AMENDED IN ASSEMBLY AUGUST 18, 2014

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 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, 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 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 DMHC on compliance with those standards in a manner specified by DMHC. Under existing law, every 3 years, DMHC is required to review information regarding compliance with those standards and make recommendations for changes that further protect enrollees.

This bill would 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,~~ *plan, as part of the annual reports, to* 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.~~ *Act. The bill would require, if DMHC requests additional information to be reported, that the department provide health care service plans with notice of the change by November 1 of the year prior to the change. The bill would also require a health care service plan that provides services to Medi-Cal beneficiaries to provide the report data to the State Department of Health Care Services.* Because a violation of 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 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 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 DMHC the medical audit conducted by DHCS as part of the Medi-Cal contracting process.

This bill would eliminate that exemption and would require DMHC to coordinate the surveys conducted with respect to Medi-Cal managed care plans with DHCS, to the extent possible, provided that the coordination does not result in a delay of the surveys or the failure of DMHC to conduct the surveys.

This bill would also require DHCS to publicly report its *findings of finalized* medical ~~audit findings~~ *audits* as soon as possible, as specified, and to share those findings and other information with respect to Knox-Keene plans with 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:

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

1367.03. (a) Not later than January 1, 2004, the department shall develop and adopt regulations to ensure that enrollees have access to needed health care services in a timely manner. In developing these regulations, the department shall develop indicators of timeliness of access to care and, in so doing, shall consider the following as indicators of timeliness of access to care:

(1) Waiting times for appointments with physicians, including primary care and specialty physicians.

(2) Timeliness of care in an episode of illness, including the timeliness of referrals and obtaining other services, if needed.

(3) Waiting time to speak to a physician, registered nurse, or other qualified health professional acting within his or her scope of practice who is trained to screen or triage an enrollee who may need care.

(b) In developing these standards for timeliness of access, the department shall consider the following:

(1) Clinical appropriateness.

(2) The nature of the specialty.

(3) The urgency of care.

(4) The requirements of other provisions of law, including Section 1367.01 governing utilization review, that may affect timeliness of access.

(c) The department may adopt standards other than the time elapsed between the time an enrollee seeks health care and obtains care. If the department chooses a standard other than the time elapsed between the time an enrollee first seeks health care and obtains it, the department shall demonstrate why that standard is more appropriate. In developing these standards, the department shall consider the nature of the plan network.

(d) The department shall review and adopt standards, as needed, concerning the availability of primary care physicians, specialty physicians, hospital care, and other health care, so that consumers have timely access to care. In so doing, the department shall consider the nature of physician practices, including individual and group practices as well as the nature of the plan network. The department shall also consider various circumstances affecting the delivery of care, including urgent care, care provided on the same day, and requests for specific providers. If the department finds that health care service plans and health care providers have difficulty meeting these standards, the department may make recommendations to the Assembly Committee on Health and the Senate Committee on Insurance of the Legislature pursuant to subdivision (i).

(e) In developing standards under subdivision (a), the department shall consider requirements under federal law, requirements under other state programs, standards adopted by other states, nationally recognized accrediting organizations, and professional associations. The department shall further consider the needs of rural areas, specifically those in which health facilities are more than 30 miles apart and any requirements imposed by the State Department of Health Care Services on health care service plans that contract with the State Department of Health Care Services to provide Medi-Cal managed care.

(f) (1) Contracts between health care service plans and health care providers shall ensure compliance with the standards developed under this section. These contracts shall require reporting by health care providers to health care service plans and by health care service plans to the department to ensure compliance with the standards.

(2) Health care service plans shall report annually to the department on compliance with the standards in a manner specified by the department. The reported information shall allow consumers to compare the performance of plans and their contracting providers in complying with the standards, as well as changes in the compliance of plans with these standards.

(3) The department may develop standardized methodologies for reporting that shall be used by health care service plans to demonstrate compliance with this section and any regulations adopted pursuant to it. The methodologies shall be sufficient to determine compliance with the standards developed under this section for different networks of providers if a health care service plan uses a different network for Medi-Cal managed care products than for other products or if a health care service plan uses a different network for individual market products than for small group market products. The development and adoption of these methodologies shall not be subject to the Administrative Procedure 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~~ *stakeholders* 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.

(4) The administrative 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.

(h) The department shall work with the patient advocate to assure that the quality of care report card incorporates information provided pursuant to subdivision (f) regarding the degree to which health care service plans and health care providers comply with the requirements for timely access to care.

(i) The department shall annually review information regarding compliance with the standards developed under this section and shall make recommendations for changes that further protect enrollees. Commencing no later than December 1, 2015, and annually thereafter, the department shall post its *final* findings from the review on its Internet Web site.

(j) The department shall post on its Internet Web site any waivers or alternative standards that the department approves under this section on or after January 1, 2015.

SEC. 2. Section 1367.035 is added to the Health and Safety Code, to read:

1367.035. (a) ~~Commencing March 1, 2015, and annually thereafter,~~ *As part of the reports submitted to the department pursuant to subdivision (f) of Section 1367.03 and regulations adopted pursuant to that section,* a health care service plan shall submit to the department, in a manner specified by the department, data regarding network adequacy, including, but not limited to, the following:

(1) Provider location.

(2) Area of specialty.

(3) ~~Provider~~ *Hospitals where providers have* admitting privileges, *if any*.

(4) Providers with open practices.

(5) ~~Provider patient capacity.~~ *Provider to enrollee ratios for providers on a full-time equivalent basis.*

(6) The number of patients assigned to a *primary care* provider *or, for providers who do not have assigned enrollees, the number of enrollee primary care provider visits for the calendar year being reported*.

(7) ~~Complaints~~ *Grievances* regarding network adequacy and timely access that the health care service plan received during the preceding year.

(b) A health care service plan that uses a network for its Medi-Cal managed care product line that is different from the network used for its other product lines shall submit the data required under subdivision (a) for its Medi-Cal managed care product line separately from the data submitted for its other 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.~~ *chapter.*

(e) In ~~collecting~~ *submitting* 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~~ *a health care service plan that provides services to Medi-Cal beneficiaries pursuant to Chapter 7 (commencing with Section 14087.98) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, shall provide the same data to the State Department of Health Care Services pursuant to Section 14456.3 of the Welfare and Institutions Code.*

(f) In developing the format and requirements for reports, data, or other information provided by plans pursuant to subdivision (a), the department shall not create duplicate reporting requirements, but, instead, shall take into consideration all existing relevant reports, data, or other information provided by plans to the department. 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.

(g) If the department requests additional information or data to be reported pursuant to subdivision (a), which is different or in addition to the information required to be reported in paragraphs (1) to (7), inclusive, of subdivision (a), the department shall provide health care service plans notice of that change by November 1 of the year prior to the change.

(h) A health care service plan may include in the provider contract provisions requiring compliance with the reporting requirements of Section 1367.03 and this section.

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

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

1380.3. The department shall coordinate the surveys conducted pursuant to 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 required under Section 1380 or in the failure of the department to conduct those surveys.

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, 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, if reviews 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, 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 *finalized* 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, *if any,* 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. 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 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).

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

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