SENATE THIRD READING
SB 221 (Wiener)
As Amended September 3, 2021
Majority vote

SUMMARY

Codifies the regulations adopted by the Department of Managed Health Care (DMHC) and the Department of Insurance (CDI) to provide timely access standards for health care service plans (health plans) and insurers for nonemergency health care services. Requires, beginning July 1, 2022, a health plan and a health insurer, including a Medi-Cal Managed Care Plan, to ensure that an enrollee or insured that is undergoing a course of treatment for an ongoing mental health (MH) or substance use disorder (SUD) condition is able to get a followup appointment with a nonphysician MH care or SUD provider within 10 business days of the prior appointment. Requires that a referral to a specialist by another provider meet the timely access standards. Requires the health plan, including a Medi-Cal Managed Care Plan, to arrange coverage outside the plan's contracted network if a health plan is operating in a service area that has a shortage of providers and is not able to meet the geographic and timely access standards for providing MH or SUD services with an in-network provider. Specify that the development and adoption of standardized methodologies for timely access reporting not be subject to the Administrative Procedure Act, as specified, until July 1, 2025. Provide that nothing in this bill be construed to prevent the DMHC or CDI from developing additional standards to improve timely access to care and network adequacy.

Major Provisions

COMMENTS

1) *Existing Network Adequacy Requirements.* California law sets forth various network adequacy requirements on health plans and insurers. For example, health plans are subject to the following:

    a) Timely Access. Timely Access Regulations require that health plans meet a set of standards which include specific time frames under which enrollees must be able to access care. These requirements generally include the following standards for appointment availability:

        i) *Urgent care without prior authorization*: within 48 hours;

        ii) *Urgent care with prior authorization*: within 96 hours;

        iii) *Non-urgent primary care appointments*: within 10 business days;

        iv) *Non-urgent specialist appointments*: within 15 business days;

        v) Non-Urgent mental health appointments: within 15 business days for psychiatrist, within 10 business days for non-physician mental health provider; and,

        vi) *Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness or other health condition*: within 15 business days.

Existing regulations also authorize the applicable waiting time for a particular appointment to be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee. This bill codifies into statute existing law currently set forth in timely access regulations and adds a provision specifically related to follow up MH and SUD appointments.

b) Geographic Access. Health plans are also generally required to ensure geographic access such that there are a sufficient number of providers located within a reasonable distance from where each enrollee lives or works. For example, primary care physician (PCPs) and hospitals should be *located within 15 miles or 30 minutes* from work or home.

Health plans must also ensure provider capacity such that health plan networks have enough of each of the right types of providers to deliver the volume of services needed. For example, plan networks should include one PCP for every 2,000 beneficiaries.

c) Grievance Process. Health plan enrollees can also file a complaint (also known as an appeal or grievance) if he or she has a problem with a health plan, for example, if he or she is unable to schedule an appointment pursuant to the above. Additionally, enrollees can apply for an Independent Medical Review (IMR) with the DMHC when a health care service or treatment has been denied, modified or delayed. An IMR is a review by independent doctors who are not part of the health plan.

2) *Pending DMHC regulations.* Health plans report to the DMHC, on an annual basis, compliance with timely access to care standards and report to the DMHC the adequacy of the health plan's provider network. In 2010, the DMHC adopted clarifying regulations for timely access to care compliance. In the years following implementation of the regulation, health plan timely access reports received by the DMHC were filled with errors and reflected inaccurate information that was often incomplete and unhelpful during the DMHC's review. The disparate, incomplete, and poor quality information contained within the health plan reports made it impossible for the DMHC to determine timely access to care compliance. SB 964 (Hernandez), Chapter 573, Statutes of 2014, authorized DMHC to develop standardized reporting methodologies for the health plans' annual timely access reporting and annual network adequacy reporting. The authority for the DMHC to develop a standardized methodology for the annual timely access report and the annual network adequacy report is pursuant to an exemption from the Administrative Procedures Act (APA). The exemption expired on January 1, 2020. The current rulemaking process proposes to codify and implement the processes and methodologies developed during the APA exemption period. The DMHC recently concluded its third public comment period to clarify and make specific the timely access to care and annual network reporting requirements for health plans.

3) *Appointment availability surveys.* According to the California Health Care Foundation's (CHCF) 2020 survey of California residents, 52% of those who tried to make an appointment believe they waited longer than was reasonable to get one. The author also provided the results of a December 2020 survey of mental health therapists practicing at California's largest HMO, in which 88% of therapists reported that weekly individual psychotherapy treatment 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. Therapists reported that they had no follow-up appointments available in their schedules for an average of twenty-two business days. In another survey, Californians ranked access to mental health treatment as the state's top health care priority in a 2019 survey conducted jointly by the CHCF and the Kaiser Family Foundation. A majority (57%) of Californians responded that most people with mental health conditions in the state are not able to get the services they need, and nearly half (48%) said the same about people with alcohol or drug use problems.

4) *Work force issues.* A recent Sac Bee article reported that Sacramento County received funding to begin pairing MH counselors with law enforcement agencies and until recently could only staff six of the 11 teams funded. County officials cited the intense competition for therapists. The article also noted a 2019 report by the Legislative Analyst's Office (LAO) that concluded that there was only "mixed evidence" of a shortage. The LAO report cast doubt on the shortage assumption because salaries for MH professions were not growing at a rapid pace, a possible sign of intense competition. The LAO report referred to researchers at the University of California, San Francisco (UCSF) who project that, unless the total number of people entering MH professions in the state increases, California would face a shortage of MH professionals between 2016 and 2028. If the total number of people entering MH professions does *not* increase, these projections show that the supply of MH professionals could fall short of demand for MH professionals by between 12% and 40% by 2028. At the time of the LAO publication, the state had experienced growth in the number of masters- and doctoral-level professional mental health graduates. The LAO report also noted that *the growth in professional MH graduates brought uncertainty to whether the state is facing a shortage.* To see whether the number of people entering MH professions has in fact remained constant in recent years (which would suggest that the education and training of new MH professionals is likely not meeting the state's workforce needs), the LAO reviewed data on the number of individuals graduating with professional masters or doctoral degrees in MH-related fields from California universities. From 2009-10 to 2016-17, the annual number of professional degree graduates in the fields of clinical psychology, social work, counseling, and psychiatric nursing increased from 4,700 to around 8,000 – a 70% increase. (Over this same time period, California's resident population increased by about 6%.) If sustained, this increase in the number of graduates may, but is not guaranteed to, significantly ameliorate the projected MH workforce shortage that does not necessarily assume an increase. More than 80% of the increase in professional MH graduates is from graduates of private universities in the state, which do not rely on augmentations in state funding to grow enrollment.

According to the Author
This bill will ensure the 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 MH and SUD. The author states that in the absence of clear, timely access standards for follow-up appointments with non-physician MH and SUD providers, such as social workers and therapists, large numbers of Californians requiring ongoing courses of treatment for MH and SUD 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 MH and SUD 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 study finding that one in four people age 18 to 24 has seriously considered suicide in the past 30 days. The author concludes that timely access to ongoing MH and SUD treatment is essential and must be accessible when medically necessary.

Arguments in Support
National Union of Healthcare Workers (NUHW), sponsor of this bill, writes that this bill will close a loophole in state law and regulations and establish a clear and appropriate timely access standard for follow-up appointments for MH and SUD treatment. This bill will hold health plans and insurers accountable to arrange for the timely follow-up care to which enrollees are entitled, and help minimize negative consequences associated with delays in treatment. The sponsor states that it is common for patients to wait more than four weeks for a follow-up appointment for clinically appropriate treatment. Delays in accessing appropriate treatment can lead to longer recovery times; worse outcomes; increased morbidity and mortality rates; increased time away from work; increased strain on families; increased risk of decompensation; and, accelerating crisis requiring more costly and intensive care.

Concerns

Kaiser Permanente writes that the change to a 10-day follow-up appointment standard for non-physician MH providers locks in a return interval not tied to clinical judgement. Return appointments for MH and SUD 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 MH care. As the UCSF San Francisco benchmark study of the mental health care workforce illustrates, we face a MH workforce shortage crisis in California. In 2018, UCSF noted that without concerted effort California will have 50% fewer psychiatrists and nearly 30% fewer therapists than we need to meet patterns of demand for behavioral health services by 2028. Forty-five percent of psychiatrists and 37% of psychologists will be approaching retirement age in that same period. Kaiser Permanente concludes that the COVID-19 pandemic has exacerbated the shortage we were already facing, as demand for MH care has greatly increased.

With the most recent amendments, the California Association of Health Plans removed their opposition and the California Life and Health Insurance Companies are now neutral on this bill.

Arguments in Opposition
The Department of Finance is opposed to this bill because it results in significant General Fund impacts not included in the 2021 Budget Act.

FISCAL COMMENTS

According to the Assembly Appropriations Committee:

1) CDI anticipates regulations will be necessary to align network adequacy requirements with this bill's provisions. CDI estimates costs of $88,000 in fiscal year (FY) 2021-22 and $97,000 in FY 2022-23 (Insurance Fund).

2) The Department of Health Care Services anticipates additional staffing needs in the Managed Care Quality and Monitoring Division and the Medi-Cal Behavioral Health Division. The

initial estimate is $954,000 with ongoing costs of $900,000 (50% General Fund, 50% federal funds).

3) DMHC anticipates increased workload to promulgate regulations; review health plan documents; develop a methodology for monitoring plan compliance; and address the increased volume of health plan surveys. DMHC estimates the total cost of this bill to be approximately $1,772,000 (including 5.8 personnel years (PYs)) in FY 2021-22; $3,719,000 (15.7 PYs) in FY 2022-23; $3,893,000 (16.7 PYs) in FY 2023-24; $3,698,000 (16.7 PYs) in FY 2024-25; and $3,788,000 (16.7 PYs) in FY 2025-26 and annually thereafter (Managed Care Fund).

VOTES

SENATE FLOOR: 32-7-1
YES: Allen, Archuleta, Atkins, Becker, Bradford, Caballero, Cortese, Dodd, Durazo, Eggman, Glazer, Gonzalez, Hertzberg, Hueso, Hurtado, Kamlager, Laird, Leyva, Limón, McGuire, Min, Newman, Nielsen, Pan, Portantino, Roth, Rubio, Skinner, Stern, Umberg, Wieckowski, Wiener
NO: Bates, Dahle, Grove, Jones, Melendez, Ochoa Bogh, Wilk
ABS, ABST OR NV: Borgeas

ASM HEALTH: 15-0-0
YES: Wood, Mayes, Aguiar-Curry, Arambula, Bigelow, Calderon, Carrillo, Flora, Maienschein, McCarty, Nazarian, Luz Rivas, Rodriguez, Santiago, Waldron

ASM APPROPRIATIONS: 16-0-0
YES: Lorena Gonzalez, Bigelow, Bryan, Calderon, Carrillo, Chau, Megan Dahle, Davies, Fong, Gabriel, Eduardo Garcia, Levine, Quirk, Robert Rivas, Akilah Weber, Kalra

UPDATED

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