

AMENDED IN ASSEMBLY JULY 14, 2008
AMENDED IN ASSEMBLY JULY 2, 2008
AMENDED IN ASSEMBLY JUNE 19, 2008
AMENDED IN SENATE MAY 23, 2008
AMENDED IN SENATE APRIL 23, 2008
AMENDED IN SENATE APRIL 9, 2008

SENATE BILL

No. 1553

**Introduced by Senator Lowenthal
(Coauthor: Senator Kuehl)**

(Coauthors: Assembly Members Berg, Hernandez, and Huffman)

February 22, 2008

An act to amend ~~Sections 1367.01 and~~ *Section* 1368.015 of, *and to add Section 1367.015 to*, the Health and Safety Code, relating to health care service plans.

LEGISLATIVE COUNSEL'S DIGEST

SB 1553, as amended, Lowenthal. Health care service plans.

Existing law provides for licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law imposes various requirements on health care service plans, including, among other things, requirements related to utilization review procedures regarding approval, modification, delay, or denial of health care services to enrollees. Existing law also requires a health care service plan, other than a plan that primarily serves Medi-Cal or Healthy Families Program enrollees, to establish a Web site. A willful violation of *the* provisions governing health care service plans is a crime.

This bill would ~~provide that~~ *prohibit a health care service plan from basing* decisions to deny requests by providers for authorization or to deny claim reimbursement ~~shall not be based~~ on whether admission was voluntary or involuntary or the method of transportation to the health care facility. The bill would also require a plan Web site to include information on accessing mental health services.

Because this bill would impose additional requirements on health care service plans, the willful violation of which would be a crime, the bill would impose a state-mandated local program.

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.

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 1367.01 of the Health and Safety Code~~
 2 ~~is amended to read:~~
 3 ~~1367.01. (a) A health care service plan and any entity with~~
 4 ~~which it contracts for services that include utilization review or~~
 5 ~~utilization management functions, that prospectively,~~
 6 ~~retrospectively, or concurrently reviews and approves, modifies,~~
 7 ~~delays, or denies, based in whole or in part on medical necessity,~~
 8 ~~requests by providers prior to, retrospectively, or concurrent with~~
 9 ~~the provision of health care services to enrollees, or that delegates~~
 10 ~~these functions to medical groups or independent practice~~
 11 ~~associations or to other contracting providers, shall comply with~~
 12 ~~this section.~~
 13 ~~(b) A health care service plan that is subject to this section shall~~
 14 ~~have written policies and procedures establishing the process by~~
 15 ~~which the plan prospectively, retrospectively, or concurrently~~
 16 ~~reviews and approves, modifies, delays, or denies, based in whole~~
 17 ~~or in part on medical necessity, requests by providers of health~~
 18 ~~care services for plan enrollees. These policies and procedures~~
 19 ~~shall ensure that decisions based on the medical necessity of~~
 20 ~~proposed health care services are consistent with criteria or~~
 21 ~~guidelines that are supported by clinical principles and processes.~~

1 These criteria and guidelines shall be developed pursuant to Section
2 1363.5. These policies and procedures, and a description of the
3 process by which the plan reviews and approves, modifies, delays,
4 or denies, requests by providers prior to, retrospectively, or
5 concurrent with the provision of health care services to enrollees,
6 shall be filed with the director for review and approval, and shall
7 be disclosed by the plan to providers and enrollees upon request,
8 and by the plan to the public upon request.

9 (e) A health care service plan subject to this section, except a
10 plan that meets the requirements of Section 1351.2, shall employ
11 or designate a medical director who holds an unrestricted license
12 to practice medicine in this state issued pursuant to Section 2050
13 of the Business and Professions Code or pursuant to the
14 Osteopathic Act, or, if the plan is a specialized health care service
15 plan, a clinical director with California licensure in a clinical area
16 appropriate to the type of care provided by the specialized health
17 care service plan. The medical director or clinical director shall
18 ensure that the process by which the plan reviews and approves,
19 modifies, or denies, based in whole or in part on medical necessity,
20 requests by providers prior to, retrospectively, or concurrent with
21 the provision of health care services to enrollees, complies with
22 the requirements of this section.

23 (d) If health plan personnel, or individuals under contract to the
24 plan to review requests by providers, approve the provider's
25 request, pursuant to subdivision (b), the decision shall be
26 communicated to the provider pursuant to subdivision (h).

27 (e) No individual, other than a licensed physician or a licensed
28 health care professional who is competent to evaluate the specific
29 clinical issues involved in the health care services requested by
30 the provider, may deny or modify requests for authorization of
31 health care services for an enrollee for reasons of medical necessity.
32 The decision of the physician or other health care professional
33 shall be communicated to the provider and the enrollee pursuant
34 to subdivision (h).

35 (f) The criteria or guidelines used by the health care service
36 plan to determine whether to approve, modify, or deny requests
37 by providers prior to, retrospectively, or concurrent with, the
38 provision of health care services to enrollees shall be consistent
39 with clinical principles and processes. These criteria and guidelines
40 shall be developed pursuant to the requirements of Section 1363.5.

1 ~~(g) If the health care service plan requests medical information~~
2 ~~from providers in order to determine whether to approve, modify,~~
3 ~~or deny requests for authorization, the plan shall request only the~~
4 ~~information reasonably necessary to make the determination.~~

5 ~~(h) In determining whether to approve, modify, or deny requests~~
6 ~~by providers prior to, retrospectively, or concurrent with the~~
7 ~~provision of health care services to enrollees, based in whole or~~
8 ~~in part on medical necessity, a health care service plan subject to~~
9 ~~this section shall meet the following requirements:~~

10 ~~(1) Decisions to approve, modify, or deny, based on medical~~
11 ~~necessity, requests by providers prior to, or concurrent with the~~
12 ~~provision of health care services to enrollees that do not meet the~~
13 ~~requirements for the 72-hour review required by paragraph (2),~~
14 ~~shall be made in a timely fashion appropriate for the nature of the~~
15 ~~enrollee's condition, not to exceed five business days from the~~
16 ~~plan's receipt of the information reasonably necessary and~~
17 ~~requested by the plan to make the determination. In cases where~~
18 ~~the review is retrospective, the decision shall be communicated to~~
19 ~~the individual who received services, or to the individual's~~
20 ~~designee, within 30 days of the receipt of information that is~~
21 ~~reasonably necessary to make this determination, and shall be~~
22 ~~communicated to the provider in a manner that is consistent with~~
23 ~~current law. For purposes of this section, retrospective reviews~~
24 ~~shall be for care rendered on or after January 1, 2000.~~

25 ~~(2) When the enrollee's condition is such that the enrollee faces~~
26 ~~an imminent and serious threat to his or her health including, but~~
27 ~~not limited to, the potential loss of life, limb, or other major bodily~~
28 ~~function, or the normal timeframe for the decisionmaking process,~~
29 ~~as described in paragraph (1), would be detrimental to the enrollee's~~
30 ~~life or health or could jeopardize the enrollee's ability to regain~~
31 ~~maximum function, decisions to approve, modify, or deny requests~~
32 ~~by providers prior to, or concurrent with, the provision of health~~
33 ~~care services to enrollees shall be made in a timely fashion~~
34 ~~appropriate for the nature of the enrollee's condition, not to exceed~~
35 ~~72 hours after the plan's receipt of the information reasonably~~
36 ~~necessary and requested by the plan to make the determination.~~
37 ~~Nothing in this section shall be construed to alter the requirements~~
38 ~~of subdivision (b) of Section 1371.4. Notwithstanding Section~~
39 ~~1371.4, the requirements of this division shall be applicable to all~~

1 health plans and other entities conducting utilization review or
2 utilization management.

3 (3) ~~Decisions to deny requests by providers for authorization
4 or deny claim reimbursement shall not be based on either of the
5 following:~~

6 ~~(A) Whether admission was voluntary or involuntary.~~

7 ~~(B) The method of transportation to the health facility.~~

8 (4) ~~Decisions to approve, modify, or deny requests by providers
9 for authorization prior to, or concurrent with, the provision of
10 health care services to enrollees shall be communicated to the
11 requesting provider within 24 hours of the decision. Except for
12 concurrent review decisions pertaining to care that is underway,
13 which shall be communicated to the enrollee's treating provider
14 within 24 hours, decisions resulting in denial, delay, or
15 modification of all or part of the requested health care service shall
16 be communicated to the enrollee in writing within two business
17 days of the decision. In the case of concurrent review, care shall
18 not be discontinued until the enrollee's treating provider has been
19 notified of the plan's decision and a care plan has been agreed
20 upon by the treating provider that is appropriate for the medical
21 needs of that patient.~~

22 (5) ~~Communications regarding decisions to approve requests
23 by providers prior to, retrospectively, or concurrent with the
24 provision of health care services to enrollees shall specify the
25 specific health care service approved. Responses regarding
26 decisions to deny, delay, or modify health care services requested
27 by providers prior to, retrospectively, or concurrent with the
28 provision of health care services to enrollees shall be
29 communicated to the enrollee in writing, and to providers initially
30 by telephone or facsimile, except with regard to decisions rendered
31 retrospectively, and then in writing, and shall include a clear and
32 concise explanation of the reasons for the plan's decision, a
33 description of the criteria or guidelines used, and the clinical
34 reasons for the decisions regarding medical necessity. Any written
35 communication to a physician or other health care provider of a
36 denial, delay, or modification of a request shall include the name
37 and telephone number of the health care professional responsible
38 for the denial, delay, or modification. The telephone number
39 provided shall be a direct number or an extension, to allow the
40 physician or health care provider easily to contact the professional~~

1 responsible for the denial, delay, or modification. Responses shall
2 also include information as to how the enrollee may file a grievance
3 with the plan pursuant to Section 1368, and in the case of Medi-Cal
4 enrollees, shall explain how to request an administrative hearing
5 and aid paid pending under Sections 51014.1 and 51014.2 of Title
6 22 of the California Code of Regulations.

7 ~~(6) If the health care service plan cannot make a decision to~~
8 ~~approve, modify, or deny the request for authorization within the~~
9 ~~timeframes specified in paragraph (1) or (2) because the plan is~~
10 ~~not in receipt of all of the information reasonably necessary and~~
11 ~~requested, or because the plan requires consultation by an expert~~
12 ~~reviewer, or because the plan has asked that an additional~~
13 ~~examination or test be performed upon the enrollee, provided the~~
14 ~~examination or test is reasonable and consistent with good medical~~
15 ~~practice, the plan shall, immediately upon the expiration of the~~
16 ~~timeframe specified in paragraph (1) or (2) or as soon as the plan~~
17 ~~becomes aware that it will not meet the timeframe, whichever~~
18 ~~occurs first, notify the provider and the enrollee, in writing, that~~
19 ~~the plan cannot make a decision to approve, modify, or deny the~~
20 ~~request for authorization within the required timeframe, and specify~~
21 ~~the information requested but not received, or the expert reviewer~~
22 ~~to be consulted, or the additional examinations or tests required.~~
23 ~~The plan shall also notify the provider and enrollee of the~~
24 ~~anticipated date on which a decision may be rendered. Upon receipt~~
25 ~~of all information reasonably necessary and requested by the plan,~~
26 ~~the plan shall approve, modify, or deny the request for authorization~~
27 ~~within the timeframes specified in paragraph (1) or (2), whichever~~
28 ~~applies.~~

29 ~~(7) If the director determines that a health care service plan has~~
30 ~~failed to meet any of the timeframes in this section, or has failed~~
31 ~~to meet any other requirement of this section, the director may~~
32 ~~assess, by order, administrative penalties for each failure. A~~
33 ~~proceeding for the issuance of an order assessing administrative~~
34 ~~penalties shall be subject to appropriate notice to, and an~~
35 ~~opportunity for a hearing with regard to, the person affected, in~~
36 ~~accordance with subdivision (a) of Section 1397. The~~
37 ~~administrative penalties shall not be deemed an exclusive remedy~~
38 ~~for the director. These penalties shall be paid to the Managed Care~~
39 ~~Fund.~~

1 ~~(i) A health care service plan subject to this section shall~~
2 ~~maintain telephone access for providers to request authorization~~
3 ~~for health care services.~~

4 ~~(j) A health care service plan subject to this section that reviews~~
5 ~~requests by providers prior to, retrospectively, or concurrent with,~~
6 ~~the provision of health care services to enrollees shall establish,~~
7 ~~as part of the quality assurance program required by Section 1370,~~
8 ~~a process by which the plan's compliance with this section is~~
9 ~~assessed and evaluated. The process shall include provisions for~~
10 ~~evaluation of complaints, assessment of trends, implementation~~
11 ~~of actions to correct identified problems, mechanisms to~~
12 ~~communicate actions and results to the appropriate health plan~~
13 ~~employees and contracting providers, and provisions for evaluation~~
14 ~~of any corrective action plan and measurements of performance.~~

15 ~~(k) The director shall review a health care service plan's~~
16 ~~compliance with this section as part of its periodic onsite medical~~
17 ~~survey of each plan undertaken pursuant to Section 1380, and shall~~
18 ~~include a discussion of compliance with this section as part of its~~
19 ~~report issued pursuant to that section.~~

20 ~~(l) This section shall not apply to decisions made for the care~~
21 ~~or treatment of the sick who depend upon prayer or spiritual means~~
22 ~~for healing in the practice of religion as set forth in subdivision~~
23 ~~(a) of Section 1270.~~

24 ~~(m) Nothing in this section shall cause a health care service plan~~
25 ~~to be defined as a health care provider for purposes of any provision~~
26 ~~of law, including, but not limited to, Section 6146 of the Business~~
27 ~~and Professions Code, Sections 3333.1 and 3333.2 of the Civil~~
28 ~~Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the~~
29 ~~Code of Civil Procedure.~~

30 *SECTION 1. Section 1367.015 is added to the Health and*
31 *Safety Code, to read:*

32 *1367.015. In addition to complying with subdivision (h) of*
33 *Section 1367.01, in determining whether to approve, modify, or*
34 *deny requests by providers prior to, retrospectively, or concurrent*
35 *with the provision of health care services to enrollees, based in*
36 *whole or in part on medical necessity, a health care service plan*
37 *subject to Section 1367.01 shall not base decisions to deny requests*
38 *by providers for authorization or to deny claim reimbursement on*
39 *either of the following:*

40 *(a) Whether admission was voluntary or involuntary.*

1 **(b) The method of transportation to the health facility.**

2 SEC. 2. Section 1368.015 of the Health and Safety Code is
3 amended to read:

4 1368.015. (a) Effective July 1, 2003, every plan with a Web
5 site shall provide an online form through its Web site that
6 subscribers or enrollees can use to file with the plan a grievance,
7 as described in Section 1368, online.

8 (b) The Web site shall have an easily accessible online grievance
9 submission procedure that shall be accessible through a hyperlink
10 on the Web site’s home page or member services portal clearly
11 identified as “GRIEVANCE FORM.” All information submitted
12 through this process shall be processed through a secure server.

13 (c) The online grievance submission process shall be approved
14 by the Department of Managed Health Care and shall meet the
15 following requirements:

16 (1) It shall utilize an online grievance form in HTML format
17 that allows the user to enter required information directly into the
18 form.

19 (2) It shall allow the subscriber or enrollee to preview the
20 grievance that will be submitted, including the opportunity to edit
21 the form prior to submittal.

22 (3) It shall include a current hyperlink to the California
23 Department of Managed Health Care Web site, and shall include
24 a statement in a legible font that is clearly distinguishable from
25 other content on the page and is in a legible size and type,
26 containing the following language:

27 “The California Department of Managed Health Care is
28 responsible for regulating health care service plans. If you have a
29 grievance against your health plan, you should first telephone your
30 health plan at (insert health plan’s telephone number) and use your
31 health plan’s grievance process before contacting the department.
32 Utilizing this grievance procedure does not prohibit any potential
33 legal rights or remedies that may be available to you. If you need
34 help with a grievance involving an emergency, a grievance that
35 has not been satisfactorily resolved by your health plan, or a
36 grievance that has remained unresolved for more than 30 days,
37 you may call the department for assistance. You may also be
38 eligible for an Independent Medical Review (IMR). If you are
39 eligible for IMR, the IMR process will provide an impartial review
40 of medical decisions made by a health plan related to the medical

1 necessity of a proposed service or treatment, coverage decisions
2 for treatments that are experimental or investigational in nature
3 and payment disputes for emergency or urgent medical services.
4 The department also has a toll-free telephone number
5 (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the
6 hearing and speech impaired. The department's Internet Web site
7 <http://www.hmohelp.ca.gov> has complaint forms, IMR application
8 forms and instructions online."

9 The plan shall update the URL, hyperlink, and telephone numbers
10 in this statement as necessary.

11 (d) A plan that utilizes a hardware system that does not have
12 the minimum system requirements to support the software
13 necessary to meet the requirements of this section is exempt from
14 these requirements until January 1, 2006.

15 (e) For purposes of this section, the following terms shall have
16 the following meanings:

17 (1) "Homepage" means the first page or welcome page of a
18 Web site that serves as a starting point for navigation of the Web
19 site.

20 (2) "HTML" means Hypertext Markup Language, the authoring
21 language used to create documents on the World Wide Web, which
22 defines the structure and layout of a Web document.

23 (3) "Hyperlink" means a special HTML code that allows text
24 or graphics to serve as a link that, when clicked on, takes a user
25 to another place in the same document, to another document, or
26 to another Web site or Web page.

27 (4) "Member services portal" means the first page or welcome
28 page of a Web site that can be reached directly by the Web site's
29 homepage and that serves as a starting point for a navigation of
30 member services available on the Web site.

31 (5) "Secure server" means an Internet connection to a Web site
32 that encrypts and decrypts transmissions, protecting them against
33 third-party tampering and allowing for the secure transfer of data.

34 (6) "URL" or "Uniform Resource Locator" means the address
35 of a Web site or the location of a resource on the World Wide Web
36 that allows a browser to locate and retrieve the Web site or the
37 resource.

38 (7) "Web site" means a site or location on the World Wide Web.

39 (f) Every health care service plan, except a plan that primarily
40 serves Medi-Cal or Healthy Families Program enrollees, shall

1 maintain a Web site. The Web site shall include, but not be limited
2 to, useful information on accessing mental health services, which
3 shall be available to subscribers, enrollees, and providers.

4 SEC. 3. No reimbursement is required by this act pursuant to
5 Section 6 of Article XIII B of the California Constitution because
6 the only costs that may be incurred by a local agency or school
7 district will be incurred because this act creates a new crime or
8 infraction, eliminates a crime or infraction, or changes the penalty
9 for a crime or infraction, within the meaning of Section 17556 of
10 the Government Code, or changes the definition of a crime within
11 the meaning of Section 6 of Article XIII B of the California
12 Constitution.