AMENDED IN ASSEMBLY AUGUST 4, 2014

AMENDED IN ASSEMBLY JULY 1, 2014

AMENDED IN SENATE APRIL 9, 2014

SENATE BILL No. 964

Introduced by Senator Hernandez

February 10, 2014

An act to amend Section 1367.03 of, to add ~~Sections 1380.4, 1380.5,1380.6, and 1380.7~~ *Section 1367.035* to, and to repeal *and add* Section 1380.3 of, the Health and Safety Code, and to *amend Section 14456 of, and to* add Section 14456.3 ~~to~~ *to,* the Welfare and Institutions Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 964, as amended, Hernandez. Health care coverage.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care *(DMHC)* and makes a willful violation of the act a crime. Existing law requires ~~the department~~ *DMHC* to adopt standards for timeliness of access to care and requires that contracts between health care service plans and providers ensure compliance with those standards. Existing law requires health care service plans to annually report to ~~the department~~ *DMHC* on compliance with those standards in a manner specified by ~~the department~~ *DMHC*. Under existing law, every 3 years, ~~the department~~ *DMHC* is required to review information regarding compliance with those standards and make recommendations for changes that further protect enrollees.

This bill would ~~instead require the department to conduct that review annually. The bill would also require health care service plans, in making reports to the department on compliance with the timeliness standards, to use standardized survey methodology if developed by the department~~ *authorize DMHC to develop standardized methodologies to be used by plans in making the reports on compliance with the timeliness standards, as specified, and would make the development and adoption of those methodologies exempt from the Administrative Procedure Act until January 1, 2020. The bill would require DMHC to annually review information regarding compliance with the timeliness standards and to post its findings from the reviews, and any waivers or alternative standards approved by DMHC, on its Internet Web site. The bill would also require a health care service plan to annually, commencing March 1, 2015, submit data regarding network adequacy to DMHC, as specified, and would require DMHC to review that data for compliance with the Knox-Keene Act and post its findings from that review on its Internet Web site*. Because a violation of ~~that requirement~~ *the requirements imposed on health care service plans* would be a crime, the bill would impose a state-mandated local program.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services *(DHCS)*, under which qualified low-income individuals receive health care services. One of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed health care plans. ~~Existing law establishes the California Health Benefit Exchange for the purpose of facilitating the enrollment of qualified individuals and small employers in qualified health plans.~~ *Existing law requires DHCS to conduct annual medical audits of specified managed care plans and requires that these reviews be scheduled and carried out jointly with reviews carried out pursuant to the Knox-Keene Act.* The Knox-Keene Act requires ~~the department~~ *DMHC* to periodically conduct an onsite medical survey of the health delivery system of each health care service plan and exempts a plan that provides services solely to Medi-Cal beneficiaries from the survey upon submission to ~~the department~~ *DMHC* the medical ~~survey~~ audit conducted by ~~the State Department of Health Care Services~~ *DHCS* as part of the Medi-Cal contracting process.

This bill would eliminate that exemption~~, would require a plan that provides services to Medi-Cal beneficiaries and a plan that provides services to enrollees in the California Health Benefit Exchange to be surveyed by those product lines distinct from other product lines and~~

~~to be annually reviewed with respect to those product lines for compliance with accessibility and availability of services, continuity of care, and quality management, as specified. The bill would also require a plan that provides services to Medi-Cal beneficiaries through specified programs to be surveyed annually with respect to the populations enrolled in those products until 5 years after completion of initial enrollment in those products, as specified. The bill~~ *and* would require ~~the department~~ *DMHC* to coordinate ~~these surveys and reviews~~ *the surveys* conducted with respect to Medi-Cal managed care plans with ~~the State Department of Health Care Services~~ *DHCS, to the extent possible*, provided that the coordination does not result in a delay of the surveys ~~or reviews~~ or the failure of ~~the department~~ *DMHC* to conduct the ~~surveys or reviews.~~ *surveys.*

This bill would also require ~~the State Department of Health Care Services to post its medical survey audit findings of Medi-Cal managed care plans on its Internet Web site~~ *DHCS to publicly report its medical audit findings as soon as possible, as specified,* and to share those findings and other information with respect to Knox-Keene plans with ~~the Department of Managed Health Care~~ *DMHC. The bill would specify that any preliminary audit findings shared with DMHC under this provision would be exempt from disclosure under the California Public Records Act*.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1367.03 of the Health and Safety Code
2 is amended to read:

1 1367.03. (a) Not later than January 1, 2004, the department
2 shall develop and adopt regulations to ensure that enrollees have
3 access to needed health care services in a timely manner. In
4 developing these regulations, the department shall develop
5 indicators of timeliness of access to care and, in so doing, shall
6 consider the following as indicators of timeliness of access to care:
7 (1) Waiting times for appointments with physicians, including
8 primary care and specialty physicians.
9 (2) Timeliness of care in an episode of illness, including the
10 timeliness of referrals and obtaining other services, if needed.
11 (3) Waiting time to speak to a physician, registered nurse, or
12 other qualified health professional acting within his or her scope
13 of practice who is trained to screen or triage an enrollee who may
14 need care.
15 (b) In developing these standards for timeliness of access, the
16 department shall consider the following:
17 (1) Clinical appropriateness.
18 (2) The nature of the specialty.
19 (3) The urgency of care.
20 (4) The requirements of other provisions of law, including
21 Section 1367.01 governing utilization review, that may affect
22 timeliness of access.
23 (c) The department may adopt standards other than the time
24 elapsed between the time an enrollee seeks health care and obtains
25 care. If the department chooses a standard other than the time
26 elapsed between the time an enrollee first seeks health care and
27 obtains it, the department shall demonstrate why that standard is
28 more appropriate. In developing these standards, the department
29 shall consider the nature of the plan network.
30 (d) The department shall review and adopt standards, as needed,
31 concerning the availability of primary care physicians, specialty
32 physicians, hospital care, and other health care, so that consumers
33 have timely access to care. In so doing, the department shall
34 consider the nature of physician practices, including individual
35 and group practices as well as the nature of the plan network. The
36 department shall also consider various circumstances affecting the
37 delivery of care, including urgent care, care provided on the same
38 day, and requests for specific providers. If the department finds
39 that health care service plans and health care providers have
40 difficulty meeting these standards, the department may make

1 recommendations to the Assembly Committee on Health and the
2 Senate Committee on Insurance of the Legislature pursuant to
3 subdivision (i).
4 (e) In developing standards under subdivision (a), the department
5 shall consider requirements under federal law, requirements under
6 other state programs, standards adopted by other states, nationally
7 recognized accrediting organizations, and professional associations.
8 The department shall further consider the needs of rural areas,
9 specifically those in which health facilities are more than 30 miles
10 apart and any requirements imposed by the State Department of
11 Health Care Services on health care service plans that contract
12 with the State Department of Health Care Services to provide
13 Medi-Cal managed care.
14 (f) (1) Contracts between health care service plans and health
15 care providers shall ensure compliance with the standards
16 developed under this section. These contracts shall require
17 reporting by health care providers to health care service plans and
18 by health care service plans to the department to ensure compliance
19 with the standards.
20 (2) Health care service plans shall report annually to the
21 department on compliance with the standards in a manner specified
22 by the department. The reported information shall allow consumers
23 to compare the performance of plans and their contracting providers
24 in complying with the standards, as well as changes in the
25 compliance of plans with these standards.
26 ~~(3) In making reports to the department pursuant to this~~
27 ~~subdivision, health care service plans shall use standardized survey~~
28 ~~methodology if developed by the department.~~
29 *(3) The department may develop standardized methodologies*
30 *for reporting that shall be used by health care service plans to*
31 *demonstrate compliance with this section and any regulations*
32 *adopted pursuant to it. The methodologies shall be sufficient to*
33 *determine compliance with the standards developed under this*
34 *section for different networks of providers if a health care service*
35 *plan uses a different network for Medi-Cal managed care products*
36 *than for other products or if a health care service plan uses a*
37 *different network for individual market products than for small*
38 *group market products. The development and adoption of these*
39 *methodologies shall not be subject to the Administrative Procedure*
40 *Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of*

Division 3 of Title 2 of the Government Code) until January 1, 2020. The department shall consult with stakeholder groups in developing standardized methodologies under this paragraph.

(g) (1) When evaluating compliance with the standards, the department shall focus more upon patterns of noncompliance rather than isolated episodes of noncompliance.

(2) The director may investigate and take enforcement action against plans regarding noncompliance with the requirements of this section. Where substantial harm to an enrollee has occurred as a result of plan noncompliance, the director may, by order, assess administrative penalties subject to appropriate notice of, and the opportunity for, a hearing in accordance with Section 1397. The plan may provide to the director, and the director may consider, information regarding the plan's overall compliance with the requirements of this section. The administrative penalties shall not be deemed an exclusive remedy available to the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45. The director shall periodically evaluate grievances to determine if any audit, investigative, or enforcement actions should be undertaken by the department.

(3) The director may, after appropriate notice and opportunity for hearing in accordance with Section 1397, by order, assess administrative penalties if the director determines that a health care service plan has knowingly committed, or has performed with a frequency that indicates a general business practice, either of the following:

(A) Repeated failure to act promptly and reasonably to assure timely access to care consistent with this chapter.

(B) Repeated failure to act promptly and reasonably to require contracting providers to assure timely access that the plan is required to perform under this chapter and that have been delegated by the plan to the contracting provider when the obligation of the plan to the enrollee or subscriber is reasonably clear.

(C) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed warranted by the director to enforce this chapter.

1 (4) The administrative penalties shall be paid to the Managed
2 Care Administrative Fines and Penalties Fund and shall be used
3 for the purposes specified in Section 1341.45.
4 (h) The department shall work with the patient advocate to
5 assure that the quality of care report card incorporates information
6 provided pursuant to subdivision (f) regarding the degree to which
7 health care service plans and health care providers comply with
8 the requirements for timely access to care.
9 (i) The department shall annually review information regarding
10 compliance with the standards developed under this section and
11 shall make recommendations for changes that further protect
12 enrollees. *Commencing no later than December 1, 2015, and*
13 *annually thereafter, the department shall post its findings from*
14 *the review on its Internet Web site.*
15 *(j) The department shall post on its Internet Web site any*
16 *waivers or alternative standards that the department approves*
17 *under this section on or after January 1, 2015.*
18 *SEC. 2. Section 1367.035 is added to the Health and Safety*
19 *Code, to read:*
20 *1367.035. (a) Commencing March 1, 2015, and annually*
21 *thereafter, a health care service plan shall submit to the*
22 *department, in a manner specified by the department, data*
23 *regarding network adequacy, including, but not limited to, the*
24 *following:*
25 *(1) Provider location.*
26 *(2) Area of specialty.*
27 *(3) Provider admitting privileges.*
28 *(4) Providers with open practices.*
29 *(5) Provider patient capacity.*
30 *(6) The number of patients assigned to a provider.*
31 *(7) Complaints regarding network adequacy and timely access*
32 *that the health care service plan received during the preceding*
33 *year.*
34 *(b) A health care service plan that uses a network for its*
35 *Medi-Cal managed care product line that is different from the*
36 *network used for its other product lines shall submit the data*
37 *required under subdivision (a) for its Medi-Cal managed care*
38 *product line separately from the data submitted for its other*
39 *product lines.*

(c) A health care service plan that uses a network for its individual market product line that is different from the network used for its small group market product line shall submit the data required under subdivision (a) for its individual market product line separate from the data submitted for its small group market product line.

(d) The department shall review the data submitted pursuant to this section for compliance with this chapter and the regulations adopted thereunder. The department shall post its findings from that review on its Internet Web site.

(e) In collecting data under this section, the department shall maximize the use of all relevant existing reports and information already submitted to the department by a plan and, if applicable, the outcomes of medical audits and monthly provider files provided to the department by the State Department of Health Care Services pursuant to Section 14456.3 of the Welfare and Institutions Code. This subdivision does not limit the authority of the department to request additional information from the plan as deemed necessary to carry out and complete any enforcement action initiated under this chapter.

~~SEC. 2.~~

SEC. 3. Section 1380.3 of the Health and Safety Code is repealed.

~~SEC. 3. Section 1380.4 is added to the Health and Safety Code, to read:~~

~~1380.4. A plan that provides services to Medi-Cal beneficiaries pursuant to Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code shall do both of the following:~~

~~(a) Be surveyed under Section 1380 by its Medi-Cal managed care product lines distinct from its other product lines, if any, in order to determine whether the services received by Medi-Cal beneficiaries comply with the requirements of this chapter.~~

~~(b) (1) Be annually reviewed, with respect to its Medi-Cal managed care product lines, for compliance with all of the following:~~

~~(A) Accessibility and availability of services, including network adequacy and timely access to care.~~

~~(B) Continuity of care.~~

~~(C) Quality management.~~

~~(2) This subdivision shall not be construed to require an onsite survey in addition to the survey required by Section 1380.~~

~~(3) The department may conduct the annual review required by this subdivision through telephonic or other means and is not required to perform the review onsite, unless the director determines that an onsite review is necessary.~~

~~(4) In conducting the annual review required by this subdivision, the department shall maximize the use of all relevant existing reports and information already submitted to the department by the plan and, if applicable, the outcomes of medical survey audits and monthly provider files provided to the department by the Department of Health Care Services pursuant to Section 14456.3 of the Welfare and Institutions Code. This paragraph shall not limit the authority of the department to request additional information from the plan as deemed necessary to carry out and complete the annual review required by this subdivision and any enforcement action initiated as a result of the review.~~

~~SEC. 4. Section 1380.5 is added to the Health and Safety Code, to read:~~

~~1380.5. (a) A plan that provides services to enrollees in the California Health Benefit Exchange pursuant to Title 22 (commencing with Section 100500) of the Government Code shall do both of the following:~~

~~(1) Be surveyed under Section 1380 by its product lines sold through the Exchange distinct from its product lines sold outside the Exchange, if any, in order to determine whether the services received by the Exchange enrollees comply with the requirements of this chapter.~~

~~(2) (A) Be annually reviewed, with respect to its product lines sold through the Exchange, for compliance with all of the following:~~

~~(i) Accessibility and availability of services, including network adequacy and timely access to care.~~

~~(ii) Continuity of care.~~

~~(iii) Quality management.~~

~~(B) This paragraph shall not be construed to require an onsite survey in addition to the survey required by Section 1380.~~

~~(C) The department may conduct the annual review required by this paragraph through telephonic or other means and is not~~

~~required to perform the review onsite, unless the director determines that an onsite review is necessary.~~

~~(D) In conducting the annual review required by this paragraph, the department shall maximize the use of all relevant existing reports and information already submitted to the department by the plan and, if applicable, the outcomes of medical survey audits and monthly provider files provided to the department by the Department of Health Care Services pursuant to Section 14456.3 of the Welfare and Institutions Code. This subparagraph shall not limit the authority of the department to request additional information from the plan as deemed necessary to carry out and complete the annual review required by this paragraph and any enforcement action initiated as a result of the review.~~

~~(b) This section shall not apply to either of the following:~~

~~(1) A plan that uses the same network for its product lines sold in the individual and small group markets through the Exchange as the network used for its product lines sold in the individual and small group markets outside the Exchange.~~

~~(2) A plan that uses the same network for its product lines sold through the Exchange as the network used for its Medi-Cal managed care product lines.~~

~~SEC. 5. Section 1380.6 is added to the Health and Safety Code, to read:~~

~~1380.6. A plan that enrolls Medi-Cal beneficiaries as a result of any of the following shall be surveyed annually under Section 1380 with respect to the populations enrolled in those products until five years after the completion of initial enrollment under those products:~~

~~(a) The transition of Healthy Families Program enrollees to the Medi-Cal program pursuant to Chapter 16.2 (commencing with Section 12694.1) of Part 6.2 of Division 2 of the Insurance Code.~~

~~(b) Article 2.82 (commencing with Section 14087.98) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.~~

~~(c) Section 14182 of the Welfare and Institutions Code.~~

~~(d) Sections 14182.16 and 14182.17, or Section 14132.275, of the Welfare and Institutions Code.~~

~~SEC. 6.~~

SEC. 4. Section ~~1380.7~~ *1380.3* is added to the Health and Safety Code, to read:

~~1380.7.~~

1380.3. The department shall coordinate the surveys ~~and reviews~~ conducted pursuant to ~~Sections 1380.4 and 1380.6~~ *Section 1380* with the State Department of Health Care Services*, to the extent possible,* in order to allow for simultaneous oversight of Medi-Cal managed care plans by both departments, provided that this coordination does not result in a delay of the surveys ~~or reviews~~ required under ~~Sections 1380.4and 1380.6~~ *Section 1380* or in the failure of the department to conduct those surveys ~~or reviews~~.

SEC. 5. Section 14456 of the Welfare and Institutions Code is amended to read:

14456. The department shall conduct annual medical audits of each prepaid health plan unless the director determines there is good cause for additional reviews.

The reviews shall use the standards and criteria established pursuant to the Knox-Keene Health Care Service Plan Act of 1975, ~~or to Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code,~~ as appropriate. Except in those instances where major unanticipated administrative obstacles prevent, or after a determination by the director of good cause, the reviews shall be scheduled and carried out jointly with reviews carried out pursuant to the Knox-Keene Health Care Service Plan Act of 1975, ~~or to Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code, as appropriate,~~ if reviews ~~under either act~~ will be carried out within time periods which satisfy the requirements of federal law.

The department shall be authorized to contract with professional organizations or the Department of Managed Health ~~Care or the Department of Insurance,~~ *Care,* as appropriate, to perform the periodic review required by this section. The department, or its designee, shall make a finding of fact with respect to the ability of the prepaid health plan to provide quality health care services, effectiveness of peer review, and utilization control mechanisms, and the overall performance of the prepaid health plan in providing health care benefits to its enrollees.

The director shall publicly report the findings of annual medical audits conducted pursuant to this section as soon as possible but no later than 90 days following completion of any corrective action plan initiated pursuant to the audit unless the director determines,

in his or her discretion, that additional time is reasonably necessary to fully and fairly report the results of the audit.

~~SEC. 7.~~

SEC. 6. Section 14456.3 is added to the Welfare and Institutions Code, to read:

14456.3. (a) The department shall share with the Department of Managed Health Care its findings from medical ~~survey~~ audits and monthly provider files of a Medi-Cal managed care plan that provides services to Medi-Cal beneficiaries pursuant to Chapter 7 (commencing with Section 14000) or this chapter and is subject to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(b) To the extent that the department communicates its preliminary investigative audit findings to the Department of Managed Health Care under subdivision (a), those communications shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

~~(b) The department shall post on its Internet Web site its findings from medical survey audits of a Medi-Cal managed care plan that provides services to Medi-Cal beneficiaries pursuant to Chapter 7 (commencing with Section 14000) or this chapter.~~

SEC. 7. The Legislature finds and declares that Section 6 of this act, which adds Section 14456.3 to the Welfare and Institutions Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

In order to ensure the confidentiality of preliminary investigative findings disclosed by the State Department of Health Care Services to the Department of Managed Health Care pursuant to this act, the limitation on the public's right of access to those files is necessary.

SEC. 8. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or

1 infraction, eliminates a crime or infraction, or changes the penalty
2 for a crime or infraction, within the meaning of Section 17556 of
3 the Government Code, or changes the definition of a crime within
4 the meaning of Section 6 of Article XIII B of the California
5 Constitution.

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