Date of Hearing: June 28, 2022

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
SB 225 (Wiener) – As Amended June 16, 2022

SENATE VOTE: 29-0

SUBJECT: Health care coverage: timely access to care.

SUMMARY: Requires a health care service plan (health plan) to incorporate timely access to care standards and processes into its quality assurance systems. Authorizes the Department of Managed Health Care (DMHC) to develop methodologies to demonstrate appointment wait time compliance and averages, take compliance or disciplinary action, review and adopt standards concerning the availability of health care to ensure enrollees have timely access to care, and make recommendations to the Legislature if it finds that health care service plans and providers have difficulty meeting the standards the department develops. Requires the DMHC Director to consider, as an aggravating factor when assessing administrative penalties, if harm to an enrollee has occurred as a result of plan noncompliance. Clarifies that the timely access to care provisions do not alter requirements or standards for Medi-Cal managed care (MCMC) plans, except as specified. Specifically, **this bill**:

1) Specifies that a plan operating in a network service area that has a shortage of one or more types of providers is required to ensure timely access to covered health care services as required by this bill, including applicable time-elapsed standards, by referring an enrollee to, or, in the case of a preferred provider network, by assisting an enrollee to locate available and accessible network providers in neighboring network service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs (existing law requires a plan to arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network if medically necessary for the enrollee's condition).

2) Requires a health plan to incorporate existing timely access standards into a plan's quality assurance systems.

3) Allows the DMHC to develop methodologies to demonstrate compliance with, and the average appointment wait time for, each class of dental appointments, as specified. Extends the Administrative Procedure Act (APA) exemption for the development and adoption of timely access regulations from July 1 to December 31, 2025.

4) Expands the definition of preventive care to include references to existing law with respect to minimum required coverage and comprehensive preventive care of children.

5) Authorizes the DMHC to take compliance or disciplinary action, including assessment of administrative penalties, on the basis of noncompliance with this bill, including timeframes for appointments and follow-up appointments.

6) Authorizes the DMHC to review and adopt standards, in addition to those specified in this bill, concerning the availability of primary care physicians, specialty physicians, hospital care, and other health care, so that consumers have timely access to care. Requires DMHC to

consider the nature of physician practices, including individual and group practices, as well as the nature of the plan network. Requires DMHC to also consider various circumstances affecting the delivery of care, including urgent care, care provided on the same day, and requests for specific providers. Authorizes the DMHC to make recommendations to the Assembly Committee on Health and the Senate Committee on Health, as specified, if the DMHC finds that health plans and health care providers have difficulty meeting these standards. Exempts the development and adoption of standards from the APA until December 31, 2028. Requires the DMHC to consult with stakeholders in developing the standards and methodologies.

7) Authorizes the DMHC Director to investigate and, by order, take enforcement action against plans, including, but not limited to, assessing administrative penalties subject to appropriate notice of, and the opportunity for, a hearing, as specified, regarding noncompliance. Requires the DMHC to consider, as an aggravating factor when assessing administrative penalties, if harm to an enrollee, including financial or health impacts to an enrollee or substantial harm as defined, has occurred as a result of plan noncompliance. Gives the DMHC Director the discretion to determine what constitutes harm to an enrollee. Allows the DMHC Director to consider patterns of noncompliance when taking enforcement action against a plan.

8) Applies provisions of this bill to a licensed health plan that provides services to Medi-Cal beneficiaries. Specifies that, except for appointment wait time standards, this bill does not alter the requirements or standards of the Department of Health Care Services (DHCS), as specified.

9) Makes other technical and conforming changes.

EXISTING LAW:

1) Establishes DMHC to regulate health plans and the California Department of Insurance (CDI) to regulate health insurers.

2) Establishes the federal Patient Protection and Affordable Care Act (ACA), which enacts various health care coverage market reforms including the availability of health insurance exchanges (exchanges) and new individual and small group products offered on and off the exchanges beginning 2014.

3) Requires health plans and health insurers providing health coverage in the individual and small group markets to cover, at a minimum, essential health benefits (EHBs), including the 10 EHB benefit categories in the ACA, as specified in state law, which include the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health (MH) and substance use disorder (SUD) services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and, pediatric services, including oral and vision care.

4) Requires health plans to provide basic health care services, including: physician services; hospital inpatient and ambulatory care services; diagnostic laboratory and diagnostic and therapeutic radiologic services; home health services; preventive health services; emergency health care services; and, hospice care.

5) Requires every health plan contract issued, amended, or renewed on or after January 1, 2021 to provide coverage for medically necessary treatment of MH and SUD under the same terms and conditions applied to other medical conditions, as specified.

6) Defines medically necessary treatment of MH or SUD as a service or product addressing the specific needs of that patient, for the purposes of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner as specified.

7) Requires health plans to ensure that all services be readily available at reasonable times to each enrollee consistent with good professional practice, and to the extent feasible, a health plan to make all services readily accessible to all enrollees consistent with existing law on timely access to health care services.

8) Requires, beginning July 1, 2022, a health plan and a health insurer, including a Medi-Cal Managed Care Plan, to ensure that an enrollee or insured that is undergoing a course of treatment for an ongoing MH or SUD condition is able to get a follow-up appointment with a nonphysician MH care or SUD provider within 10 business days of the prior appointment. Requires that a referral to a specialist by another provider meet the timely access standards. Requires the health plan, including a MCMC plan, to arrange coverage for the provision of specialty services from specialists outside the plan's contracted network if a health plan is operating in a service area that has a shortage of providers and is not able to meet the geographic and timely access standards for providing MH or SUD services with an in-network provider. Specifies that the development and adoption of standardized methodologies for timely access reporting is not subject to the APA, as specified, until July 1, 2025.

9) Establishes, in regulations, health plan quality assurance programs that must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

FISCAL EFFECT: This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, this bill is clean-up legislation that ensures the DMHC can effectively enforce SB 221 (Wiener), Chapter 724, Statutes of 2021, which codified timely access standards for follow-up appointments. The existing timely access statute uses more limited terminology to refer to the health care providers in a health plan’s network, which inadvertently limits the applicability of SB 221’s follow-up appointment standards. The follow-up appointment standards added by SB 221 also do not apply to specific preventative care required for children and adolescents. Furthermore, the existing statute implies that the DMHC’s enforcement authority is limited to assessing administrative penalties. Moreover, the APA waiver provided to the DMHC to develop reporting methodologies does not provide the DMHC with enough time to test the efficacy of the methodologies. The author concludes that this bill remedies this by updating relevant terminology and clarifying the DMHC’s enforcement authority.

2) BACKGROUND.

a) Existing Network Adequacy Requirements. California law sets forth various network adequacy requirements on health plans and insurers. For example, health plans are subject to the following:

i) Timely Access. Timely Access Laws and 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 requirements generally include the following standards for appointment availability and are codified in SB 221:

(1) Urgent care without prior authorization: within 48 hours;
(2) Urgent care with prior authorization*:* within 96 hours;
(3) Non-urgent primary care appointments: within 10 business days;
(4) Non-urgent specialist appointments: within 15 business days;
(5) Non-Urgent mental health appointments: within 15 business days for psychiatrist, within 10 business days for non-physician mental health provider;
(6) Non-urgent follow up appointments for nonphysician MH care or SUD providers within 10 business days of the prior appointment; and,
(7) Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness or other health condition: within 15 business days.

Existing regulations also authorize the applicable waiting time for a particular appointment to be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee.

ii) Timely Access Report. DMHC recently published its Timely Access Report for Measurement Year 2020 and the key findings are as follows:

(1) Full Service Health Plans: For non-urgent and urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 98% to a low of 53%. For non-urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 98% to a low of 69%. For urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 97% to a low of 35%.
(2) Behavioral Health Plans: For non-urgent and urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 79% to a low of 75%. For non-urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 88% to a low of 83%. For urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 72% to a low of 64%.

iii) SB 221. The author provided information that this bill is clean-up legislation that ensures the DMHC can effectively enforce SB 221 (Wiener), Chapter 724, Statutes of 2021. In 2021, SB 221 codified timely access standards set forth above for follow-up appointments, including appointments with non-physician MH and SUD providers. In 2021, the DMHC also promulgated a robust regulation which requires health plans to provide the DMHC with annual data to prove that they are complying with the timely access and network adequacy laws. This bill addresses two issues:

(1) SB 221 uses more limited terminology to refer to the health care providers in a health plan's network, which inadvertently limits the applicability of SB 221's follow-up appointment standards. The follow-up appointment standards added by SB 221 also do not apply to specific preventative care required for children and adolescents, as the statute does not cross reference preventative care described elsewhere in existing law. This bill will update the terminology in the timely access statutes to align with the DMHC's timely access and annual network reporting regulation, thereby allowing the DMHC to enforce the follow-up appointment standards in all situations. This bill will amend the definition of "preventative care" to ensure that the follow-up appointment standards apply to specific preventative care required for children and adolescents; and,

(2) SB 221 implies that the DMHC's enforcement authority is limited to assessing administrative penalties. Moreover, the APA waiver provided to the DMHC to develop reporting methodologies does not provide the DMHC with enough time to test the efficacy of the methodologies. This bill will clarify the DMHC's enforcement authority and allow the DMHC to consider patterns of a health plan's noncompliance with the timely access standards when taking an enforcement action against a health plan. Finally, this bill will extend the DMHC's APA waiver to 2027, which will allow the DMHC time to test the complex annual reporting methodology over multiple reporting cycles, resulting in a more effective final methodology.

3) SUPPORT. The Center for Autism and Related Disorders writes that this bill updates to the definition of "preventative care" to include the most recent recommendations by the American Academy of Pediatrics. This change ensures that follow-up appointment standards apply to autism screenings. In addition, this bill strengthens DMHC's enforcement authority by allowing them to consider patterns of noncompliance.

4) PREVIOUS LEGISLATION.

a) SB 221 codifies existing timely access to care standards for health plans and health insurers, applies these requirements to MCMC plans, adds a standard for non-urgent follow-up appointments for nonphysician MH care or SUD providers that is within 10 business days of the prior appointment.

b) SB 855 revises and recasts California's Mental Health Parity provisions, and requires a health plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of MH and SUD, as defined, under the same terms and conditions applied to other medical conditions and prohibits a health plan or disability insurer from limiting benefits or

coverage for MH and SUD to short-term or acute treatment. Specifies that if services for the medically necessary treatment of a MH and SUD are not available in network within the geographic and timely access standards in existing law, the health plan or insurer is required to arrange coverage to ensure the delivery of medically necessary out of network services and any medically necessary follow up services, as specified.

c) SB 964 (Hernandez), Chapter 573, Statutes of 2014, requires a health plan to annually report specified network adequacy data, as specified, to DMHC as a part of its annual timely access compliance report, and requires DMHC to review the network adequacy data for compliance.

d) AB 2179 (Cohn), Chapter 797, Statutes of 2002, requires DMHC and CDI to develop and adopted regulations to ensure that enrollees have access to needed health care services.

5) AUTHOR'S AMENDMENTS. The author proposes the following amendments,

a) Add parallel provisions in the Insurance Code to address technical assistance from CDI;

b) Make clarifications to address the following:

i) To ensure plans understand that they must incorporate timely access requirements standards into every aspect of their quality assurance systems and processes; and,

ii) To specify that this bill does not in any way limit the scope of the DMHC's authority to take compliance or disciplinary action as it determines, and that noncompliance with any of the provisions, including but not limited to timeframes, has standing as a factor in the DMHC's determinations

REGISTERED SUPPORT / OPPOSITION:

Support

Center for Autism and Related Disorders

Opposition

None on file.

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