ASSEMBLY BILL No. 613

Introduced by Assembly Member Beall

February 25, 2009

An act to amend Sections 14133.01, 14133.1, 14133.10, 14133.25, and 14133.9 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 613, as introduced, Beall. Medi-Cal: treatment authorization requests.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, and pursuant to which, health care services are provided to qualified low-income persons.

Under existing law, one of the utilization controls to which services are subject under the Medi-Cal program is the treatment authorization request (TAR) process, which is approval by a department consultant of a specified service in advance of the rendering of that service based upon a determination of medical necessity. Existing law requires the department to pursue means to improve and streamline the TAR process.

This bill would require the department, in pursuing means to improve and streamline the TAR process, to do so in specified ways, including performing a cost-benefit analysis for each TAR and reducing the number of TARs required.

Existing law requires the Director of Health Care Services to determine which of the utilization controls shall be applied to any specific service or group of services which are subject to utilization controls. Existing law authorizes the director, in conducting Medi-Cal acute care inpatient hospital utilization control, to establish a program

of aggressive case management of elective, nonemergency acute care hospital admissions. Existing law requires the director to identify those surgical and medical procedures capable of outpatient performance and establish conditions for ensuring performance in an outpatient rather than inpatient setting when medically appropriate.

This bill would require the director to carry out these duties in a manner that is consistent with the above-described means for improving the TAR process.

Existing law specifies the number of days within which certain TARs shall be authorized.

This bill would reduce the number of days these TARs shall be authorized.

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

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

SECTION 1. Section 14133.01 of the Welfare and Institutions Code is amended to read:

14133.01. (a) Notwithstanding any other provision of law, the director or his or her designee may apply prior authorization by designing a sampling methodology that will result in a generally acceptable audit standard for approval of a treatment authorization request (TAR), or a class of TARs. The director or his or her designee shall determine the applicable sampling methodology based upon health care industry standards and discussions with applicable Medi-Cal providers or their representatives. This sampling methodology shall be implemented by no later than July 1, 2005, and an outline of it shall be provided to the fiscal and policy committees of both houses of the Legislature. It is the intent of the Legislature for the department to review the sampling methodology on an ongoing basis and update it as applicable on a periodic basis in order to keep abreast of health care industry trends and the need to manage an efficient and effective Medi-Cal program.

(b) The department shall pursue additional means to improve and streamline the treatment authorization request process including, where applicable, those identified by independent analyses such as the July 2003 report by the California Healthcare Foundation entitled Medi-Cal Treatment Authorizations and Claims

Processing: Improving Efficiency and Access to Care, and those identified by Medi-Cal providers. ~~It is the Legislature's intent that any identified improvements be cost-beneficial to the state and to the Medi-Cal program as a whole.~~ *The department shall pursue additional means to improve and streamline the treatment authorization request process in all of the following ways:*

(1) Perform a cost-benefit analysis for each TAR and reduce the number of TARs required. TARs shall only be required for services with documented overutilization or a high level of fraudulent activity.

(2) Develop alternative approaches for fraud and abuse detection, through targeted analysis of utilization baselines for each drug or service, that identify potential anomalies.

(3) Develop an alternative to the requirement that a patient obtain a TAR for each individual day of his or her stay in the hospital and consider adopting a single TAR for the entire length of a patient's hospital stay.

(4) Make publicly available the rules and criteria for determining medical necessity.

(5) Work with licensed health care providers that are affected by the TAR process in developing processes to improve efficiency and access to care through a more streamlined and relevant TAR process.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific, this section by means of all-county letters, provider bulletins, or similar instructions. Thereafter, the department may adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 2. Section 14133.1 of the Welfare and Institutions Code is amended to read:

14133.1. (a) The director shall determine which of the utilization controls in Section 14133 shall be applied to any specific service or group of services ~~which~~ *that* are subject to utilization controls. *The director shall also determine which of the utilization controls in Section 14133 are consistent with the means for improvement provided for in subdivision (b) of Section 14133.01.*

Each utilization control shall be reasonably related to the purpose for which it is imposed.

(b) Except as provided in Sections 14103.6 and 14133.15, neither prior authorization nor the limitation specified in subdivision (d) of Section 14133 shall be required for the first two services per month which are included among the services listed in subdivision (a) of Section 14132, or for the first two drug prescriptions purchased during any one month, provided that the prescription drugs are included in the Medi-Cal Drug Formulary and the prescription otherwise conforms to applicable formulary requirements.

(c) The director shall, after a determination of cost benefit, modify or eliminate the requirement of prior authorization as a control for treatment, supplies, or equipment which costs less than one hundred dollars ($100), except for prescribed drugs, provided that the requirement of prior authorization for treatment, supplies, or equipment may be reinstituted upon a finding by the department that the elimination of the requirement has resulted in unnecessary utilization, and upon notice to the Joint Legislative Budget Committee 30 days prior to the reinstitution of the requirement of prior authorization. Modification of the utilization controls may include establishing prior authorization review thresholds at levels other than one hundred dollars ($100) if indicated by the cost-benefit analysis.

SEC. 3. Section 14133.10 of the Welfare and Institutions Code is amended to read:

14133.10. (a) Where it is expected to be cost-effective, the director may, in conducting Medi-Cal acute care inpatient hospital utilization control, establish a program of aggressive case management of elective, nonemergency acute care hospital admissions for the purpose of reducing both the numbers and duration of acute care hospital stays by Medi-Cal beneficiaries. *If the director establishes a program of aggressive case management, he or she shall do so in a manner that is consistent with the means for improvement provided for in subdivision (b) of Section 14133.01.*

(b) In conducting the case management program, the department may, conduct daily reviews to determine the need for additional days of inpatient care.

(c) In undertaking this case management program, the director may enter into contracts, on a bid or nonbid basis, for the purposes of obtaining the necessary expertise to train and educate utilization control staff in case management concepts, principles and techniques, identify and recommend cost-effective therapies, services and technology as alternatives to elective acute care hospitalization or to directly provide the case management and diversion services.

(d) In order to achieve maximum cost savings the Legislature hereby determines that an expedited contract process for contracts under this section is necessary. Therefore, contracts under this article may be on a nonbid basis, and shall be exempt from the provisions of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code. Contracts shall have no force and effect unless approved by the Department of Finance.

(e) The department shall seek all federal waivers necessary to allow for federal financial participation under this section.

SEC. 4. Section 14133.25 of the Welfare and Institutions Code is amended to read:

14133.25. (a) The director shall identify those surgical and medical procedures capable of outpatient performance and establish conditions for assuring performance in an outpatient rather than inpatient setting when medically appropriate. *The director shall establish these conditions in a manner that is consistent with the means for improvement provided for in subdivision (b) of Section 14133.01.*

(b) The director shall identify and apply appropriate utilization controls to review outpatient and office medical and surgical procedures for medical necessity and program coverage. The director may under this section identify and require prior authorization for any specified outpatient or office medical or surgical procedure performed during a month without regard to the provisions of Section 14133.1, provided that, with respect to outpatient or office medical procedures, those medical procedures which remain not subject to prior authorization are sufficient in number and scope as to achieve the general purpose of Section 14133. 1.

(c) The director may establish a schedule of differential reimbursement rates to the operating surgeon for surgery procedures. Those surgery procedures which can safely be

performed on an outpatient basis may be reimbursed at a higher level when performed in an outpatient setting than the same procedures performed on an inpatient basis.

(d) Provisions of this section shall not be applied to mental health services as defined under Division 5 (commencing with Section 5000) or Section 14021, or any other mental health services funded by the Medi-Cal program.

SEC. 5. Section 14133.9 of the Welfare and Institutions Code is amended to read:

14133.9. The implementation of prior authorization permitted by subdivision (a) of Section 14133 shall be subject to all of the following provisions:

(a) The department shall secure a ~~toll free phone~~ *toll-free telephone* number for the use of providers of Medi-Cal services listed in Section 14132. For providers, the department shall provide access to an individual knowledgeable in the program to provide Medi-Cal providers with information regarding available services. Access shall include a toll-free ~~phone~~ *telephone* number that provides reasonable access to that person. The *toll-free telephone* number shall be operated 24 hours a day, seven days a week.

(b) For major categories of treatment subject to prior authorization, the department shall publicize and continue to develop its list of objective medical criteria that indicate when authorization should be granted. Any request meeting these criteria, as determined by the department, shall be approved, or deferred as authorized in subdivision (e) by specific medical information.

(c) The objective medical criteria required by subdivision (d) shall be adopted and published in accordance with the Administrative Procedure Act, and shall be made available at appropriate cost.

(d) When a proposed treatment meets objective medical criteria, and is not contraindicated, authorization for the treatment shall be provided within an average of ~~five~~ *two* working days. When a treatment authorization request is not subject to objective medical criteria, a decision on medical necessity shall be made by a professional medical employee or contractor of the department within an average of ~~five~~ *two* working days.

(e) Notwithstanding the provisions of subdivisions (c) and (d), the department shall adopt, by emergency regulations as provided by this subdivision, a list of elective services that the director

determines may be nonurgent. In determining these services, the department shall be guided by commonly accepted medical practice parameters. Authorization for these services may be deferred for a period of up to ~~90~~ *15* days. In making determinations regarding these referrals, the department may use criteria separate from, or in addition to, those specified in subdivision (c). These deferrals shall be determined through the treatment authorization request process. When a proposed service is on the list of elective services that the director determines may be considered nonurgent, authorization for the service shall be granted or deferred within an average of ~~10~~ *five* working days. The State Department of Health *Care* Services may adopt emergency regulations to implement this subdivision in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The initial adoption of emergency regulations and one readoption of the initial regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety or general welfare. Initial emergency regulations and the first readoption of those regulations shall be exempt from review by the Office of Administrative Law. The emergency regulations authorized by this subdivision shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations and shall remain in effect for no more than 120 days.

(f) The department shall submit to the Legislature, every three months, its treatment authorization request status report.

(g) Final decisions of the department on denial of requests for prior authorization for inpatient acute hospital care shall be reviewable upon request of a provider by a Professional Standards Review Organization established pursuant to Public Law 92-603, or a successor organization if either of the following applies:

(1) The original decision on the request was not performed by a Professional Standards Review Organization, or its successor organization.

(2) The original decision on the request was performed by a Professional Standards Review Organization, or its successor organization, and the original decision was reversed by the department. The department shall contract with one or more of these organizations to, among other things, perform the review

function required by this subdivision. The review performed by the contracting organization shall result in a finding that the department's decision is either appropriate or unjustified, in accordance with existing law, regulation, and medical criteria. The cost of each review shall be borne by the party that does not prevail.

The decision of this body shall be reviewable by civil action.

(h) This section, and any amendments made to Section 14103.6 by Assembly Bill 2254 of the 1985–86 Regular Legislative Session, shall not apply to treatment or services provided under contracts awarded by the department under which the contractor agrees to assume the risk of utilization or costs of services.

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