across all health plan and provider groups, using as weights the number of providers within a county provider group. This means that a timely access rate for a health plan's provider group in a county with 100 providers receives a weight ten times the weight of a rate for a provider group with 10 providers. The resulting rates, which are then weighted by the number of providers (so as not to create an aggregated rate that is biased toward counties or product types with smaller numbers of providers), show the percentage of successful appointment requests within the standard for non-urgent appointments (non-urgent appointments must be offered within 10 or 15 days of the request depending on the provider type).

Ancillary Provider Calculations

In 2016, several health plans surveyed individual ancillary providers when the proper unit for these providers is ancillary service centers (e.g., the health plan surveyed a radiologist instead of an MRI imaging facility). As a result, the number of ancillary providers was not representative of the number of ancillary provider service centers within these health plan networks. Because the analysis weighted the calculation of rates by the number of providers (either service centers for ancillary providers or individuals for other provider types), failing to correct for this issue would lead to an over-representation of ancillary providers from these health plans in any measures that combine rates across provider types. To address this issue, the analysis counted the number of unique addresses for individual ancillary providers for health plans that sampled individuals. The analysis then used the number of unique address counts as a proxy for service center counts for weighting in the calculation of ancillary provider timely access rates.

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

2016 Data Issues

The validation process the DMHC required health plans to conduct identified numerous data issues. Though issues with the data were common, many of those issues did not impact results substantively. Some health plan provider type data points were excluded from the analysis due to reliability issues or concerns they would unduly skew timely access rate results. Some of the charts omit data for providers that were improperly surveyed. Issues that were deemed substantive and not correctable were also omitted from the charts. Additional information regarding excluded data is discussed below. Kaiser Permanente utilized both the audit methodology for its integrated providers and the survey methodology for its external providers. Kaiser Permanente's survey results are included in charts 1-5 and its audit results are shown separately in charts 10-13.

Excluded Data – Full Service Plans

Charts 1, 2 and 3:

- Care 1st Health Plan: Non-Physician Mental Health Provider Groups
  - These providers were excluded in the 2016 survey conducted by the health plan's survey vendor. The health plan provided some data for non-physician mental health providers who were individually contracted, but not all. This issue could bias results if the rates that were included for these providers were different than the rates of those omitted.
- Cigna HealthCare of California, Inc.: Mammogram Technicians
  - The health plan's data show substantial differences between the providers in the Mammography provider contact list and the providers in the survey results, and entire provider groups were missing from the results. Omission of provider groups could introduce bias.
- The Health Plan of San Joaquin: Non-Physician Mental Health Provider Groups
  - The health plan's Timely Access survey data excludes several large provider groups found in the contact list for non-physician mental health providers. While some missing providers would simply increase the sampling error (assuming the missing rates are random), the low sample number could introduce bias if the omitted provider groups have systematically different compliance rates.
- Health Plan of San Mateo: Specialists
  - More than 200 specialists were contacted for the survey, but only 10% of the specialists contacted were listed on the health plan's specialist contact list and in the raw data. Discrepancies in the survey data and contact list raised concern for bias and reliability.
- Seaside Health Plan: Ancillary Providers
  - The health plan did not survey any in-network ancillary providers, but included results for one non-network provider. The small, and inaccurate, sample is insufficient to compute a reliable rate.

Chart 5:

- Health Plan of San Mateo: Specialists
  - More than 200 specialists were contacted for the survey, but only 10% of the specialists contacted were listed on the health plan's specialist contact list and in the raw data. Discrepancies in the survey data and contact list raised concern for bias and reliability.

Excluded Data – Behavioral Health Plans

Charts 6, 8 and 9:

- Value Behavioral Health of CA: All Providers
  - This health plan conducted survey calls outside of the 2016 time frame and included surveys that were conducted in 2017 in its rate calculations. The rates are therefore inaccurate and unusable.
- Holman Professional Counseling Centers: All Providers
  - For this health plan, all contact occurred outside of the survey time frame. Thus, the survey results do not represent the plan's compliance with timely access standards for 2016.

Chart 7:

- Value Behavioral Health of CA: All Providers
  - This health plan conducted survey calls outside of the 2016 time frame and included surveys that were conducted in 2017 in its rate calculations. The rates are therefore inaccurate and unusable.
- Holman Professional Counseling Centers: All Providers
  - For this health plan, all contact occurred outside of the survey time frame. Thus, the survey results do not represent the plan's compliance with timely access standards for 2016.
- OptumHealth Behavioral Solutions of California: Urgent Care Rates
  - For this health plan, the data for urgent care rates had a sampling error greater than 5%. Thus, the plan's urgent care data was not included in the charts.

Data Issues Not Resulting in Exclusion of Data

- **Erroneous compliance calculations:**

  These errors include improperly including ineligible providers in the denominator of the compliance rate (deflating compliance rates) or miscellaneous calculation errors where calculations from raw data did not exactly match rates calculated for some county provider groups. For the calculation errors with a specific bias (either expected to inflate or deflate the compliance rate), the impact on the compliance rate was expected to be less than two percentage points, and was determined to be non-substantive.
- **Raw data omits information required for validation:**

  These issues included failure to identify whether providers refused to respond. There is no clear statistical impact, though this may raise a concern for reliability.
- **Total number of providers or target sample in provider group/IPA not calculated accurately:**

  These errors often resulted from de-duplication issues with the contact list, or an incomplete contact list. Since setting target sample size at the provider group level by county leads to low sampling errors at the plan level, failure to meet group/IPA target samples generally did not inflate sampling errors to an unacceptable level. Improper provider counts may produce weighting problems, and cause some providers to be over or under represented.

- **Contact list or survey data does not completely represent plan network:**

  This results from omission of provider groups or individual providers that appear in contact lists or networks but not in survey results. In most cases, this reduces reliability (increases sampling error), but still leads to acceptable sampling errors (5% or less) at the plan level. Where the omissions represent a substantial share of providers, the rates or the plan providers are dropped from the analysis.

- **Failure to survey or submit survey results for one or more provider types:**

  Rates for plans that failed to submit results for certain provider types may not accurately represent overall compliance rates. These plans are noted in the report.

- **Failure to separate results by product type or submit results for one or more product types:**

  To the extent that compliance rates differed by product type for a plan, plan-level results may not accurately represent overall rates for a plan. The results for these plans are noted as showing results only for certain product types.

- **Survey includes incorrect provider types:**

  This often occurred when non-physician or physician extenders were included in inapplicable results, such as the specialist results. This creates a weighting issue and potential bias to the extent that these providers have a compliance rate that differs from the specified provider types.

- **Survey timing:**

  Some surveys were conducted outside the measurement year, or plans failed to conduct two distinct surveys with at least a six-week separation. In cases where only a small number of surveys fell outside the measurement year, it was determined the results would not substantively impact results. For plans that did not allow a six week separation between surveys, it was determined that the time frame for the survey provided a sufficient representation of appointments over time.

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

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

DEPARTMENT OF
Managed
Health Care

Timely Access to Care

In California, health care consumers have the right to an appointment when needed.

The law requires health plans licensed by the DMHC to make providers available within specific geographic and time-elapsed standards. Health plans must ensure their network of providers, including doctors, can provide enrollees with an appointment within a specific number of days or hours.

Appointment Type	Time frame
Urgent Care (Prior authorization not required by health plan)	48 hours
Urgent Care (prior authorization required by health plan)	96 hours
Non-Urgent Doctor Appointment (primary care physician)	10 business days
Non-Urgent Doctor Appointment (specialty physician)	15 business days
Non-Urgent Mental Health Appointment (non-physician[1])	10 business days
Non-Urgent Appointment (ancillary provider[2])	15 business days

[1] Examples of non-physician mental health providers include counseling professionals, substance abuse professionals and qualified autism service providers.
[2] Examples of non-urgent appointment for ancillary services include lab work or diagnostic testing, such as mammogram or MRI, and reatment of an illness or injury such as physical therapy.

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

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

Health plans are required to provide (or arrange for) telephone triage or screening services on a 24/7 basis. Patients can get help to determine how urgent their condition is, including a return call within a reasonable timeframe, not to exceed 30 minutes.

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

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

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

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