SB-1287 Medi-Cal: medically necessary services. (2017-2018)

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Senate Bill No. 1287

CHAPTER 855

An act to amend Sections 14059.5 and 14133.3 of the Welfare and Institutions Code, relating to Medi-Cal.

[Approved by Governor September 27, 2018. Filed with Secretary of State September 27, 2018.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1287, Hernandez. Medi-Cal: medically necessary services.

Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive medically necessary health care services, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for an individual under 21 years of age who is covered under the Medi-Cal program, subject to utilization controls, and consistent with federal requirements. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

Under existing state law, a service is “medically necessary” if it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

This bill would revise the Medi-Cal definition of “medically necessary” for purposes of an individual under 21 years of age to incorporate the existing federal standards related to EPSDT services. The bill would require the department and its contractors to update any model evidence of specified materials to ensure the medical necessity standard for coverage for individuals under 21 years of age is accurately reflected in all materials. The bill would require the department to implement, interpret, and make specific these provisions by means of all-county letters or similar instructions until regulations are revised or adopted by July 1, 2022.

The bill would also clarify the meaning of “medically necessary” with regard to prior authorization controls in the Medi-Cal program.

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

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

SECTION 1. Section 14059.5 of the Welfare and Institutions Code is amended to read:

14059.5. (a) For individuals 21 years of age or older, a service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

(b) (1) For individuals under 21 years of age, a service is “medically necessary” or a “medical necessity” if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code.

(2) The department and its contractors shall update any model evidence of coverage documents, beneficiary handbooks, and related material to ensure the medical necessity standard for coverage for individuals under 21 years of age is accurately reflected in all materials.

(3) 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, and make specific this subdivision by means of all-county letters, plan letters, plan provider bulletins, manuals, plan contract amendments, or similar instructions until regulations are revised or adopted.

(4) By July 1, 2022, the department shall revise or 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.

(c) This section shall not be construed to limit the application of subdivisions (a) and (b) of Section 51184 of Title 22 of the California Code of Regulations.

SEC. 2. Section 14133.3 of the Welfare and Institutions Code is amended to read:

14133.3. (a) The director shall require fully documented medical justification from providers that the requested services are medically necessary or a medical necessity, as defined in Section 14059.5, on all requests for prior authorization.

(b) For services not subject to prior authorization controls, offered by noncontract hospitals in closed health facility planning areas to beneficiaries who were experiencing life-threatening or emergency situations, but could not be stabilized sufficiently in order to facilitate being transported to contracting hospitals, the director shall additionally determine utilization controls that shall be applied to ensure that the health care services provided and the conditions treated, are medically necessary to prevent significant illness, alleviate severe pain, to protect life, or prevent significant disability. These utilization controls shall take into account those diseases, illnesses, or injuries that require preventive health services or treatment to prevent serious deterioration of health.

(c) Nothing in this section shall preclude payment for family planning services or early and periodic screening, diagnosis, and treatment services mandated by federal law.

(d) For the purposes of this section, a “noncontract hospital” means a hospital that has not contracted with the department for the provision of inpatient services pursuant to Article 2.6 (commencing with Section 14081).

(e) 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.