§ 1373.7. Out of state contracts; Psychologist licensure requirements

A health care service plan contract, which is written or issued for delivery outside of California and which provides benefits for California residents that are within the scope of psychological practice, shall not be deemed to prohibit

persons covered under the contract from selecting a psychologist licensed in California to perform the services in California which are within the terms of the contract even though the psychologist is not licensed in the state where the contract is written or issued for delivery.

HISTORY:
Added Stats 1981 ch 558 § 1.

§ 1373.8. Contractees' right to select licensed professionals in California to perform contract services

A health care service plan contract where the plan is licensed to do business in this state and the plan provides coverage that includes California residents, but that may be written or issued for delivery outside of California, and where benefits are provided within the scope of practice of a licensed clinical social worker, a registered nurse licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code who possesses a master's degree in psychiatric-mental health nursing and is listed as a psychiatric-mental health nurse by the Board of Registered Nursing, an advanced practice registered nurse who is certified as a clinical nurse specialist pursuant to Article 9 (commencing with Section 2838) of Chapter 6 of Division 2 of the Business and Professions Code who participates in expert clinical practice in the specialty of psychiatric-mental health nursing, a marriage and family therapist who is the holder of a license under Section 4980.50 of the Business and Professions Code, or a professional clinical counselor who is the holder of a license under Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code shall not be deemed to prohibit persons covered under the contract from selecting those licensed persons in California to perform the services in California that are within the terms of the contract even though the licensees are not licensed in the state where the contract is written or issued for delivery.

It is the intent of the Legislature in amending this section in the 1984 portion of the 1983-84 Legislative Session that persons covered by the contract and those providers of health care specified in this section who are licensed in California should be entitled to the benefits provided by the plan for services of those providers rendered to those persons.

HISTORY:
Added Stats 1983 ch 673 § 1. Amended Stats 1984 ch 144 § 152 (ch 540 prevails), ch 540 § 2; Stats 2001 ch 420 § 4 (AB 1253), effective October 2, 2001; Stats 2002 ch 1013 § 85 (SB 2026); Stats 2011 ch 381 § 31 (SB 146), effective January 1, 2012.

§ 1373.9. Duty to give reasonable consideration to proposals for affiliation

(a) Except in the case of a specialized health care service plan, a health care service plan which negotiates and enters into a contract with professional providers to provide services at alternative rates of payment of the type described in Sections 10133 and 11512 of the Insurance Code, shall give reasonable consideration to timely written proposals for affiliation by licensed or certified professional providers.

(b) For the purposes of this section, the following definitions are applicable:

(1) "Reasonable consideration" means consideration in good faith of the terms of proposals for affiliation prior to the time that contracts for alternative rates of payment are entered into or renewed. A plan may specify the terms and conditions of affiliation to assure cost efficiency, qualifications of providers, appropriate utilization of services, accessibility, convenience to persons who would receive the provider's services, and consistency with the plan's basic method of operation, but shall not exclude providers because of their category of license.

(2) "Professional provider" means a holder of a certificate or license under Division 2 (commencing with Section 500) of the Business and Professions Code, or any initiative act referred to therein, except for those certified or licensed pursuant to Article 3 of Chapter 5 (commencing with Section 2050) or Chapter 11 (commencing with Section 4800), who may, within the scope of their licenses, perform the services of a specific plan benefit defined in the health care service plan's contracts with its enrollees.

(c) A plan which has an affiliation with an institutional provider or with professional providers is not required by this section to give consideration to affiliation with professional providers who hold the same category of license or certificate and propose to serve a geographic area served adequately by the affiliated providers that provide their professional services as employees or agents of that institutional or professional provider, or contract with that institutional or professional provider to provide professional services.

HISTORY:
Added Stats 1984 ch 977 § 1.

§ 1373.95. Written policy on continuity of care from health care service plan

(a)(1) A health care service plan, other than a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis, shall file a written continuity of care policy as a material modification with the department before March 31, 2004.

(2) A health care service plan shall include all of the following in its written continuity of care policy:

(A) A description of the plan's process for the block transfer of enrollees from a terminated provider group or hospital to a new provider group or hospital.

(B) A description of the manner in which the plan facilitates the completion of covered services pursuant to Section 1373.96.

(C) A template of the notice the plan proposes to send to enrollees describing its policy and informing enrollees of their right to completion of covered services.

(D) A description of the plan's process to review an enrollee's request for the completion of covered services.

(E) A provision ensuring that reasonable consideration is given to the potential clinical effect on an enrollee's treatment caused by a change of provider.

(3) If approved by the department, the provisions of the written continuity of care policy shall replace all prior continuity of care policies. The plan shall

file a revision of the policy with the department if it makes a material change to it.

(b)(1) The provisions of this subdivision apply to a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis.

(2) The plan shall file with the department a written policy describing the manner in which it facilitates the continuity of care for a new enrollee who has been receiving services from a nonparticipating mental health provider for an acute, serious, or chronic mental health condition when his or her employer changed health plans. The written policy shall allow the new enrollee a reasonable transition period to continue his or her course of treatment with the nonparticipating mental health provider prior to transferring to a participating provider and shall include the provision of mental health services on a timely, appropriate, and medically necessary basis from the nonparticipating provider. The policy may provide that the length of the transition period take into account on a case-by-case basis, the severity of the enrollee's condition and the amount of time reasonably necessary to effect a safe transfer. The policy shall ensure that reasonable consideration is given to the potential clinical effect of a change of provider on the enrollee's treatment for the condition. The policy shall describe the plan's process to review an enrollee's request to continue his or her course of treatment with a nonparticipating mental health provider. Nothing in this paragraph shall be construed to require the plan to accept a nonparticipating mental health provider onto its panel for treatment of other enrollees. For purposes of the continuing treatment of the transferring enrollee, the plan may require the nonparticipating mental health provider, as a condition of the right conferred under this section, to enter into its standard mental health provider contract.

(3) A plan may require a nonparticipating mental health provider whose services are continued pursuant to the written policy, to agree in writing to the same contractual terms and conditions that are imposed upon the plan's participating providers, including location within the plan's service area, reimbursement methodologies, and rates of payment. If the plan determines that an enrollee's health care treatment should temporarily continue with his or her existing provider or nonparticipating mental health provider, the plan shall not be liable for actions resulting solely from the negligence, malpractice, or other tortious or wrongful acts arising out of the provisions of services by the existing provider or a nonparticipating mental health provider.

(4) The written policy shall not apply to an enrollee who is offered an out-of-network option or to an enrollee who had the option to continue with his or her previous specialized health care service plan that offers professional mental health services on an employer-sponsored group basis or mental health provider and instead voluntarily chose to change health plans.

(5) This subdivision shall not apply to a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis if it includes out-of-network coverage that allows the enrollee to obtain services from his or her existing mental health provider or nonparticipating mental health provider.

(c) The health care service plan, including a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis, shall provide to all new enrollees notice of its written continuity of care policy and information regarding the process for an enrollee to request a review under the policy and shall provide, upon request, a copy of the written policy to an enrollee.

(d) Nothing in this section shall require a health care service plan or a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract.

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

(1) "Hospital" means a general acute care hospital.

(2) "Nonparticipating mental health provider" means a psychiatrist, licensed psychologist, licensed marriage and family therapist, licensed social worker, or licensed professional clinical counselor who does not contract with the specialized health care service plan that offers professional mental health services on an employer-sponsored group basis.

(3) "Provider group" means a medical group, independent practice association, or any other similar organization.

HISTORY:

Added Stats 2003 ch 591 § 5 (AB 1286). Amended Stats 2011 ch 381 § 32 (SB 146), effective January 1, 2012.