SENATE COMMITTEE ON HEALTH
Senator Dr. Richard Pan, Chair

BILL NO: SB 221
AUTHOR: Wiener
VERSION: March 9, 2021
HEARING DATE: March 17, 2021
CONSULTANT: Teri Boughton

SUBJECT: Health care coverage: timely access to care.

SUMMARY: Codifies existing timely access to care standards for health plans and health insurers, applies these requirements to Medi-Cal managed care plans, and adds a standard for non-urgent follow-up appointments for nonphysician mental health care or substance use disorder providers within ten business days of the prior appointment.

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act); California Department of Insurance (CDI) to regulate health and other insurance; and, the Department of Health Care Services (DHCS) to administer the Medi-Cal program. [HSC §1340, et seq., INS §106, et seq., and WIC §14000, et seq.]

2) Requires DMHC to develop and adopt regulations to ensure that enrollees have access to health care services in a timely manner, regarding:

   a) Waiting times for appointments, including primary and specialty care physicians;
   b) Care in an episode of illness, including timeliness of referrals and obtaining other services, as needed; and,
   c) Waiting time to speak to a physician, registered nurse, or other qualified health professional trained to screen or triage. [HSC §1367.03]

3) Requires, in developing these standards, DMHC to consider the clinical appropriateness, the nature of the specialty, the urgency or care, and the requirements of law governing utilization review. [HSC §1367.03]

4) Requires CDI to promulgate regulations applicable to health insurers to ensure access to health care in a timely manner, and designed to ensure adequacy of the number of locations of institutional facilities and professional providers, adequacy of number of professional providers, and license classifications, consistent with standards of good health care and clinically appropriate care, and that contracts are fair and reasonable. [INS §10133.5]

5) Requires, in designing the regulations, CDI to consider regulations promulgated by DMHC and all other relevant guidelines in an effort to accomplish maximum accessibility within a cost efficient system of indemnification. [INS §10133.5]

6) Requires every health plan contract that provides hospital, medical, or surgical coverage to provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions, as specified, including if these services are not available in network within the geographic and timely access standards set by law or regulation to ensure out-of-network services and any follow-up services that, to the maximum extent possible, meet those geographic and timely access standards. [HSC §1374.72]

7) Requires a disability insurer, if services for the medically necessary treatment of a mental health or substance use disorder are not available in network within the geographic and timely access standards set by law or regulation, to arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services that, to the maximum extent possible, meet those geographic and timely access standards. [INS §10144.51]

8) Requires Medi-Cal managed care plans to meet the DMHC timely access standards and establishes distance standards for providers of Medi-Cal services, including outpatient mental health services and opioid treatment programs. [WIC §14197]

This bill:

1) Deletes the requirement in existing law for DMHC to develop and adopt timely access regulations.

2) Requires a health plan that provides or arranges for the provision of hospital of physician services, including a specialized mental health plan that provides physician or hospitals services, or that provides mental health services pursuant to the contract with a full service plan to comply with timely access requirements pursuant to this bill, and for contracts issued, renewed, or amended on or after July 1, 2022, to provide information to an enrollee regarding the standards for timely access to care, including information related to interpreter services in a timely manner, no less than annually.

3) Codifies many of the requirements of the DMHC timely access regulations described in 2) of the comments section below and adds a new standard for nonurgent follow-up appointments with a nonphysician mental health care or substance use disorder provider of within ten business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition, except when the provider has determined and noted in the record that a longer time will not have a detrimental impact, as specified.

4) Requires a health plan to arrange coverage outside the plan's contracted network in accordance with existing law, if medically necessary treatment of a mental health or substance use disorder is not available in network within the geographic and timely access standards set by law or regulation, as specified.

5) Applies the DMHC timely access requirements to Medi-Cal managed care plans.

6) Requires a health insurance policy that is issued, renewed, or amended on or after July 1, 2022, that provides benefits through contract with providers for alternative rates, to provide information to an insured regarding the standards for timely access to care, as specified, including information related to receipt of interpreter services in a timely manner, no less than annually.

7) Codifies many of the requirements of the CDI timely access regulations described in 2) of the comments section below and adds a new standard for nonurgent follow-up appointments with a nonphysician mental health care or substance use disorder condition, except when the provider has determined and noted in the record that a longer time will not have a detrimental impact, as specified.

8) Requires an insurer to ensure timely access to covered heath care services, including applicable time-elapsed standards, by assisting an insured to locate available and accessible contracted providers in assisting in a timely manner appropriate for the insured's health needs. Requires an insurer to arrange for the provision of services outside the insurer's contracted network if unavailable within the network if medically necessary for the insured's condition. Requires an insureds costs for medically necessary referrals to nonnetwork providers to not exceed applicable in-network copayments, coinsurance, and deductibles.

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

COMMENTS:

1) *Author's statement.* According to the author, this bill will ensure that people are able to get timely follow-up mental health appointments. Currently, people frequently have to wait long periods of time - frequently months - for follow-up appointments, thus undermining their care. This bill will establish clear, timely access standards for follow-up appointments needed by patients in ongoing, medically necessary treatment for mental health and substance use disorders. In the absence of clear, timely access standards for follow-up appointments with non-physician mental health and substance use disorders providers, such as social workers and therapists, large numbers of Californians requiring ongoing courses of treatment for mental health and substance use disorders have been unable to access care within the timeframes that are clinically appropriate for their diagnoses. This problem is exacerbated by the significant increase in demand for mental health and substance use disorders services driven by the COVID-19 pandemic, with national survey data showing that the rate of anxiety and depression has tripled over the last year and a recent Centers for Disease Control and Prevention study finding that one in four people age 18 to 24 has seriously considered suicide in the past 30 days. Timely access to ongoing mental health and substance use disorders treatment is essential and must be accessible when medically necessary.

2) *Timely access requirements.* The DMHC timely access regulation became effective in 2010, and requires that health plan networks be sufficient to meet a set of standards, which include specific timeframes under which enrollees must be able to obtain care. These standards include wait times to access urgent and non-urgent care appointments, as well as the availability of telephone triage or screening services during and after regular business hours. If a health plan offers an enrollee an appointment within the time-elapsed standards and the enrollee chooses to select a later appointment, the health plan has met the standard. A licensed health care professional may determine that a later appointment may be appropriate based on the enrollee's condition if the later scheduling will not negatively affect the enrollee's health. The wait time standards for products regulated by DMHC and CDI are

described in the chart below and are the allowed times between when an appointment is requested and when it must be scheduled (also referred to as time-elapsed standards).

Urgent Care	48 hours (no prior authorization)	96 days when authorization is required
Non Urgent	10 business days PCP, non-physician mental health appointment (counseling including substance abuse professionals)	15 business days specialty care and ancillary (lab, diagnostic testing, PT)

CDI requires insurers that use tiered networks to demonstrate compliance with the timely access standards based on providers available at the lowest cost-sharing tier. Both CDI and DMHC have the following clinical appropriateness standard in their respective regulations: Plans and insurers shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard. CDI requires interpreter services without imposing delay on the scheduling of the appointment. DMHC does not include this requirement.

Although DMHC and CDI have somewhat different definitions of "preventive care" both have the following requirements: preventive care services, as defined, and periodic follow up care, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice. CDI's regulations include substance use disorder. Both regulations include that wait times can be extended if the referring or treating licensed provider determines and notes in the record that it will not have a detrimental impact on the enrollee or insured. CDI and DMHC have a phone call waiting standard required for insurers or plans not more than ten minutes, but only CDI allows a call back within 30 minutes. Both DMHC and CDI require a plan or insurer to ensure that the telephone triage or screening services waiting period does not exceed 30 minutes.

3) *Timely access report*. DMHC is required to do an annual report on timely access but CDI is not. According to the 2020 DMHC timely access report (based on 2019 reporting year), the DMHC Help Center resolved a total of 1,219 access to care complaints in 2019, making up 9.7% of all complaint issues resolved for the year. Generally, with these types of complaints, the DMHC Help Center works with the enrollee's health plan to quickly resolve the access issue and schedule an appointment within the timely access standards and to meet the enrollee's needs. Between January 1, 2017 and October 30, 2020, the DMHC has issued 40 access-related deficiencies to health plans through the medical survey process. Of these 40 deficiencies:

   a) Twenty deficiencies were corrected by the health plans at the issuance of the Final Report or Follow-Up Report.
   b) Four deficiencies were not corrected at the issuance of the Follow-Up Report and have been referred to the DMHC's Office of Enforcement.
   c) Fourteen deficiencies are pending the completion of the Follow-Up Survey.

d) Two deficiencies were pended to the next routine survey as part of a settlement agreement with the DMHC's Office of Enforcement.

To demonstrate performance with the timely access standards, health plans are required to submit annual compliance reports to DMHC, which includes a survey process, not measured on actual enrollee experiences, but is based on the percentage of surveyed providers who indicated they had appointments available within the appointment wait time standards. The DMHC timely access report presents the provider responses by: combining all products together, Commercial Products (e.g., large or small group employer-sponsored health plans), Individual/Family Products (e.g., individual or family health plans purchased privately or through the Covered California Exchange), and Medi-Cal Products. The health plan survey results reflect only the period in time in which a provider was surveyed, based on the sample size of surveyed providers who responded. For example, if a health plan's survey result shows a 75% aggregate rate of compliance with a two-percentage point sampling error, this means 75% of providers that responded to the survey indicated their next available appointment fell within the appointment wait time standards. Because the result is calculated from a statistical sample of a health plan's providers, it can be inferred with a high degree of reliability what the actual rate of compliance is for all health plan providers. The report does not breakout urgent or non-urgent mental health appointments from other appointments for full service health plans. However, the report does include separate charts for behavioral health plans' across mental health provider types (non-physician mental health, psychiatrist, and child and adolescent psychiatrist) for both urgent and non-urgent appointments.

Key findings for full service health plans:

e) The percentage of all surveyed providers who had appointments available within the wait time standards (urgent and non-urgent) ranged from a high of 94% to a low of 52%.
f) For non-urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 96% to a low of 60%.
g) For urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 92% to a low of 45%.

Key findings for behavioral health plans:

h) The percentage of all surveyed providers who had appointments available within the wait time standards (urgent and non-urgent) ranged from a high of 79% to a low of 66%.
i) For non-urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 87% to a low of 73%.
j) 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 59%.

4) *DMHC regulation update.* DMHC is in the process of updating their timely access regulation including developing a rate of compliance standard for both urgent and non-urgent appointments to which health plans will be held accountable. DMHC plans to report timely access data by health plan network once the updated regulation is adopted, and continue to work with and provide timely access compliance data to the Office of the Patient Advocate (OPA) for incorporation into the OPA Quality of Care Report Card.

5) *Behavioral health workforce in California.* According to the March 2018 California Health Care Foundation (CHCF) Almanac, *Mental Health in California: For Too Many, Care Not There*, in 2016 California had about 75,000 licensed mental health professionals, with marriage and family therapists (31,349) comprising the greatest share, almost double the number of licensed psychologists (16,683). This workforce does not reflect the racial and ethnic diversity of the state, and many professionals, particularly psychiatrists (5,806) and psychologists will reach retirement age within the next decade (45% of psychiatrists and 37% of psychologists are over age 60.) Per-population rates of behavioral health professionals varied by California region: the Greater Bay Area's rates were 38% to 67% greater than the state average while the Inland Empire and San Joaquin Valley regions had rates that were 39% to 88% lower than average. The Northern and Sierra regions had rates of psychiatrists and psychologists that were at least 40% lower than average. Under the Health Professional Shortage Area (HPSA) designation, areas are identified as having a shortage of primary care, dental care, or mental health providers. For mental health providers, the shortage is based on the availability of psychiatrists and other mental health professionals. Approximately 16% of Californians live in a mental health HPSA. According to the Office of Statewide Health Planning and Development website, to qualify for designation as a mental health HPSA, an area must be a rational service area; the population-to-core mental health professional and/or the population-to-psychiatrist ratio meet established shortage criteria; and there is a lack of access to mental health care in surrounding areas because of excessive distance, overutilization, or access barriers.

6) *State regulated health coverage.* According to another CHCF report, in 2019, California health insurers covered 32.7 million enrollees - 27.1 million were enrolled in commercial coverage or public managed care and 5.6 million were enrolled through administrative services only arrangements for self-insured employers. Commercial enrollment consists of small group, large group, and individual enrollment. The state can regulate private health insurance coverage but not coverage provided through self-insured employer benefit plans. According to the 2020 Employer Benefits Survey, federal law (the Employee Retirement Income Security Act of 1974 or ERISA) exempts self-funded plans established by private employers (but not public) from most state insurance laws, including reserve requirements, mandated benefits, premium taxes, and many consumer protection regulations. Nationally, 67% of covered workers were in a self-funded plan in 2020. These tend to be employers with 200 or more employees. Additionally, because Medi-Cal is administered through DHCS and has federal rules, there can be differences in requirements associated with Medi-Cal coverage vs. private state regulated coverage. This bill applies to state regulated commercial plans and Medi-Cal managed care plans.

7) *Prior legislation.* SB 855 (Wiener, Chapter 151, Statutes of 2020) repeals California's mental health parity law and replaces it with a broader requirement on health plans and disability insurers to cover medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions; establishes new requirements for medically necessary care determinations and utilization review; and bans discretionary clauses in health plan contracts.

   AB 2179 (Cohn, Chapter 792, Statures of 2002) requires DMHC and CDI to develop and adopt regulations to ensure that enrollees have access to needed health care services.

8) *Support*. The National Union of Healthcare Workers, the sponsor of this bill, writes that the American Psychological Association (APA), the premier standard-setting organization for psychological care in the United States, recommends either weekly or biweekly therapy appointments for the ongoing treatment of depression in adults and adolescents, PTSD in adults, and obsessive compulsive disorder in children. For the already very common and increasingly frequent diagnosis of depression among adults, the APA recommends seven possible treatment modalities, all of which are recommended to be delivered to patients weekly. Nevertheless, in a December 2020 survey of mental health and substance use disorders clinicians at California's largest HMO, 88% of therapists reported that weekly individual psychotherapy is unavailable for patients who need it. Fifty-one percent of therapists reported that their patients have to wait more than four weeks for a follow-up treatment appointment. On average, these therapists reported that they had no follow-up appointments available in their schedules for fully twenty-two business days. The Kennedy Forum writes this bill will hold health plans and insurers accountable in a common-sense way to ensure timely access to follow-up care, minimizing the negative consequences associated with delays in treatment.

9) *Support if amended*. Health Access California writes that while they support the goals of this bill they are suggesting several additional improvements that would work in tandem with these goals to further strengthen the bill. These amendments would accomplish the following: a) Add a provision that referrals to specialists by primary care providers or another specialist should also be subject to the same timely access standards as non-referred appointments; b) Remove a provision that, for purposes of determining compliance, requires the department to consider patterns of noncompliance rather than isolated episodes; and, c) Remove a provision related to cause of action that would be better suited to remain within the regulatory, rather than statutory, framework.

10) *Concerns*. Kaiser Permanente writes that the change to a 10-day follow-up appointment standard for non-physician mental health providers locks in a return interval not tied to clinical judgement. Return appointments for mental health and substance use conditions should meet individual patient needs and be deemed medically indicated by the patient's treating provider. This mandate will lead to an increase in caseloads for mental health therapists, which Kaiser Permanente and other health systems must manage. A primary and fundamental challenge is to build the workforce necessary to meet the current demand for mental health care. Right now, you can count the number of psychiatry residents in some regions on one hand. In others, there are none. The COVID-19 pandemic has exacerbated the shortage we were already facing, as demand for mental health care has greatly increased. There are thousands of open positions for mental health care professionals throughout California. Kaiser Permanente, other medical groups and health systems, cities, counties, local agencies, and others are all recruiting from the same pool of candidates. It is imperative that a bill that mandates increased frequency of appointments include ways to increase the mental health workforce.

11) *Opposition*. The California Association of Health Plans (CAHP) and the Association of California Life and Health Insurance Companies (ACLHIC) writes this bill assumes that health plans and insurers can easily evaluate their independently contracted providers' availability for follow-up appointments. This is not as easy as the bill presumes. Most practitioners practice independently and do not work directly for a health plan, so it would be extremely challenging for a health plan or insurer to ensure their contracted providers are scheduling follow-up appointments within ten business days. CAHP and ACLHIC are

concerned that this bill would force contracted mental health and substance use disorder providers to unnecessarily manage or limit their caseload in order to ensure enough flexibility to schedule follow-up appointments within ten business days. This bill could undermine existing provider networks by creating a disincentive for providers to continue to participate in health plan networks. Geographic distribution of mental health providers in California has been particularly challenging, especially for sub-specialties and in very rural areas of the state. That is why it is so critical to incentivize these providers to contract with health plans. Codifying the timely access standards may unnecessarily cause confusion among health plans, insurers, consumers and regulators. Further, this may undermine the DMHC and CDI's authority to fulfill oversight functions that are licensed under their respective jurisdictions.

12) *Policy comment*. In order to ensure consistency for Californians with state regulated insurance it is necessary to compare and evaluate each department's regulations. In this case, this task is also complicated in that DMHC is in the process of updating its timely access regulations. This bill is codifying the timely access standards for each department and making explicit a standard for follow-up care for mental health and substance use disorder services. Health Access California has requested an amendment to also make explicit that the existing standards apply for referrals. To provide consistency and maximum protections for Californians, the committee may wish to consider amendments to reconcile the timely access standards across departments.

13) *Amendments.*

a) Require a health plan that uses a tiered network to demonstrate compliance with the timely access standards at the lowest cost-sharing tier. (HSC 1367.03(a)(1))
b) Require a referral to a specialist by a primary care provider or another specialist to be subject to the relevant time-elapsed standard in (A), (B) or (D) and be subject to the other provisions of the section. (HSC 1367.03 and INS 10133.54)
c) Add substance use disorders to HSC 1367.03 (a)(8)(B), (a)(8)(B)(i), and (a)(8)(B)(ii).
d) Delete HSC 1367.03 (d) and (g)(1)
e) Prohibit health plans and insurers from preventing, discouraging, or disciplining providers when informing enrollees or insured about the timely access standards.
f) Include additional amendments to ensure consistency.

SUPPORT AND OPPOSITION:

Support: National Union of Healthcare Workers (sponsor)
California Association for Marriage and Family Therapists
California Catholic Conference
California Council of Community Behavioral Health Agencies
California Senior Legislature
California State Association of Psychiatrists
Center for Autism and Related Disorders
Depression and Bipolar Support Alliance
Mental Health & Autism Insurance Project
Mental Health America of California
National Alliance on Mental Illness
Steinberg Institute
The Kennedy Forum

Oppose: Association of California Life and Health Insurance Companies
California Association of Health Plan