Timely Access Report

Measurement Year 2014

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Prepared by the Department of Managed Health Care (DMHC)
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DMHC MISSION, VALUES & GOALS

MISSION

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

CORE VALUES

- Integrity
- Leadership
- Commitment to Service

GOALS

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

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Executive Summary

The Department of Managed Health Care (DMHC) protects consumers' health care rights and ensures a stable health care delivery system. As part of this mission, the DMHC licenses and regulates health care service plans (health plans) in California. Health plans are required to maintain provider networks that are sufficient to ensure that patients receive services within specified clinical and time-elapsed standards. Health plans must also follow wait time standards for telephone triage and responses to customer service inquiries. These requirements were adopted by the DMHC as part of its Timely Access Regulation.

Timely access to health care is essential to ensuring consumers get the care they need when they need it. In this report, the DMHC explains the different tools it uses to assess whether health plans have an adequate network of providers to ensure enrollees have timely access to care. These tools include assessing enrollees' geographic access to providers and reviewing physician-to-enrollee ratios. While standards for geographic access and physician-to-enrollee ratios are important factors in assessing whether provider networks are adequate, the true test of whether a health plan is meeting its commitment is whether a health plan enrollee can get an appointment with their provider within a reasonable period of time.

The DMHC is committed to ensuring health plan enrollees get needed care timely. Senate Bill (SB) 964 (Chapter 573, Statutes of 2014) gives the DMHC the authority, and the time, to develop a methodology that will ultimately standardize how plans report timely access data. Over the past two years, the DMHC has been working closely with stakeholders, including consumer advocates, health plans, provider organizations and other state departments, to develop such a methodology so that the DMHC is able to determine whether health plans are providing their enrollees with timely access to health care services. While the DMHC and the health plans have made significant progress in developing a standardized methodology, there is still work to be done. As this report shows, health plans vary greatly in how they categorize and report timely access data.

The Timely Access Regulation requires health plans to submit to the DMHC annual reports that include the plans' compliance rates for each time-specific standard during the previous calendar year. All timely access data submitted by health plans are self-reported, and attested to under penalty of perjury.

The DMHC's review of data for Measurement Year (MY) 2014 revealed significant improvements in the quality of data from previous years, as well as increased standardization in the gathering and reporting of data. However, since the data was gathered by health plans prior to the enactment of SB 964, health plans were not required to use a standardized methodology for MY 2014 data. As a result the data does not readily allow for comparison across and between plans.

In this report, the DMHC outlines its plan for changes that will improve future data and enable the Department to evaluate how well health plans are complying with timely access standards. The changes include requiring health plans to implement the standardized methodology for MY 2015, as authorized by SB 964, continuing to gather feedback from stakeholders to advance the methodology development, implementing changes to improve the methodology and reporting templates, and educating enrollees to make them aware of their rights to timely access to care.

The DMHC anticipates that the methodological changes described in this report will enable the DMHC to better understand how well plans are meeting the timely access standards and will allow consumers to be able to compare the health plans' results.

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 more than 1.7 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.

Introduction

The DMHC protects consumers' health care rights and ensures a stable health care delivery system. As part of this mission, the DMHC licenses and regulates health plans in California, including Qualified Health Plans (QHP) participating in Covered California and most Medi-Cal managed care plans, pursuant to the Knox-Keene Health Care Service Plan Act of 1975, as amended, ("Knox-Keene Act")[1] and the California Code of Regulations.[2]

In California, health plans provide health care services for plan enrollees through arrangements with providers. Health plan provider networks must be sufficient to ensure that covered health care services are available in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. Health plans must maintain provider networks with the capacity to offer appointments to enrollees within specific timeframes.[3]

In order to demonstrate compliance with established regulations concerning timely access, each health plan is required to submit to the DMHC an annual report that includes the rate of compliance with the time-elapsed standards for each contracted provider group in each county within the plan's service area.[4]

The DMHC reviews the annual reports, posts its final findings concerning the submitted data, and makes recommendations for changes that will improve enrollees' access to timely health care services. The DMHC also is collaborating with the Office of the Patient Advocate ("OPA") with the goal of incorporating plan-reported timely access compliance data into the OPA quality of care report card in the future.[5]

Report Overview

Section One of this report provides information concerning the timely access reporting process, including a discussion of the time-elapsed standards that are measured by health plans. This section also provides an overview of other regulatory activities conducted by the DMHC, all of which play a role in ensuring that health plans licensed by the DMHC maintain adequate provider networks.

Section Two provides an online link to a spreadsheet that contains the DMHC's timely access data submitted by California health plans for MY 2014 and summarizes the DMHC's findings from the data.

Section Three identifies the DMHC's next steps for changes in the timely access reporting process that will improve timely access data comparability and further protect enrollees health care rights.

Section Four responds to Frequently Asked Questions ("FAQ") about the spreadsheet that contains the timely access data for MY 2014, as well as the DMHC-established methodologies used by health plans to submit timely access data.

Section One: Timely Access and Network Adequacy Requirements

Assembly Bill 2179, (Chapter 797, Statutes of 2002), added Health and Safety Code Section 1367.03 to the Knox-Keene Act. It directed the DMHC to adopt standards to ensure that enrollees have access to needed health care services in a timely manner. The legislation directed the DMHC, in adopting its standards, to consider the following as indicators of timely access to care:

- Waiting times for appointments with providers;
- Timeliness of care in an episode of illness, including timeliness of referrals and obtaining other services; and,
- Waiting time to speak to a physician, registered nurse or other qualified health care professional acting within the scope of his or her practice that is trained to screen or triage an enrollee who may need care.

The statute also directed the DMHC to consider additional factors, including clinical appropriateness, nature of the specialty, urgency of the care needed, and other legal requirements in developing the standards for timely access.

Title 28, California Code of Regulations, Section 1300.67.2.2, Timely Access to Non-Emergency Health Care Services (referred to in this report as the "Timely Access Regulation" or "TAR") requires health plans to maintain provider networks that are adequate to meet specified clinical and time-elapsed standards in connection with the delivery of health care services to enrollees.

Evolution of Timely Access Reporting

The DMHC adopted the TAR in 2009, which became operative in 2010. Beginning in March 2012, health plans[6] were required to submit detailed annual reports, starting with MY 2011, to demonstrate compliance with the timely access standards set forth in statute and regulation which are meant to ensure health plan enrollees get needed care timely.

The findings from MY 2011 data were presented in the "Summary of Health and Mental Health Plan Compliance with the Timely Access Regulation Measurement Year 2011," published by the DMHC in August 2013. Analyses of health plans' timely access report submissions revealed that health plans used a variety of approaches to measure their individual compliance with timely access requirements. As a result, the DMHC could not compare compliance among the plans.

In February 2014, the DMHC held a series of meetings with health plans and outlined the DMHC's Timely Access Reporting Improvement Project. The DMHC provided health plans with a road map for the DMHC's goal of obtaining reliable and comparable timely access data for MY 2014 that would demonstrate whether plans are ensuring enrollees have timely access to appointments. The DMHC also shared a model methodology that health plans could use to survey providers when assessing appointment availability of providers in the health plans network. The model methodology included a set of survey questions and a detailed description for conducting the survey in a statistically reliable manner. However, health plans' use of the model methodology was voluntary, and not all health plans used it.

In late 2014, SB 964 amended the Timely Access Statute and authorized the DMHC

to develop a standardized methodology to create uniformity in health plan reporting. In order to develop this standardized timely access methodology, the DMHC held a series of stakeholder engagement meetings where health plans, provider representatives, and consumer advocates were invited to participate and comment on the DMHC's development of the standardized methodology. The standardized methodology for MY 2015 is based in large part on the model methodology that was created for MY 2014, but it also integrated improvements and standardization developed during the stakeholder engagement process. The standardized methodology for MY 2015 is published on the DMHC's public website, and all health plans must use it for MY 2015, which the health plans will report to the DMHC in 2016.

Under SB 964, the DMHC received a five-year exemption from the Administrative Procedures Act which gave the DMHC flexibility to specify, amend, and/or update the mandatory timely access methodology. At the end of the five-year period, any standardized methodology mandated by the DMHC must be set forth in a regulation. SB 964 also directed the DMHC to post on its website final findings from its review of health plan-reported data so consumers can assess health plans compliance with the timely access standards.

It is important to understand that the DMHC's final findings for MY 2014 (found in Section Two of this report) are based on data collected by health plans prior to the enactment of SB 964 and, as such, were gathered without using a mandatory standardized methodology (although many health plans did choose to follow part or all of the DMHC's model methodology for MY 2014).

The data submitted by a health plan through the timely access process are gathered by the health plan (or its contracted vendor) and self-reported to the DMHC. Health plans attest, under penalty of perjury, that the data are true and accurate. Upon receipt, the DMHC reviews the data for errors. The DMHC verifies the accuracy of the self-reported health plan data during routine medical surveys.

Know Your Health Care Rights: Timely Access To Care

Health Plans Must Provide Timely Access To Care And Interpreter Services

The law requires mandatory interpreter services to be coordinated with scheduled appointments for health care services in a manner that ensures interpreter services will be available at the time of the appointment.

The Timely Access Regulation does not change those rights, and a California enrollee must not be put in a position where they have to choose between receiving a timely appointment or required interpreter services. The health plan must meet both requirements.

If you are having trouble getting a timely appointment with interpreter services, you should first contact your health plan for assistance. If your health plan does not resolve the issue, or you are dissatisfied with your health plan's response, you should contact the DMHC Help Center for further assistance at **1-888-466-2219** or www.HealthHelp.ca.gov.

The Timely Access Regulation

The TAR requires each health plan to ensure its participating providers offer appointments that meet the standards described below. Additionally, each health plan's provider network must have sufficient capacity to ensure its providers can meet the following standards.

- Appointments for covered health care services must be provided, or arranged, in a manner that is clinically appropriate (i.e., a time period that is appropriate for the nature of the enrollee's condition, consistent with good professional practice).[7]

- In addition to ensuring compliance with the clinical appropriateness standard, each health plan must ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the timeframes[8] described in the table below.

- The applicable waiting time for an appointment may be shortened or extended as clinically appropriate in the opinion of a qualified health care professional acting within the scope their practice, consistent with professionally recognized standards of practice. If the waiting time is extended, it must be noted in the relevant patient record that a longer waiting time will not have a detrimental impact on the enrollee's health.[9]

- An annual assessment by the health plan of whether it identified any incidents of non-compliance with respect to the timely access appointment wait time standards that resulted in substantial harm to an enrollee, as well as any patterns of non-compliance, and if so, the corrective action taken to remedy patterns of non-compliance with the timely access appointment wait time standards.[10]

- A list of providers in the health plans' network that are designated as "advanced access" providers. These providers certify to the health plans that they can provide appointments on the same or next business day from the time an enrollee requests an appointment. Health plans must also include their policies and procedures for designating "advanced access" providers.[11]

Table 1: Timely Access Regulation Timeframes

Appointment Type	Timeframe
Urgent Care (prior authorization not required by health plan)	**48 hours from request**
Urgent Care (prior authorization required by health plan)	**96 hours from request**
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^)	**10 business days**
Non-Urgent Appointment (ancillary provider^^)	**15 business days**

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

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

The Timely Access Regulation, Cont.

- An annual assessment by the health plan of its use of triage, telemedicine, and health information technology to provide timely access to care.[12]

- An annual enrollee experience survey, developed using a statistically reliable methodology and designed to ascertain compliance with the timely access appointment wait time standards. Each health plan is permitted to develop its own standardized methodology for conducting this survey.[13]

- An annual provider survey, developed using a statistically reliable methodology that is designed to solicit, from physician and non-physician mental health providers their perspectives and concerns regarding health plans' compliance with the timely access appointment wait time standards. Each health plan is permitted to develop their own standardized methodology for conducting this survey.[14]

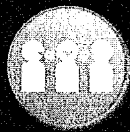
- Health plans must contract with adequate numbers of physicians and other health care providers in each geographic area to meet the clinical and time-elapsed standards for appointment waiting times detailed in Table 1 of this report.[15]

- A health plan operating in a service area that has a shortage of one or more types of providers must still ensure timely access to covered health care services. A health plan is required to refer enrollees to available and accessible contracted providers in neighboring service areas consistent with patterns of practice. In the case of a preferred provider network, the health plan is required to help enrollees locate available and accessible contracted providers in neighboring service areas.[16] When medically necessary for the enrollee's condition, a health plan is required to arrange for the provision of specialty services from a specialist outside of the plan's contracted network, if the type of specialist needed is unavailable within the plan's network.[17]

The TAR also requires health plans to ensure that enrollees have access to timely services through the following additional protections:

Health plans are required to provide (or arrange for the provision of) telephone triage or screening services on a 24/7 basis, through which patients can obtain timely assistance in determining the urgency of their condition, including a return call within a reasonable timeframe, not to exceed 30 minutes.[18]

During normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed 10 minutes.[19]



Interpreter services shall be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment.[20]

Provider Network Adequacy Oversight

The annual submission (and DMHC review) of health plan compliance reports regarding timely access to care is an important component of the DMHC's approach to ensuring enrollees have timely access to health care and health plan provider networks have the capacity to provide health care services to their enrollees. Timely access reporting is one component of the DMHC's comprehensive, integrated approach to network adequacy. The DMHC also conducts additional oversight activities.

When the DMHC finds a health plan out of compliance with network adequacy standards, the Department immediately works with the plan to correct the problem. A health plan that remains out of compliance is referred to the DMHC's Office of Enforcement. The following provides a brief description of how the DMHC ensures adequate health plan networks.

Table 2: DMHC Provider Network Oversight Activities

Provider Network Filings	The DMHC reviews a health plan's entire provider network through the new license application process. Additionally, the DMHC reviews networks when a licensed health plan wants to operate in a new area not previously approved, or has a significant change to its provider network (plus or minus 10 percent). The DMHC's review of provider networks includes examining the number and geographic location of primary care providers (PCPs), specialty physicians, hospitals, ancillary providers, and non-physician mental health professionals (including counseling professionals, substance abuse professionals, and qualified autism service providers) who will deliver services to plan enrollees. Health plans must take steps to address network adequacy issues and/or correct shortfalls in the network identified by the DMHC before the network is approved.
Alternate Geographic Access Evaluation	The Knox-Keene Act allows a health plan to request an alternate geographic access standard when it is unable to provide enrollee access to a PCP or a hospital within 15 miles or 30 minutes from where enrollees live or work (this occurs most frequently in rural areas of the state). The DMHC considers alternate geographic access requests in accordance with the numerous factors set forth in the regulation, including but not limited to analyses of established patterns of practice in the marketplace, as well as the existence of geographically closer providers.
Block Transfer Filings	When a health plan has a pending contract termination with a hospital or a provider group that would impact 2,000 or more enrollees, a health plan is required to obtain DMHC approval prior to taking such an action and transferring enrollees to different provider groups. Upon receipt of a block transfer filing from a health plan, the DMHC reviews the adequacy of the proposed alternate network and, in many cases, requires changes to ensure enrollees continue to have access to all required medically necessary services.
Medi-Cal Managed Care Health Plan Quarterly Reviews	The DMHC reviews network data and other information submitted by health plans participating in the Medi-Cal managed care program on a quarterly basis. This review ensures these networks continue to meet adequacy standards as well as requirements set forth in the health plan's contract with the California Department of Health Care Services (DHCS). The DMHC issues comments to the health plan and corrective actions are required where warranted.

Table 2: DMHC Provider Network Oversight Activities, Cont.

Annual Network Reviews	Pursuant to SB 964, the DMHC conducts an annual review of the network(s) used by each licensed health plan. To facilitate these reviews, health plans provide data regarding all contracted providers. The DMHC reviews the data for compliance with Knox-Keene Act network adequacy standards.
Consumer Complaints	Each year, the DMHC Help Center reviews thousands of health plan enrollee complaints. A team of health care analysts, nurses and attorneys review these complaints to determine whether the health plan is compliant with applicable provisions of the Knox-Keene Act. Complaints reviewed by the DMHC Help Center include network adequacy-related issues and provider balance billing issues, a number of which stem from an enrollee's inability to access medically necessary services. The DMHC Help Center also assists enrollees to obtain medically necessary services when they need them, and in accordance with TAR standards.
Routine Medical Surveys	The DMHC audits health plan operations through routine medical surveys that are conducted once every three years. A component of the medical surveys is an assessment of plan compliance with TAR standards. The DMHC reviews actions taken by a health plan's quality improvement committee in response to access and availability issues identified by the health plan, an enrollee, or the DMHC. Network adequacy issues also may be identified during the review of individual enrollee grievance and utilization management files that customarily occurs as a part of these on-site medical surveys. These surveys flag network adequacy issues including, but not limited to, findings related to compliance with timely access standards. The final report for each medical survey identifies deficiencies found by the DMHC, as well as health plan corrective actions.
Quarterly and Annual Financial Report Review	The DMHC receives quarterly and annual financial statements submitted by health plans and risk bearing organizations.[21] The DMHC looks at the timeliness of claims payments to providers and other claims-related information, which often serve as an early warning for potential network adequacy deficiencies or other access-related issues.
Enforcement Actions	The DMHC Office of Enforcement handles the DMHC's litigation matters by investigating alleged violations of the Knox-Keene Act. The Office of Enforcement prosecutes violators through administrative actions before the Director of the DMHC, the Office of Administrative Hearings, or in the California Superior Courts. When the DMHC finds Knox-Keene Act violations, including network adequacy standards, the DMHC Director has the authority to take appropriate actions, which may include assessing administrative penalties and issuing a cease and desist order.

Section Two: Findings for Measurement Year 2014

Under the Timely Access Statute, as amended in 2014, the DMHC is required to review information submitted by health plans regarding compliance with TAR standards and make recommendations for changes that will help ensure enrollees receive timely access to health care. The DMHC is required to post its final findings on its website.[22]

Timely Access Data for Measurement Year 2014

For MY 2014, health plans had the option to use the DMHC model methodology. However, not all health plans elected to use the model methodology, and some health plans that used the model methodology incorporated their own plan-specific changes to the model.

Health plans also had an option to use either an "audit methodology" or a "survey methodology" to report provider compliance with the timely access standards. The survey method is primarily prospective, utilizing survey questions to determine wait times by inquiring about a provider's next available appointment. The audit method is primarily retrospective, utilizing past provider scheduling records to determine actual wait times.

The data submitted by health plans for MY 2014 can be found online on the DMHC's website in Excel and Adobe Acrobat file formats at www.dmhc.ca.gov/TimelyAccess/.

MY 2014 data includes reporting for primary care providers; specialty physicians for the specialties of dermatology, cardiology, and allergy; psychiatrist and, other mental health providers. MY 2014 is the first year that plans are assessing timely access to appointments for specific specialty physicians, rather than just looking at timely access to specialty physicians in general. For example, in previous years, health plans reported one overall rate of compliance for specialty physicians. Given the many different types of specialty physicians, the DMHC's model methodology included survey questions that were targeted to the following specific physicians: dermatologists, cardiologists, allergists, and psychiatrists because they are common specialists sought by enrollees. In future years, the DMHC plans to rotate the different specialty physician types that are surveyed.

Information in the Excel spreadsheet is sortable by health plan, medical group, and rate of compliance. Users may click to identify a particular health plan, and then sort by provider group, to view compliance rates for that plan's providers. Users may also click to identify only those health plans that provide services in a particular county. In addition, users may sort data by rate of compliance for each of the TAR standards.

In coming years, when health plan data reporting is standardized, such a spreadsheet will allow users to compare health plan and provider compliance with TAR standards. However, because of the methodology problems discussed in this report, such comparisons are not possible for MY 2014 data.

Final Findings for Measurement Year 2014 Timely Access Data

1) There has been improvement in health plans' data collection techniques and in the types of data gathered over the past three years. As a result, the data submitted for MY 2014 is far more standardized than the data submitted for MY 2011.

2) Even with improvement in health plans' data collection there are still significant differences in data collection techniques and data gathered. This means that the MY 2014 data are not comparable across and between all licensed health plans.

3) Some plans either did not use or varied from the optional model methodology. Health plans' methods for calculating compliance rates varied significantly.

4) Health plans did not uniformly apply the standards and directions set forth in the model methodology.

5) Those health plans that chose to follow the model methodology appear to have variation both in how questions were asked and in how answers were received, therefore responses vary widely for some standards.

6) Confusion around some of the provider survey questions led to errors in the data reported.

7) Only one plan, Kaiser, used an audit methodology to calculate compliance. All other plans used a survey methodology.

Section Three: Next Steps for Changes to Timely Access Data

The DMHC is committed to ensuring health plan enrollees receive timely access to needed health care services. To that end, the DMHC will take the following steps to standardize health plan data, improve timely access to care for health plan enrollees, and address problem areas:

1) The DMHC will conduct outreach to educate enrollees on their rights to timely access to care both directly and through stakeholder partners.

2) The DMHC will continue to work with Covered California and the Department of Health Care Services to ensure the plans they contract with provide timely access to health care for their enrollees.

3) The DMHC will require all health plans to use the Standardized Methodology for MY 2015. SB 964 gives the DMHC the option to develop a standardized methodology that shall be used by plans for reporting. By increasing standardization the DMHC will gather better data to determine whether enrollees are receiving timely access to care.

4) The DMHC will continue to meet with stakeholders to solicit input regarding the TAR compliance process.

5) The DMHC will improve the template and standardized methodology including correcting the standardized model methodologies for MY 2016 to eliminate errors by health plans and streamlining the reporting of more accurate compliance data. This includes properly phrasing the survey questions to minimize confusion and variation in response.

6) The DMHC will provide guidance to health plans regarding DMHC expectations that all health plans will replace the survey methodology with the audit methodology for MY 2018.

7) The DMHC will continue to host training webinars that educate health plans and their vendors regarding reporting methodologies. Additionally, the DMHC will host training webinars that inform and educate medical groups, federally qualified health centers and other community clinics, groups that assist California health plan enrollees, individual physicians, other health care providers and other managed care industry personnel regarding timely access standards and the steps that enrollees can take to obtain a timely appointment to see their plan provider.

8) The DMHC will work with health plans to improve and standardize enrollee and provider surveys. The DMHC will incorporate the survey results into the annual provider network reviews being completed pursuant to SB 964 to improve the DMHC's overall assessment of whether health plans have sufficient providers to meet the needs of enrollees.

9) The DMHC will continue to collaborate with the OPA to incorporate timely access data into the OPA Quality of Care Report Card.

10) The DMHC will take enforcement action against plans that do not follow their own policies and procedures for determining compliance with the timely access standards.

11) Health plan reports of provider non-compliance with the timely access appointment wait time standards will be integrated into the DMHC's annual provider network reviews to assess whether health plans have sufficient providers to meet the needs of enrollees.

12) The DMHC will integrate health plan reports on how they utilize triage mechanisms, telemedicine, and health information technology to improve timely access to appointments into the annual provider network review process.

The DMHC expects that many of the issues with MY 2014 should be resolved for MY 2015, because all health plans must follow a standardized methodology. The DMHC will continue to educate health plans and improve the templates by which health plans report data to the DMHC.

Section Four: Frequently Asked Questions

1. What is the best way to view health plan timely access data?

The DMHC has made the data available in Excel and Adobe Acrobat PDF file format, and both can be downloaded from the DMHC website at www.dmhc.ca.gov/TimelyAccess/. The data can be printed from either format. Electronic viewing of the Excel file may allow for the easiest navigation, as the reader can sort and filter columns on the spreadsheet, in order to narrow results and focus on areas of interest.

2. Why didn't the DMHC require all health plans to use its model methodology for MY 2014?

The DMHC did not have the authority to mandate the use of a model methodology for MY 2014. SB 964 authorized the DMHC to require plans to use a standardized methodology. By the time this legislation was enacted, health plans had already implemented DMHC approved methodologies for measuring compliance for MY 2014. Use of the DMHC's standardized methodology will be required starting with MY 2015, the results for which will be reported to the DMHC on March 31, 2016.

3. Why isn't the data separated by health plan line of business?

SB 964 requires health plans to report separate timely access data for their commercial, Medi-Cal and individual/family lines of business. The DMHC's MY 2014 model methodology was developed in 2013, prior to enactment of SB 964. Accordingly, data for MY 2014 is not separated out by these different lines of business. Future standardized methodologies developed by the DMHC, beginning with MY 2015, will require plans to separately report timely access data by their commercial, Medi-Cal and individual/family plan lines of business.

4. Why does it appear in some cases that the reported compliance rates do not appear to align with the number of providers surveyed?

The "number of providers" surveyed represents the number of providers that responded to the survey within each medical group. This figure does not necessarily correlate with the number of providers that responded to each individual question. For instance, a provider that is not subject to prior authorization requirements may not respond to the questions regarding time frames for prior authorizations (as the questions were not applicable) but may still respond to the other questions in the survey. This provider would be included in the number of providers surveyed but would not be included in the answers regarding prior authorization. For MY 2016, health plans will be required to specify the number of providers who responded to each question, resulting in data that are easier to analyze and compare.

5. Are the specialist types reported the same for MY 2014 and MY 2015?

For MY 2015 health plans will continue to report on the specialties of Dermatology, Cardiology, and Allergy, and plans will also report on the newly added specialties of Psychiatry and Child Psychiatry. By surveying the same specialty physician types in both MY 2014 and MY 2015, the DMHC will be able to compare enrollees' experience in obtaining timely appointments to these commonly used specialty physician types.

6. Why are some columns blank?

For MY 2014, health plans provided data and other information in a variety of ways. The DMHC worked to create a template that captured the information in a clear, readable format. Columns where questions were not answered or were inapplicable were left blank.

7. How do I search for a specific health plan?

Health plans are listed by the name on the plan's DMHC license. However, some plans' data were not included because their data was too disparate to include. The DMHC is working closely with these plans to improve reporting for future years.

8. How were the provider group names selected?

The provider group names were self-reported by the health plans. The DMHC is working to develop a standardized list of provider group names to improve data consistency in future measurement years.

9. Sometimes plans did not meet the required sample sizes. Why did this occur?

Under the DMHC model methodology for MY 2014, if a provider did not respond to the survey, the health plan was allowed to use a replacement provider. If several providers did not respond, the plan may have run out of replacement providers for a particular medical group before reaching the required sample size. This will change in MY 2015. In MY 2015, if a provider declines to participate in the survey, that provider must be recorded as non-compliant for each item on the survey and may not be replaced.

10. How do the sample sizes affect the plan data?

In some cases health plans did not meet the specified sample sizes; therefore, the reported compliance rates may not portray an accurate representation of the total number of available providers within the medical group. Further, for MY 2014, if a provider declined to participate, the plan was permitted to replace the provider with another randomly selected provider. This could result in biased results (e.g. some providers who declined may have chosen to do so because they were not meeting the standards). This will change in MY 2015. If a provider refuses to participate, that provider must be recorded as non-compliant for each item listed on the survey.

11. Why are some compliance rates blank?

For MY 2014, if none of the providers from a provider group in a county responded to the survey, there is no compliance rate to calculate and so the space is left blank. For MY 2015, failure by a provider to respond will be counted as non-compliant, which should result in fewer blank responses in future years.

12. What is the difference between the survey methodology and the audit methodology?

The survey methodology is primarily prospective; utilizing survey questions to inquire about a provider's next available appointment to determine wait time. The audit methodology is primarily retrospective; utilizing provider scheduling records to determine actual wait times. The DMHC will require health plans to use an audit methodology to assess timely access to appointments by MY 2018.

13. Can you compare the data across plans?

The DMHC model methodology, used by many plans for MY 2014, improved the comparability of data across plans. However, there were still many differences in how plans gathered and reported data, which makes it difficult to accurately compare the MY 2014 data across and between health plans. As the DMHC moves toward finalization of the standardized methodology, comparability across plans should improve. The DMHC is also working to develop its standardized methodology in a way that will make data easier to search and use for parties interested in comparisons across the data.

14. I have ideas regarding how to improve the timely access methodology or the annual timely access report. Who should I contact?

The DMHC welcomes feedback and input from all stakeholders regarding improvements to the timely access methodology and/or the annual timely access report. Please contact the DMHC directly with comments at timelyaccess@dmhc.ca.gov.

Endnotes

Note: The Knox-Keene Act is codified at California Health and Safety Code (HSC) § 1340 et seq. The regulations promulgated from the Knox-Keene Act are codified at Title 28 of the California Code of Regulations (CCR) § 1000 et seq.

[1] HSC § 1340 et seq.

[2] 28 CCR § 1001 et seq.

[3] 28 CCR § 1300.67.2.2(a)(1);(a)(5)

[4] HSC § 1367.03(f)(2); 28 CCR § 1300.67.2.2(g)(2)

[5] HSC § 1367.03(h) and (i)

[6] All health care service plans that provide or arrange for the provision of hospital or physician services, including specialized mental health plans that provide physician or hospital services, or that provide mental health services pursuant to a contract with a full service plan, shall comply with the Timely Access Regulation requirements. Dental, vision, chiropractic, and acupuncture plans shall comply with specified sections of the Timely Access Regulation, but are not subject to the reporting requirements discussed herein.

[7] 28 CCR § 1300.67.2.2(c)(1)

[8] 28 CCR § 1300.67.2.2(c)(5)(A)-(F)

[9] 28 CCR § 1300.67.2.2(c)(5)(G)

[10] 28 CCR § 1300.67.2.2(g)(C)(2)

[11] 28 CCR § 1300.67.2.2(g)(D)

[12] 28 CCR § 1300.67.2.2(g)(E)

[13] 28 CCR § 1300.67.2.2(g)(F)

[14] 28 CCR § 1300.67.2.2(g)(F)

[15] 28 CCR § 1300.67.2.2(c)(5)&(7)

[16] 28 CCR § 1300.67.2.2(c)(7)(B)

[17] 28 CCR § 1300.67.2.2(c)(7)(B)

[18] 28 CCR § 1300.67.2.2

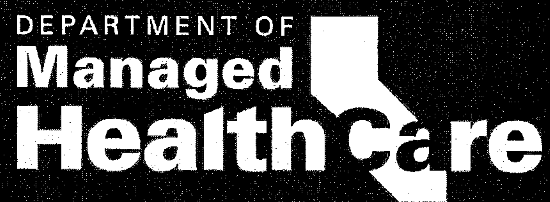
Endnotes, cont.

[19] 28 CCR § 1300.67.2.2(c)(10)

[20] 28 CCR § 1300.67.2.2(c)(4)

[21] Risk bearing organizations, or RBOs, are medical groups delegated by health plans to take on risk for claims payment to other professional providers, subject to requirements set forth in HSC § 1375.4.

[22] HSC § 1367.03(i)


DEPARTMENT OF
Managed
Health Care

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Timely Access To Care

In California, health care consumers have the right to receive timely access to care under health plans licensed by the California Department of Managed Health Care (DMHC). The law requires health plans to ensure their network of providers, including doctors, can see health plan members within a specific number of days or hours for certain types of appointments.

The Timely Access Regulation identifies the timeframes for certain types of appointments. The clock starts when the request for the appointment is made.

Appointment Type	Timeframe
Urgent Care (prior authorization <u>not</u> 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^)	**10 business days**
Non-Urgent Appointment (ancillary provider^^)	**15 business days**

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

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

Know Your Health Care Rights

In California, health plan members have many rights:

- **The right to choose your primary doctor**
- ***<u>The right to an appointment when you need one</u>***
- **The right to see a specialist when medically necessary**
- **The right to receive treatment for certain mental health conditions**
- **The right to get a second doctor's opinion**
- **The right to know why your plan denies a service or treatment**
- **The right to understand your health problems and treatments**
- **The right to see a written diagnosis (description of your health problem)**
- **The right to give informed consent when you have a treatment**
- **The right to file a complaint and ask for an Independent Medical Review**
- **The right to a copy of your medical records (you may be charged for the copying)**
- **The right to continue to see your doctor if they are no longer covered in your plan under certain circumstances (continuity of care)**

*Visit **www.HealthHelp.ca.gov** for more information.*
*If your health care rights have been violated contact the DMHC Help Center at **www.HealthHelp.ca.gov** or **1-888-466-2219***

The California Department of Managed Health Care protects consumers' health care rights and ensures a stable health care delivery system.

April 2016

DEPARTMENT OF Managed Health Care

Timely Access To Care

Know Your Health Care Rights: Timely Access to Care

Did Judy's Urgent Appointment Meet Timely Access To Care Standards?

Judy has a fever and a skin rash. She calls her doctor's office on Monday at 9 a.m., and describes her symptoms. The triage nurse explains her symptoms could represent a serious threat to her health and she should see the doctor right away. Judy is transferred back to the receptionist at her doctor's office and is told the doctor's schedule is very busy and there are no openings until Friday morning. Judy accepts the Friday appointment.

Did The Offered Appointment Meet Timely Access Standards? **No, it did not.**

The triage nurse concluded Judy needed an urgent appointment. Under the Timely Access Regulation, health plan provider networks must have the capacity to provide urgent primary care appointments within 48 hours. The appointment offered 5 days after the request did not meet the standard.

What Can Judy Do To Get An Earlier Appointment?

Judy should call her health plan, tell the representative that she needs to file a urgent grievance over the phone, and ask for assistance getting an earlier appointment. If she is unable to get the assistance she needs from her health plan, Judy should call the **DMHC Help Center** at **1-888-466-2219**.

Did Hector's Specialist Appointment Meet Timely Access To Care Standards?

Over the past several months Hector has experienced recurring indigestion and mild stomach pain. It isn't terribly painful, but it hasn't gone away. Last month, Hector's primary care physician prescribed a prescription medication for his condition. It helped a little but did not take care of the problem so his physician asked for authorization for Hector to see a specialist, Dr. Jackson who is a gastroenterologist.

On Tuesday, Hector received a letter from his medical group approving the referral. He immediately called Dr. Jackson's office. Although he was offered an appointment on Thursday afternoon, Hector has to go out of town on Thursday. The next available appointment is in four weeks. Hector accepts the appointment, even though it is nearly a month away.

Did The Offered Appointment With Dr. Jackson Meet Timely Access Standards? **Yes, it did.**

The standard for a non-urgent appointment with a specialist physician is 15 business days. The offered appointment met the timeliness standard. The fact that Hector's personal schedule prevents him from accepting the Thursday afternoon appointment does not mean that the health plan failed to comply with the Timely Access Regulation.