AB-205 Medi-Cal: Medi-Cal managed care plans. (2017-2018)

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Assembly Bill No. 205

CHAPTER 738

An act to amend Sections 10950, 10951, 10952, and 10959 of, to add Section 10951.5 to, to add Article 6.3 (commencing with Section 14197) to Chapter 7 of Part 3 of Division 9 of, and to repeal Section 14197 of, the Welfare and Institutions Code, relating to Medi-Cal.

[Approved by Governor October 13, 2017. Filed with Secretary of State October 13, 2017.]

LEGISLATIVE COUNSEL'S DIGEST

AB 205, Wood. Medi-Cal: Medi-Cal managed care plans.

(1) Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which health care services are provided to qualified, low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans. Existing federal regulations, published on May 6, 2016, revise regulations governing Medicaid managed care plans to, among other things, align, where feasible, those rules with those of other major sources of coverage, including coverage through qualified health plans offered through an American Health Benefit Exchange, such as the California Health Benefit Exchange, and promote quality of care and strengthen efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries. These federal regulations, among other things, authorize an enrollee to request a state fair hearing only after receiving notice that the Medicaid managed care plan is upholding an adverse benefit determination, and requires the enrollee to request a state fair hearing no later than 120 calendar days from the date of the Medicaid managed care plans notice of resolution. These federal regulations require, with regards to a state fair hearing request filed by an enrollee entitled to an expedited resolution of an appeal by a managed care plan, an agency to take final administrative action as expeditiously as the enrollee's health condition requires, but not later than 3 working days after the agency receives, from the managed care plan, the case file and information for any appeal of a denial or a service that, as indicated by the managed care plan meets the criteria for expedited resolution of an appeal, but was not resolved within the timeframe for expedited resolution, or was resolved within the timeframe for expedited resolution of an appeal, but the managed care plan reached a decision wholly or partially adverse to the enrollee.

Existing state law establishes hearing procedures for an applicant for or beneficiary of Medi-Cal who is dissatisfied with certain actions regarding health care services and medical assistance to request a hearing from the State Department of Social Services under specified circumstances, and requires a request for a hearing to be filed within 90 days after the order or action complained of.

This bill would implement various provisions in regard to those federal regulations, as amended May 6, 2016, governing Medicaid managed care plans. The bill would authorize a person, after he or she has exhausted the Medi-Cal managed care plan's appeals process, to request a hearing involving a Medi-Cal managed care plan within 120 calendar days after he or she has either received notice from the Medi-Cal managed care plan that the adverse benefit determination, as defined, is upheld, or the person

is deemed to have exhausted the Medi-Cal managed care plans appeals process, as specified, and would exclude a request from the 120-calendar day filing time if there is good cause, as defined, for filing the request beyond the 120-calendar day period. The bill would authorize the State Department of Social Services, until January 1, 2019, to implement these provisions through an all-county information letter or similar instruction. The bill would require the State Department of Social Services, by January 1, 2019, to adopt any necessary rules and regulations to implement these changes.

The bill would generally require the State Department of Social Services, for a beneficiary of a Medi-Cal managed care plan who meets the criteria for an expedited resolution of an appeal, to take final administrative action as expeditiously as the individual's health condition requires, but no later than 3 working days after the State Department of Social Services receives certain information from the Medi-Cal managed care plan consistent with the federal regulation described above. The bill would require a Medi-Cal managed care plan, upon notice from the State Department of Social Services that a beneficiary has requested a state fair hearing, to provide to the department a copy of the case file and any information for any appeal of an adverse benefit determination within 3 business days of the Medi-Cal managed care plan's receipt of the department's notice of a request by a beneficiary for a state fair hearing. The bill would make conforming changes.

(2) These federal regulations require a state that contracts with specified Medicaid managed care plans to develop and enforce network adequacy standards and requires each state to ensure that all services covered under the Medicaid state plan are available and accessible to enrollees of specified Medicaid managed care plans in a timely manner.

This bill would establish, until January 1, 2022, certain time and distance and appointment time standards for specified services consistent with those federal regulations to ensure that all Medi-Cal managed care covered services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as specified. The bill would authorize the State Department of Health Care Services, upon the request of a Medi-Cal managed care plan, to allow alternative access standards for the time and distance standards, if the applying Medi-Cal managed care plan has exhausted all other reasonable options to obtain providers to meet the time and distance standards or if the department determines that the requesting Medi-Cal managed care plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access, and would set forth the process for submitting and reviewing a request for alternative access standards. The bill would authorize the use of clinically appropriate telecommunications technology, including telehealth, as a means of determining annual compliance with the time and distance standards established under this provision or the department's approval of a request for alternative access standards. The bill, effective for contract periods commencing on or after July 1, 2018, would require, on an annual basis and when requested by the department, a Medi-Cal managed care plan to demonstrate to the department its compliance with the time and distance and appointment time standards developed under this provision, and, effective for contract periods commencing on or after July 1, 2018, would require the department, on an annual basis, to evaluate a Medi-Cal managed care plan's compliance with the standards developed under this provision. The bill would authorize the department to implement, interpret, or make specific these provisions by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. The bill would require the department to seek any federal approvals necessary to implement these provisions, and would require these provisions to be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

The bill would require, as part of the federally required external quality review organization review of Medi-Cal managed care plans in the annual detailed technical report required under federal regulations, the external quality review organization entity designated by the department to compile specified data by Medi-Cal managed care plan and by county for the purpose of informing the status of the implementation of the time and distance and appointment time standards described above. The bill would require the department to make this information publicly available, as specified.

(3) These federal regulations require specified managed care plans to have a grievance and appeal system in place for enrollees, and requires managed care plans to resolve each grievance and appeal, and to provide timely and adequate notice, as expeditiously as the enrollee's health condition requires, within certain state-established timeframes that may not exceed specified timeframes.

This bill would require a Medi-Cal managed care plan, as defined, to give a beneficiary timely and adequate notice of an adverse benefit determination, as defined, in writing consistent with those federal regulations. The bill would require a Medi-Cal managed care plan to establish and maintain an expedited review process for a beneficiary or the beneficiary's provider to request an expedited resolution of an appeal based on specified circumstances, including when the beneficiary's condition is such that the beneficiary faces an imminent and serious threat to his or her health, or the standard timeline would be detrimental to the beneficiary's life or health or could jeopardize the beneficiary's ability to regain maximum function. The bill would require a Medi-Cal managed care plan to resolve a standard appeal no more than 30 calendar days from the day the Medi-Cal managed care plan receives the appeal, and would require the Medi-Cal managed care plan to resolve an expedited appeal no longer than 72 hours after the Medi-Cal managed care plan receives the appeal.

(4) This bill would become operative only if SB 171 of the 2017–18 Regular Session is enacted and becomes effective on or before January 1, 2018.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. It is the intent of the Legislature to implement the revisions to federal regulations governing Medicaid managed care plans at Parts 431, 433, 438, 440, 457, and 495 of Title 42 of the Code of Federal Regulations, as amended May 6, 2016, as published in the Federal Register (81 Fed. Reg. 27498).

SEC. 2. Section 10950 of the Welfare and Institutions Code is amended to read:

10950. (a) If any applicant for or recipient of public social services is dissatisfied with any action of the county department relating to his or her application for or receipt of public social services, if his or her application is not acted upon with reasonable promptness, or if any person who desires to apply for public social services is refused the opportunity to submit a signed application therefor, and is dissatisfied with that refusal, he or she shall, in person or through an authorized representative, without the necessity of filing a claim with the board of supervisors, upon filing a request with the State Department of Social Services or the State Department of Health Care Services, whichever department administers the public social service, be accorded an opportunity for a state hearing.

(b) (1) The requirements of Sections 100506.2 and 100506.4 of the Government Code apply to state hearings regarding eligibility for or enrollment in an insurance affordability program administered by the State Department of Health Care Services to the extent that those sections conflict with the state hearing requirements under this chapter.

(2) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this subdivision by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted. The department shall adopt regulations by July 1, 2017, 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. Notwithstanding Section 10231.5 of the Government Code, beginning July 1, 2015, the department shall provide a semiannual status report to the Legislature, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

(3) This subdivision shall be implemented only to the extent it does not conflict with federal law.

(c) Priority in setting and deciding cases shall be given in those cases in which aid is not being provided pending the outcome of the hearing. This priority shall not be construed to permit or excuse the failure to render decisions within the time allowed under federal and state law.

(d) Notwithstanding any other provision of this code, there is no right to a state hearing when either (1) state or federal law requires automatic grant adjustments for classes of recipients unless the reason for an individual request is incorrect grant computation, or (2) the sole issue is a federal or state law requiring an automatic change in services or medical assistance which adversely affects some or all recipients.

(e) For the purposes of administering health care services and medical assistance, the Director of Health Care Services shall have those powers and duties conferred on the Director of Social Services by this chapter to conduct state hearings in order to secure approval of a state plan under applicable federal law.

(f) The Director of Health Care Services may contract with the State Department of Social Services for the provisions of state hearings in accordance with this chapter.

(g) For purposes of this chapter, the following terms have the following meanings:

(1) “Adverse benefit determination” means, in the case of a Medi-Cal managed care plan, any of the following:

(A) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

(B) The reduction, suspension, or termination of a previously authorized service.

(C) The denial, in whole or in part, of payment for a service.

(D) The failure to provide services in a timely manner, as described in Section 14197.

(E) The failure of a Medi-Cal managed care plan to act within the timeframes provided in Section 438.408(b)(1) and Section 438.408(b)(2) of Title 42 of the Code of Federal Regulations regarding the standard resolution of grievances and appeals.

(F) For a resident of a rural area with only one Medi-Cal managed care plan, excluding a Medi-Cal managed care plan defined in subparagraphs (H) and (I) of paragraph (2), the denial of an enrollee's request to exercise his or her right under Section 438.52(b)(2)(ii) of Title 42 of the Code of Federal Regulations to obtain services outside the network.

(G) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

(2) "Medi-Cal managed care plan" means any individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(A) Article 2.7 (commencing with Section 14087.3) of Chapter 7 of Part 3, including dental managed care programs developed pursuant to Section 14087.46.

(B) Article 2.8 (commencing with Section 14087.5) of Chapter 7 of Part 3.

(C) Article 2.81 (commencing with Section 14087.96) of Chapter 7 of Part 3.

(D) Article 2.82 (commencing with Section 14087.98) of Chapter 7 of Part 3.

(E) Article 2.9 (commencing with Section 14088) of Chapter 7 of Part 3.

(F) Article 2.91 (commencing with Section 14089) of Chapter 7 of Part 3.

(G) Chapter 8 (commencing with Section 14200) of Part 3, including dental managed care plans.

(H) Chapter 8.9 (commencing with Section 14700) of Part 3.

(I) A county Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services and described in the Special Terms and Conditions. For purposes of this subdivision, "Special Terms and Conditions" shall have the same meaning as set forth in subdivision (o) of Section 14184.10.

(3) "Recipient" means an applicant for or recipient of public social services except aid exclusively financed by county funds or aid under Article 1 (commencing with Section 12000) to Article 6 (commencing with Section 12250), inclusive, of Chapter 3 of Part 3, and under Article 8 (commencing with Section 12350) of Chapter 3 of Part 3, or those activities conducted under Chapter 6 (commencing with Section 18350) of Part 6, and shall include any individual who is an approved adoptive parent, as described in paragraph (3) of subdivision (a) of Section 8708 of the Family Code, and who alleges that he or she has been denied or has experienced delay in the placement of a child for adoption solely because he or she lives outside the jurisdiction of the department.

SEC. 3. Section 10951 of the Welfare and Institutions Code is amended to read:

10951. (a) (1) A person is not entitled to a hearing pursuant to this chapter unless he or she files his or her request for the same within 90 days after the order or action complained of.

(2) Notwithstanding paragraph (1), a person shall be entitled to a hearing pursuant to this chapter if he or she files the request more than 90 days after the order or action complained of and there is good cause for filing the request beyond the 90-day period. The director may determine whether good cause exists. The department shall not grant a request for a hearing for good cause if the request is filed more than 180 days after the order or action complained of.

(b) (1) Notwithstanding subdivision (a), a person who is enrolled in a Medi-Cal managed care plan and who has received an adverse benefit determination from the Medi-Cal managed care plan shall, to the extent required by federal law or regulation, appeal the adverse benefit determination to the Medi-Cal managed care plan before requesting a state fair hearing pursuant to this chapter. After appealing to the Medi-Cal managed care plan, the enrollee may request a hearing pursuant to this chapter involving a Medi-Cal managed care plan within 120 calendar days after either of the following:

(A) The enrollee receives notice from the Medi-Cal managed care plan that the adverse benefit determination is upheld.

(B) The enrollee's appeal is deemed exhausted because the Medi-Cal managed care plan failed to comply with state or federal requirements for notice and timeliness related to the disputed action or the appeal, including when a Medi-Cal managed care plan fails to respond to an appeal within 30 days as required pursuant to subdivision (b) of Section 14197.3.

(2) Notwithstanding paragraph (1), a person shall be entitled to a hearing pursuant to this chapter if he or she files the request more than 120 calendar days after receiving notice from the Medi-Cal managed care plan that the adverse benefit determination is upheld and there is good cause for filing the request beyond the 120-calendar day period. The director may determine whether good cause exists. The department shall not grant a request for a hearing for good cause if the request is filed more than 180 days after receipt of the notice from the Medi-Cal managed care plan that the adverse benefit determination is upheld.

(c) For purposes of this section, “good cause” means a substantial and compelling reason beyond the party’s control, considering the length of the delay, the diligence of the party making the request, and the potential prejudice to the other party. The inability of a person to understand an adequate and language-compliant notice, in and of itself, shall not constitute good cause.

(d) This section shall not preclude the application of the principles of equity jurisdiction as otherwise provided by law.

(e) Notwithstanding 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 department, until January 1, 2019, may implement this section through an all-county information letter or similar instruction. The department may also provide further instructions through training notes.

(f) Notwithstanding subdivision (e), the department, by January 1, 2019, shall implement the amendments made to this section by the act that added this subdivision by adopting any necessary rules and regulations 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).

SEC. 4. Section 10951.5 is added to the Welfare and Institutions Code, to read:

10951.5. (a) For a beneficiary of a Medi-Cal managed care plan who meets the criteria for an expedited resolution of an appeal as set forth in subdivision (c) of Section 14197.3 or Section 438.410 of Title 42 of the Code of Federal Regulations, the department shall take final administrative action as expeditiously as the individual’s health condition requires, but no later than three working days after the department receives, from the Medi-Cal managed care plan, the case file and information for any appeal of an adverse benefit determination that, as indicated by the Medi-Cal managed care plan or determined by the administrative law judge, meets either of the following criteria:

(1) Meets the criteria for expedited resolution as set forth in Section 438.410 (a) of Title 42 of the Code of Federal Regulations, but was not resolved within the timeframe for expedited resolution.

(2) Was resolved within the timeframe for expedited resolution, but reached a decision wholly or partially adverse to the beneficiary.

(b) Upon notice from the department that a Medi-Cal managed care plan’s beneficiary has requested a state fair hearing, the Medi-Cal managed care plan shall provide to the department a copy of the following information within three business days of the Medi-Cal managed care plan’s receipt of the department’s notice of a request by a beneficiary for a state fair hearing:

(1) The case file.

(2) Any information for any appeal of an adverse benefit determination that, as indicated by the Medi-Cal managed care plan, meets either of the criteria described in paragraph (1) or (2) of subdivision (a).

(c) (1) The department shall take final administrative action on a fair hearing request within the time limits set forth in this section except under either of the following unusual circumstances:

(A) The department cannot reach a decision because the beneficiary requests a delay or fails to take a required action.

(B) There is an administrative or other emergency beyond the department’s control.

(2) The department shall document the reasons for any delay in the beneficiary’s record.

SEC. 5. Section 10952 of the Welfare and Institutions Code is amended to read:

10952. (a) The department shall set the hearing to commence within 30 working days after the request is filed, and, at least 10 days prior to the hearing, shall give all parties concerned written notice of the time and place of the hearing.

(b) The 30 working day and 10-day requirements described in subdivision (a) shall not apply to a request filed by a beneficiary of a Medi-Cal managed care plan who meets the criteria for an expedited resolution of an appeal as described in subdivision (a) of Section 10951.5.

SEC. 6. Section 10959 of the Welfare and Institutions Code is amended to read:

10959. After an administrative law judge has held a hearing and issued a proposed decision, within 30 days after the department has received a copy of the administrative law judge's proposed decision, or within the three business days for an expedited resolution of an appeal of an adverse benefit determination described in Section 10951.5 after any extensions that may apply under subdivision (c) of Section 10951.5, the director may adopt the decision in its entirety; decide the matter himself or herself on the record, including the transcript, with or without taking additional evidence; or order a further hearing to be conducted by himself or herself, or another administrative law judge on behalf of the director. Failure of the director to adopt the proposed decision, decide the matter himself or herself on the record, including the transcript, with or without taking additional evidence or order a further hearing within the 30 days, or within the three business days for an expedited resolution of an appeal of an adverse benefit determination described in Section 10951.5 after any extensions that may apply under subdivision (c) of Section 10951.5, shall be deemed an affirmation of the proposed decision. If the director decides the matter, a copy of his or her decision shall be served on the applicant or recipient and on the affected county, and, if his or her decision differs materially from the proposed decision of the administrative law judge, a copy of that proposed decision shall also be served on the applicant or recipient and on the affected county. If a further hearing is ordered, it shall be conducted in the same manner and within the same time limits specified for the original hearing.

SEC. 7. Article 6.3 (commencing with Section 14197) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 6.3. Medi-Cal Managed Care Plans

14197. (a) It is the intent of the Legislature that the department implement and monitor compliance with the time and distance requirements set forth in Sections 438.68, 438.206, and 438.207 of Title 42 of the Code of Federal Regulations and this section, to ensure that all Medi-Cal managed care covered services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as those standards were enacted in May 2016.

(b) Commencing January 1, 2018, for covered benefits under its contract, as applicable, a Medi-Cal managed care plan shall maintain a network of providers that are located within the following time and distance standards for the following services:

(1) For primary care, both adult and pediatrics, 10 miles or 30 minutes from the beneficiary's place of residence.

(2) For hospitals, 15 miles or 30 minutes from the beneficiary's place of residence.

(3) For dental services provided by a Medi-Cal managed care plan, 10 miles or 30 minutes from the beneficiary's place of residence.

(4) For obstetrics and gynecology primary care, 10 miles or 30 minutes from the beneficiary's place of residence.

(c) Commencing July 1, 2018, for the covered benefits under its contracts, as applicable, a Medi-Cal managed care plan shall maintain a network of providers that are located within the following time and distance standards for the following services:

(1) For specialists, as defined in subdivision (h), adult and pediatric, including obstetric and gynecology specialty care, as follows:

(A) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(B) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(C) Up to 45 miles or 75 minutes from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(D) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

(2) For pharmacy services, 10 miles or 30 minutes from the beneficiary's place of residence.

(3) For outpatient mental health services, as follows:

(A) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(B) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(C) Up to 45 miles or 75 minutes from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(D) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

(4) (A) For outpatient substance use disorder services other than opioid treatment programs, as follows:

(i) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(ii) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(iii) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Monterey, Mono, Napa, Nevada, Plumas, San Benito, San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba.

(B) For opioid treatment programs, as follows:

(i) Up to 15 miles or 30 minutes from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(ii) Up to 30 miles or 60 minutes from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(iii) Up to 45 miles or 75 minutes from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(iv) Up to 60 miles or 90 minutes from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

(d) (1) (A) A Medi-Cal managed care plan shall comply with the appointment time standards developed pursuant to Section 1367.03 of the Health and Safety Code, Section 1300.67.2.2 of Title 28 of the California Code of Regulations, subject to any allowable exceptions in Section 1300.67.2.2 of Title 28 of the California Code of Regulations, and the standards set forth in contracts entered into between the department and Medi-Cal managed care plans.

(B) Subparagraph (A) shall, commencing July 1, 2018, apply to Medi-Cal managed care plans that are not, as of January 1, 2018, subject to the appointment time standards described in subparagraph (A).

(2) A Medi-Cal managed care plan shall comply with the following availability standards for skilled nursing facility services and intermediate care facility services, as follows:

(A) Within five business days of the request for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.

(B) Within seven business days of the request for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.

(C) Within 14 calendar days of the request for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.

(D) Within 14 calendar days of the request for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

(3) A county Drug Medi-Cal organized delivery system shall provide an appointment within three business days to an opioid treatment program.

(4) A dental managed care plan shall provide an appointment within four weeks of a request for routine pediatric dental services and within 30 calendar days of a request for specialist pediatric dental services.

(e) (1) The department, upon request of a Medi-Cal managed care plan, may allow alternative access standards for the time and distance standards established under this section if either of the following occur:

(A) The requesting Medi-Cal managed care plan has exhausted all other reasonable options to obtain providers to meet the applicable standard.

(B) The department determines that the requesting Medi-Cal managed care plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.

(2) If a Medi-Cal managed care plan cannot meet the time and distance standards set forth in this section, the Medi-Cal managed care plan shall submit a request for alternative access standards to the department, in the form and manner specified by the department. A request may be submitted at the same time as the Medi-Cal managed care plan submits its annual demonstration of compliance with time and distance standards, if known at that time.

(3) A request for alternative access standards shall be approved or denied on a ZIP Code and provider type, including specialty type, basis by the department within 90 days of submission of the request. The Medi-Cal managed care plan shall also include a description of the reasons justifying the alternative access standards based on those facts and circumstances. The department may stop the 90-day timeframe, on one or more occasions as necessary, in the event of an incomplete submission or to obtain additional information from the Medi-Cal managed care plan requesting the alternative access standards. Upon submission of sufficient additional information to the department, the 90-day timeframe shall resume at the same point in time it was previously stopped, except if there is less than 30 days remaining in which case the department shall approve or deny the request within 30 days of submission of sufficient additional information. If the department rejects the Medi-Cal managed care plan's proposal, the department shall inform the Medi-Cal managed care plan of the department's reason for rejecting the proposal. The department shall post any approved alternative access standards on its Internet Web site.

(4) The department may allow for the use of clinically appropriate telecommunications technology as a means of determining annual compliance with the time and distance standards established pursuant to this section or approving alternative access to care, including telehealth consistent with the requirements of Section 2290.5 of the Business and Professions Code, e-visits, or other evolving and innovative technological solutions that are used to provide care from a distance.

(f) (1) Effective for contract periods commencing on or after July 1, 2018, a Medi-Cal managed care plan shall, on an annual basis and when requested by the department, demonstrate to the department its compliance with the time and distance and appointment time standards developed pursuant to this section. The report shall measure compliance separately for adult and pediatric services for primary care, behavioral health, and core specialist services.

(2) Effective for contract periods commencing on or after July 1, 2018, the department shall evaluate on an annual basis a Medi-Cal managed care plan's compliance with the time and distance and appointment time standards implemented pursuant to this section. This evaluation may include, but need not be limited to, annual and random surveys, investigation of complaints, grievances or other indicia of noncompliance. Nothing in this subdivision shall be construed to limit the appeal rights of a Medi-Cal managed care plan under its contracts with the department.

(3) The department shall annually publish on its Internet Web site a report in which it details its findings in evaluating a Medi-Cal managed care plan's compliance under paragraph (2). At a minimum, the department shall specify in this report those Medi-Cal managed care plans, if any, that were subject to a corrective action plan due to noncompliance with the time and distance and appointment time standards implemented pursuant to this section during the applicable year and the basis for the department's finding of noncompliance. The report shall include a Medi-Cal managed care plan's response to the corrective plan, if available.

(g) The department shall consult with Medi-Cal managed care plans, including mental health plans, health care providers, consumers, providers and consumers of LTSS, and organizations representing Medi-Cal beneficiaries in the implementation of the requirements of this section.

(h) For purposes of this section, the following definitions apply:

(1) "Medi-Cal managed care plan" means any individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(A) Article 2.7 (commencing with Section 14087.3), including dental managed care programs developed pursuant to Section 14087.46.

(B) Article 2.8 (commencing with Section 14087.5).

(C) Article 2.81 (commencing with Section 14087.96).

(D) Article 2.82 (commencing with Section 14087.98).

(E) Article 2.9 (commencing with Section 14088).

(F) Article 2.91 (commencing with Section 14089).

(G) Chapter 8 (commencing with Section 14200), including dental managed care plans.

(H) Chapter 8.9 (commencing with Section 14700).

(I) A county Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services and described in the Special Terms and Conditions. For purposes of this subdivision, "Special Terms and Conditions" shall have the same meaning as set forth in subdivision (o) of Section 14184.10.

(2) "Specialist" means any of the following:

(A) Cardiology/interventional cardiology.

(B) Nephrology.

(C) Dermatology.

(D) Neurology.

(E) Endocrinology.

(F) Ophthalmology.

(G) Ear, nose, and throat/otolaryngology.

(H) Orthopedic surgery.

(I) Gastroenterology.

(J) Physical medicine and rehabilitation.

(K) General surgery.

(L) Psychiatry.

(M) Hematology.

(N) Oncology.

(O) Pulmonology.

(P) HIV/AIDS specialists/infectious diseases.

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted.

(j) The department shall seek any federal approvals it deems necessary to implement this section. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(k) This section shall remain in effect only until January 1, 2022, and as of that date is repealed, unless a later enacted statute that is enacted before January 1, 2022, deletes or extends that date.

14197.05. (a) As part of the federally required external quality review organization (EQRO) review of Medi-Cal managed care plans in the annual detailed technical report required by Section 438.364 of Title 42 of the Code of Federal Regulations, effective for contract periods commencing on or after July 1, 2018, the EQRO entity designated by the department shall compile the data described in subdivision (b) by plan and by county for the purpose of informing the status of implementation of the requirements of Section 14197.

(b) (1) The information compiled by the EQRO entity shall include all of the following:

(A) Number of requests for alternative access standards in the plan service area for time and distance, categorized by all provider types, including specialists, and by adult and pediatric.

(B) Number of allowable exceptions for the appointment time standard, if known, categorized by all provider types, including specialists, and by adult and pediatric.

(C) Distance and driving time between the nearest network provider and ZIP Code of the beneficiary furthest from that provider for requests for alternative access standards.

(D) Approximate number of beneficiaries impacted by alternative access standards or allowable exceptions.

(E) Percentage of providers in the plan service area by provider and specialty type that are under a contract with a Medi-Cal managed care plan.

(F) The number of requests for alternative access standards approved or denied by ZIP Code and provider and specialty type, and the reasons for the approval or denial of the request for alternative access standards.

(G) The process of ensuring out-of-network access.

(H) Descriptions of contracting efforts and explanation for why a contract was not executed.

(I) Timeframe for approval or denial of a request for alternative access standards by the department.

(J) Consumer complaints, if any.

(2) The information described in paragraph (1) shall be presented in a chart format to enable comparison among counties, provider types, and plans.

(c) The EQRO entity shall develop a methodology to assess information that will help inform the experience of individuals placed in a skilled nursing facility or intermediate care facility and the distance that they are placed from their place of residence. The EQRO entity shall report the results from the use of this methodology in the EQRO annual Medi-Cal managed care plan technical report.

(d) The department shall comply with the requirements of subsection (c) of Section 438.364 of Title 42 of the Code of Federal Regulations in making the information described in this section publicly available.

14197.3. (a) A Medi-Cal managed care plan shall give a beneficiary timely and adequate notice of an adverse benefit determination in writing consistent with the requirements in Sections 438.404, 438.408, and 438.10 of Title 42 of the Code of Federal Regulations. For purposes of this subdivision, “adverse benefit determination” means either of the following:

(1) Any action described in Section 10950.

(2) Any health care service eligible for coverage and payment under a Medi-Cal managed care plan contract that has been denied, modified, or delayed by a decision of the Medi-Cal managed care plan, or by one of its contracting providers.

(b) Except as provided in subdivision (c), a Medi-Cal managed care plan shall resolve an appeal no more than 30 calendar days from the day the Medi-Cal managed care plan receives the appeal.

(c) A Medi-Cal managed care plan shall resolve an expedited appeal no longer than 72 hours after the Medi-Cal managed care plan receives the appeal. A Medi-Cal managed care plan shall establish and maintain an expedited review process for a beneficiary or the beneficiary’s provider to request an expedited resolution of an appeal based on either of the following circumstances:

(1) If the Medi-Cal managed care plan determines, for a request from the beneficiary, or the provider indicates, in making the request on the beneficiary’s behalf or supporting the beneficiary’s request, that taking the time for a standard resolution under the timeframe described in subdivision (b) could seriously jeopardize the beneficiary’s life, physical or mental health, or ability to attain, or regain, maximum function.

(2) When the beneficiary’s condition is such that the beneficiary faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the timeframe described in subdivision (b) would be detrimental to the beneficiary’s life or health or could jeopardize the beneficiary’s ability to regain maximum function.

(d) For purposes of this section, “Medi-Cal managed care plan” means any individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to any of the following:

(1) Article 2.7 (commencing with Section 14087.3), including dental managed care programs developed pursuant to Section 14087.46.

(2) Article 2.8 (commencing with Section 14087.5).

(3) Article 2.81 (commencing with Section 14087.96).

(4) Article 2.82 (commencing with Section 14087.98).

(5) Article 2.9 (commencing with Section 14088).

(6) Article 2.91 (commencing with Section 14089).

(7) Chapter 8 (commencing with Section 14200), including dental managed care plans.

(8) Chapter 8.9 (commencing with Section 14700).

(9) A county Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services and described in the Special Terms and Conditions. For purposes of this subdivision, “Special Terms and Conditions” shall have the same meaning as set forth in subdivision (o) of Section 14184.10.

SEC. 8. This act shall become operative only if Senate Bill 171 of the 2017–18 Regular Session is enacted and becomes effective on or before January 1, 2018.