§ 1367.015. Decisions to deny requests by providers for authorization or claim reimbursement for mental health services

In addition to complying with subdivision (h) of Section 1367.01, in determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to Section 1367.01 shall not base decisions to deny requests by providers for authorization for mental health services or to deny claim reimbursement for mental health services on either of the following:

(a) Whether admission was voluntary or involuntary.

(b) The method of transportation to the health facility.

HISTORY:

Added Stats 2008 ch 722 § 1 (SB 1553), effective January 1, 2009.

§ 1367.016. Premium payments from third-party entities; Reimburse- ment; Dispute resolution

(a) A health care service plan shall accept premium payments from the following third-party entities without the need to comply with subdivision (c):

(1) A Ryan White HIV/AIDS Program under Title XXVI of the federal Public Health Service Act.

(2) An Indian tribe, tribal organization, or urban Indian organization.

(3) A local, state, or federal government program, including a grantee directed by a government program to make payments on its behalf.

(4) A member of the individual's family, defined for purposes of this section to include the individual's spouse, domestic partner, child, parent, grandparent, and siblings, unless the true source of funds used to make the premium payment originates with a financially interested entity.

(b) A financially interested entity that is not specified in subdivision (a) and is making third-party premium payments shall comply with all of the following requirements:

(1) It shall provide assistance for the full plan year and notify the enrollee prior to an open enrollment period, if applicable, if financial assistance will be discontinued. Notification shall include information regarding alternative coverage options, including, but not limited to, Medicare, Medicaid, individual market plans, and employer plans, if applicable. Assistance may be discontinued at the request of an enrollee who obtains other health coverage, or if the enrollee dies during the plan year.

(2) It shall agree not to condition financial assistance on eligibility for, or receipt of, any surgery, transplant, procedure, drug, or device.

(3) It shall inform an applicant of financial assistance, and shall inform a recipient annually, of all available health coverage options, including, but not limited to, Medicare, Medicaid, individual market plans, and employer plans, if applicable.

(4) It shall agree not to steer, direct, or advise the patient into or away from a specific coverage program option or health care service plan contract.

(5) It shall agree that financial assistance shall not be conditioned on the use of a specific facility, health care provider, or coverage type.

(6) It shall agree that financial assistance shall be based on financial need in accordance with criteria that are uniformly applied and publicly available.

(c) A financially interested entity shall not make a third-party premium payment unless the entity complies with both of the following requirements:

(1) Annually provides a statement to the health care service plan that it meets the requirements set forth in subdivision (b), as applicable.

(2) Discloses to the health care service plan, prior to making the initial payment, the name of the enrollee for each health care service plan contract on whose behalf a third-party premium payment described in this section will be made.

(d)(1) Reimbursement for enrollees for whom a nonprofit financially interested entity described in paragraph (2) of subdivision (h) that was already making premium payments to a health care service plan on the enrollee's behalf prior to October 1, 2019, is not subject to subdivisions (e) and (f) and the financially interested entity is not required to comply with the disclosure requirements described in subdivision (c) for those enrollees.

(2) Notwithstanding paragraph (1), a financially interested entity shall comply with the disclosure requirements of subdivision (c) for an enrollee on whose behalf the financially interested entity was making premium payments to a health care service plan on the enrollee's behalf prior to October 1, 2019, if the enrollee changes health care service plans on or after March 1, 2020.

(3) The amount of reimbursement for services paid to a financially interested provider shall be governed by the terms of the enrollee's health care service plan contract, except for an enrollee who has changed health care service plans pursuant to paragraph (2), in which case, commencing January 1, 2022, the reimbursement amount shall be determined in accordance with subdivisions (e) and (f).

(e) Commencing January 1, 2022, if a financially interested entity makes a third-party premium payment to a health care service plan on behalf of an enrollee, reimbursement to a provider who is also a financially interested entity for covered services provided shall be determined by the following:

(1) For a contracted financially interested provider that makes a third-party premium payment or has a financial relationship with the entity making the third-party premium payment, the amount of reimbursement for covered services that shall be paid to the financially interested provider on behalf of the enrollee shall be the higher of the Medicare reimbursement or the rate determined pursuant to the process described in this subdivision, if a rate determination pursuant to that process is sought by either the provider or the health care service plan. Financially interested providers shall neither bill the enrollee nor seek reimbursement from the enrollee for services provided, except for cost sharing pursuant to the terms and conditions of the enrollee's health care service plan contract. If an enrollee's contract imposes a coinsurance payment for a claim that is subject to this paragraph, the coinsurance payment shall be based on the amount paid by the health care service plan pursuant to this paragraph.

(2) For a noncontracting financially interested provider that makes a third-party premium payment or has a financial relationship with the entity making the third-party premium payment, the amount of reimbursement for covered services that shall be paid to the financially interested provider on behalf of the enrollee shall be governed by the terms and conditions of the enrollee's health care service plan contract or the rate determined pursuant to the process described in this subdivision, whichever is lower, if a rate determination pursuant to that process is sought by either the provider or the health care service plan. Financially interested providers shall neither bill the enrollee nor seek reimbursement from the enrollee for services provided, except for cost sharing pursuant to the terms and conditions of the enrollee's health care service plan contract. If an enrollee's contract imposes a coinsurance payment for a claim that is subject to this paragraph, the coinsurance payment shall be based on the amount paid by the health care service plan pursuant to this paragraph. A claim submitted to a health care service plan by a noncontracting financially interested provider may be considered an incomplete claim and contested by the health care service plan pursuant to Section 1371 or 1371.35 if the financially interested provider has not provided the information as required in subdivision (c).

(f)(1) By October 1, 2021, the department shall establish an independent dispute resolution process for the purpose of determining if the amount required to be reimbursed by subdivision (e) is appropriate.

(2) If either the provider or health care service plan submits a claim to the department's independent dispute resolution process, the other party shall participate in the independent dispute resolution process.

(3) In making its determination, the independent organization shall consider information submitted by either party regarding the actual cost to provide services, patient eligibility for Medicare or Medi-Cal, and the rate that would be paid by Medicare or Medi-Cal for patients eligible for those programs.

(4) The health care service plan shall implement the determination obtained through the independent dispute resolution process. The independent organization's determination of the amount required to be reimbursed shall apply for the duration of the plan year for that enrollee. If dissatisfied, either party may pursue any right, remedy, or penalty established under any other applicable law.

(5) In establishing the independent dispute resolution process, the department shall permit the bundling of claims submitted to the same plan or the same delegated entity for the same or similar services. The department shall permit claims on behalf of multiple enrollees from the same provider to the same health care service plan to be combined into a single independent dispute resolution process.

(6) The department shall establish uniform written procedures for the submission, receipt, processing, and resolution of claim payment disputes pursuant to this section and any other guidelines for implementing this section.

(7) The department shall establish reasonable and necessary fees not to exceed the reasonable costs of administering this subdivision.

(8) The department may contract with one or more independent organizations to conduct the proceedings. The independent organization handling a dispute shall be independent of either party to the dispute.

(9) The department shall use conflict-of-interest standards consistent with the standards pursuant to subdivisions (c) and (d) of Section 1374.32.

(10) The department may contract with the same independent organization or organizations as the Department of Insurance.

(11) The independent organization retained to conduct proceedings shall be deemed to be consultants for purposes of Section 43.98 of the Civil Code.

(12) Contracts entered into pursuant to the authority in this subdivision shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Section 19130 of the Government Code, and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(13) This subdivision does not alter a health care service plan's obligations under Section 1371.

(14) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-plan

letters or similar instructions, without taking regulatory action, until regulations are adopted.

(g) For the purposes of this section, third-party premium payments only include health care service plan premium payments made directly by a provider or other third party, made indirectly through payments to the individual for the purpose of making health care service plan premium payments, or provided to one or more intermediaries with the intention that the funds be used to make health care service plan premium payments for the individuals.

(h) The following definitions apply for purposes of this section:

(1) "Enrollee" means an individual whose health care service plan premiums are paid by a financially interested entity.

(2) "Financially interested" includes any of the following entities:

(A) A provider of health care services that receives a direct or indirect financial benefit from a third-party premium payment.

(B) An entity that receives the majority of its funding from one or more financially interested providers of health care services, parent companies of providers of health care services, subsidiaries of health care service providers, or related entities.

(C) A chronic dialysis clinic that is operated, owned, or controlled by a parent entity or related entity that meets the definition of a large dialysis clinic organization (LDO) under the federal Centers for Medicare and Medicaid Services Comprehensive ESRD Care Model as of January 1, 2019. A chronic dialysis clinic that does not meet the definition of an LDO or has no more than 10 percent of California's market share of licensed chronic dialysis clinics shall not be considered financially interested for purposes of this section.

(3) "Health care service plan contract" means an individual or group health care service plan contract that provides medical, hospital, and surgical benefits, except a specialized health care service plan contract. The term does not include coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement coverage, long-term care insurance, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation law or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(4) "Provider" means a professional person, organization, health facility, or other person or institution that delivers or furnishes health care services.

(i) The following shall occur if a health care service plan subsequently discovers that a financially interested entity fails to provide disclosure pursuant to subdivision (c):

(1) The health care service plan shall be entitled to recover 120 percent of the difference between a payment made to a provider and the payment to which the provider would have been entitled pursuant to subdivision (e), including interest on that difference.

(2) The health care service plan shall notify the department of the amount by which the provider was overpaid and shall remit to the department any amount exceeding the difference between the payment made to the provider

and the payment to which the provider would have been entitled pursuant to subdivision (e), including interest on that difference that was recovered pursuant to paragraph (1).

(j) Commencing January 1, 2022, each health care service plan licensed by the department and subject to this section shall provide to the department information regarding premium payments by financially interested entities and reimbursement for services to providers under subdivision (e). The information shall be provided at least annually at the discretion of the department and shall include, to the best of the health care service plan's knowledge, the number of enrollees whose premiums were paid by financially interested entities, disclosures provided to the plan pursuant to subdivision (c), the identities of any providers whose reimbursement rate was governed by subdivision (e), the identities of any providers who failed to provide disclosure as described in subdivision (c), and, at the discretion of the department, additional information necessary for the implementation of this section.

(k) This section does not limit the authority of the Attorney General to take action to enforce this section.

(l) This section does not affect a contracted payment rate for a provider who is not financially interested.

(m) This section does not alter any of a health care service plan's obligations and requirements under this chapter, including, but not limited to, the following:

(1) The obligation of a health care service plan to fairly and affirmatively offer, market, sell, and issue a health benefit plan to any individual, consistent with Article 11.8 (commencing with Section 1399.845), or small employer, consistent with Article 3.1 (commencing with Section 1357).

(2) The obligations of a health care service plan with respect to cancellation or nonrenewal as provided in this chapter, including, but not limited to, Section 1365.

(3) A health care service plan may not deny coverage to an enrollee whose premiums are paid by a third party.

(n) This section does not supersede or modify any privacy and information security requirements and protections in federal and state law regarding protected health information or personally identifiable information, including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 300gg).

(o) Notwithstanding clause (iii) of subparagraph (A) of paragraph (1) of subdivision (d) of Section 1399.849, an enrollee's loss of coverage due to a financially interested entity's failure to pay premiums on a timely basis shall be deemed a triggering event for special enrollment pursuant to subparagraph (A) of paragraph (1) of subdivision (d) of Section 1399.849.

HISTORY:
Added Stats 2019 ch 862 § 3 (AB 290), effective January 1, 2020.

§ 1367.02. Filing relating to any economic profiling policies or proce- dures; Availability to public; "Economic profiling"

(a) On or before July 1, 1999, for purposes of public disclosure, every health care service plan shall file with the department a description of any policies

and procedures related to economic profiling utilized by the plan and its medical groups and individual practice associations. The filing shall describe how these policies and procedures are used in utilization review, peer review, incentive and penalty programs, and in provider retention and termination decisions. The filing shall also indicate in what manner, if any, the economic profiling system being used takes into consideration risk adjustments that reflect case mix, type and severity of patient illness, age of patients, and other enrollee characteristics that may account for higher or lower than expected costs or utilization of services. The filing shall also indicate how the economic profiling activities avoid being in conflict with subdivision (g) of Section 1367, which requires each plan to demonstrate that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management. Any changes to the policies and procedures shall be filed with the director pursuant to Section 1352. Nothing in this section shall be construed to restrict or impair the department, in its discretion, from utilizing the information filed pursuant to this section for purposes of ensuring compliance with this chapter.

(b) The director shall make each plan's filing available to the public upon request. The director shall not publicly disclose any information submitted pursuant to this section that is determined by the director to be confidential pursuant to state law.

(c) Each plan that uses economic profiling shall, upon request, provide a copy of economic profiling information related to an individual provider, contracting medical group, or individual practice association to the profiled individual, group, or association. In addition, each plan shall require as a condition of contract that its medical groups and individual practice associations that maintain economic profiles of individual providers shall, upon request, provide a copy of individual economic profiling information to the individual providers who are profiled. The economic profiling information provided pursuant to this section shall be provided upon request until 60 days after the date upon which the contract between the plan and the individual provider, medical group, or individual practice association terminates, or until 60 days after the date the contract between the medical group or individual practice association and the individual provider terminates, whichever is applicable.

(d) For the purposes of this article, "economic profiling" shall mean any evaluation of a particular physician, provider, medical group, or individual practice association based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, provider, medical group, or individual practice association.

HISTORY:

Added Stats 1998 ch 893 § 1 (SB 984). Amended Stats 1999 ch 525 § 95 (AB 78), operative July 1, 2000.