

Introduced by Senator Valladares

February 14, 2025

An act to amend Section 2290.5 of, and to add Chapter 17 (commencing with Section 4999.200) to Division 2 of, the Business and Professions Code, to amend Sections 1367.27, 1374.72, and 1374.73 of the Health and Safety Code, to amend Sections 10133.15, 10144.5, and 10144.51 of the Insurance Code, and to amend Section 11165.7 of the Penal Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 402, as introduced, Valladares. Health care coverage: autism.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or a health insurance policy to provide coverage for behavioral health treatment for pervasive developmental disorder or autism and defines “behavioral health treatment” to mean specified services and treatment programs, including treatment provided pursuant to a treatment plan that is prescribed by a qualified autism service provider and administered either by a qualified autism service provider or by a qualified autism service professional or qualified autism service paraprofessional. Existing law defines “qualified autism service provider,” “qualified autism service professional,” and “qualified autism service paraprofessional” for those purposes. Those definitions are contained in the Health and Safety Code and the Insurance Code.

This bill would move those definitions to the Business and Professions Code. The bill would also make technical and conforming changes.

Vote: majority. Appropriation: no. Fiscal committee: no.
State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 2290.5 of the Business and Professions
2 Code is amended to read:
3 2290.5. (a) For purposes of this division, the following
4 definitions apply:
5 (1) “Asynchronous store and forward” means the transmission
6 of a patient’s medical information from an originating site to the
7 health care provider at a distant site.
8 (2) “Distant site” means a site where a health care provider who
9 provides health care services is located while providing these
10 services via a telecommunications system.
11 (3) “Health care provider” means any of the following:
12 (A) A person who is licensed under this division.
13 (B) An associate marriage and family therapist or marriage and
14 family therapist trainee functioning pursuant to Section 4980.43.3.
15 (C) A qualified autism service provider ~~or qualified autism~~
16 ~~service professional certified by a national entity pursuant to~~
17 ~~Section 1374.73 of the Health and Safety Code and Section~~
18 ~~10144.51 of the Insurance Code. as defined in Section 4999.200~~
19 ~~or a qualified autism service professional as defined in Section~~
20 ~~4999.201.~~
21 (D) An associate clinical social worker functioning pursuant to
22 Section 4996.23.2.
23 (E) An associate professional clinical counselor or clinical
24 counselor trainee functioning pursuant to Section 4999.46.3.
25 (4) “Originating site” means a site where a patient is located at
26 the time health care services are provided via a telecommunications
27 system or where the asynchronous store and forward service
28 originates.
29 (5) “Synchronous interaction” means a real-time interaction
30 between a patient and a health care provider located at a distant
31 site.
32 (6) “Telehealth” means the mode of delivering health care
33 services and public health via information and communication
34 technologies to facilitate the diagnosis, consultation, treatment,
35 education, care management, and self-management of a patient’s

1 health care. Telehealth facilitates patient self-management and
2 caregiver support for patients and includes synchronous interactions
3 and asynchronous store and forward transfers.

4 (b) Before the delivery of health care via telehealth, the health
5 care provider initiating the use of telehealth shall inform the patient
6 about the use of telehealth and obtain verbal or written consent
7 from the patient for the use of telehealth as an acceptable mode of
8 delivering health care services and public health. The consent shall
9 be documented.

10 (c) This section does not preclude a patient from receiving
11 in-person health care delivery services during a specified course
12 of health care and treatment after agreeing to receive services via
13 telehealth.

14 (d) The failure of a health care provider to comply with this
15 section shall constitute unprofessional conduct. Section 2314 shall
16 not apply to this section.

17 (e) This section does not alter the scope of practice of a health
18 care provider or authorize the delivery of health care services in
19 a setting, or in a manner, not otherwise authorized by law.

20 (f) All laws regarding the confidentiality of health care
21 information and a patient's rights to the patient's medical
22 information shall apply to telehealth interactions.

23 (g) All laws and regulations governing professional
24 responsibility, unprofessional conduct, and standards of practice
25 that apply to a health care provider under the health care provider's
26 license shall apply to that health care provider while providing
27 telehealth services.

28 (h) This section shall not apply to a patient under the jurisdiction
29 of the Department of Corrections and Rehabilitation or any other
30 correctional facility.

31 (i) (1) Notwithstanding any other law and for purposes of this
32 section, the governing body of the hospital whose patients are
33 receiving the telehealth services may grant privileges to, and verify
34 and approve credentials for, providers of telehealth services based
35 on its medical staff recommendations that rely on information
36 provided by the distant-site hospital or telehealth entity, as
37 described in Sections 482.12, 482.22, and 485.616 of Title 42 of
38 the Code of Federal Regulations.

39 (2) By enacting this subdivision, it is the intent of the Legislature
40 to authorize a hospital to grant privileges to, and verify and approve

1 credentials for, providers of telehealth services as described in
2 paragraph (1).

3 (3) For the purposes of this subdivision, “telehealth” shall
4 include “telemedicine” as the term is referenced in Sections 482.12,
5 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

6 SEC. 2. Chapter 17 (commencing with Section 4999.200) is
7 added to Division 2 of the Business and Professions Code, to read:

8
9 CHAPTER 17. QUALIFIED AUTISM SERVICE PROVIDERS

10
11 4999.200. “Qualified autism service provider” means an
12 individual who meets either of the following criteria:

13 (a) Is certified by a national entity, such as the Behavior Analyst
14 Certification Board, with a certification that is accredited by the
15 National Commission for Certifying Agencies who designs,
16 supervises, or provides treatment for pervasive developmental
17 disorder or autism, provided the services are within the experience
18 and competence of the individual who is nationally certified.

19 (b) Is licensed as a physician and surgeon, physical therapist,
20 occupational therapist, psychologist, marriage and family therapist,
21 educational psychologist, clinical social worker, professional
22 clinical counselor, speech-language pathologist, or audiologist,
23 pursuant to Division 2 (commencing with Section 500), and who
24 designs, supervises, or provides treatment for pervasive
25 developmental disorder or autism, provided the services are within
26 the experience and competence of the licensee.

27 4999.201. “Qualified autism service professional” means an
28 individual who meets all of the following criteria:

29 (a) Provides behavioral health treatment, which may include
30 clinical case management and case supervision under the direction
31 and supervision of a qualified autism service provider.

32 (b) Is supervised by a qualified autism service provider.

33 (c) Provides treatment pursuant to a treatment plan developed
34 and approved by the qualified autism service provider.

35 (d) Is either of the following:

36 (1) A behavioral service provider who meets the education and
37 experience qualifications described in Section 54342 of Title 17
38 of the California Code of Regulations for an Associate Behavior
39 Analyst, Behavior Analyst, Behavior Management Assistant,

1 Behavior Management Consultant, or Behavior Management
2 Program.

3 (2) (A) A psychological associate, an associate marriage and
4 family therapist, an associate clinical social worker, or an associate
5 professional clinical counselor, as defined and regulated by the
6 Board of Behavioral Sciences or the Board of Psychology.

7 (B) If an individual meets the requirement described in
8 subparagraph (A), they shall also meet the criteria set forth in the
9 regulations adopted pursuant to Section 4686.4 of the Welfare and
10 Institutions Code for a Behavioral Health Professional.

11 (e) (1) Has training and experience in providing services for
12 pervasive developmental disorder or autism pursuant to Division
13 4.5 (commencing with Section 4500) of the Welfare and
14 Institutions Code or Title 14 (commencing with Section 95000)
15 of the Government Code.

16 (f) Is employed by the qualified autism service provider or an
17 entity or group that employs qualified autism service providers
18 responsible for the autism treatment plan.

19 4999.202. “Qualified autism service paraprofessional” means
20 an unlicensed and uncertified individual who meets all of the
21 following criteria:

22 (a) Is supervised by a qualified autism service provider or
23 qualified autism service professional at a level of clinical
24 supervision that meets professionally recognized standards of
25 practice.

26 (b) Provides treatment and implements services pursuant to a
27 treatment plan that was developed and approved by the qualified
28 autism service provider.

29 (c) Meets the education and training qualifications described in
30 Section 54342 of Title 17 of the California Code of Regulations.

31 (d) Has adequate education, training, and experience, as certified
32 by a qualified autism service provider or an entity or group that
33 employs qualified autism service providers.

34 (e) Is employed by the qualified autism service provider or an
35 entity or group that employs qualified autism service providers
36 responsible for the autism treatment plan.

37 SEC. 3. Section 1367.27 of the Health and Safety Code is
38 amended to read:

39 1367.27. (a) Commencing July 1, 2016, a health care service
40 plan shall publish and maintain a provider directory or directories

1 with information on contracting providers that deliver health care
2 services to the plan's enrollees, including those that accept new
3 patients. A provider directory shall not list or include information
4 on a provider that is not currently under contract with the plan.

5 (b) A health care service plan shall provide the directory or
6 directories for the specific network offered for each product using
7 a consistent method of network and product naming, numbering,
8 or other classification method that ensures the public, enrollees,
9 potential enrollees, the department, and other state or federal
10 agencies can easily identify the networks and plan products in
11 which a provider participates. By July 31, 2017, or 12 months after
12 the date provider directory standards are developed under
13 subdivision (k), whichever occurs later, a health care service plan
14 shall use the naming, numbering, or classification method
15 developed by the department pursuant to subdivision (k).

16 (c) (1) An online provider directory or directories shall be
17 available on the plan's ~~Internet Web site~~ *internet website* to the
18 public, potential enrollees, enrollees, and providers without any
19 restrictions or limitations. The directory or directories shall be
20 accessible without any requirement that an individual seeking the
21 directory information demonstrate coverage with the plan, indicate
22 interest in obtaining coverage with the plan, provide a member
23 identification or policy number, provide any other identifying
24 information, or create or access an account.

25 (2) The online provider directory or directories shall be
26 accessible on the plan's public ~~Internet Web site~~ *internet website*
27 through an identifiable link or tab and in a manner that is accessible
28 and searchable by enrollees, potential enrollees, the public, and
29 providers. By July 31, 2017, or 12 months after the date provider
30 directory standards are developed under subdivision (k), whichever
31 occurs later, the plan's public ~~Internet Web site~~ *internet website*
32 shall allow provider searches by, at a minimum, name, practice
33 address, city, ZIP Code, California license number, National
34 Provider Identifier number, admitting privileges to an identified
35 hospital, product, tier, provider language or languages, provider
36 group, hospital name, facility name, or clinic name, as appropriate.

37 (d) (1) A health care service plan shall allow enrollees, potential
38 enrollees, providers, and members of the public to request a printed
39 copy of the provider directory or directories by contacting the plan
40 through the plan's toll-free telephone number, electronically, or

1 in writing. A printed copy of the provider directory or directories
2 shall include the information required in subdivisions (h) and (i).
3 The printed copy of the provider directory or directories shall be
4 provided to the requester by mail postmarked no later than five
5 business days following the date of the request and may be limited
6 to the geographic region in which the requester resides or works
7 or intends to reside or work.

8 (2) A health care service plan shall update its printed provider
9 directory or directories at least quarterly, or more frequently, if
10 required by federal law.

11 (e) (1) The plan shall update the online provider directory or
12 directories, at least weekly, or more frequently, if required by
13 federal law, when informed of and upon confirmation by the plan
14 of any of the following:

15 (A) A contracting provider is no longer accepting new patients
16 for that product, or an individual provider within a provider group
17 is no longer accepting new patients.

18 (B) A provider is no longer under contract for a particular plan
19 product.

20 (C) A provider's practice location or other information required
21 under subdivision (h) or (i) has changed.

22 (D) Upon completion of the investigation described in
23 subdivision (o), a change is necessary based on an enrollee
24 complaint that a provider was not accepting new patients, was
25 otherwise not available, or whose contact information was listed
26 incorrectly.

27 (E) Any other information that affects the content or accuracy
28 of the provider directory or directories.

29 (2) Upon confirmation of any of the following, the plan shall
30 delete a provider from the directory or directories when:

31 (A) A provider has retired or otherwise has ceased to practice.

32 (B) A provider or provider group is no longer under contract
33 with the plan for any reason.

34 (C) The contracting provider group has informed the plan that
35 the provider is no longer associated with the provider group and
36 is no longer under contract with the plan.

37 (f) The provider directory or directories shall include both an
38 email address and a telephone number for members of the public
39 and providers to notify the plan if the provider directory
40 information appears to be inaccurate. This information shall be

1 disclosed prominently in the directory or directories and on the
2 plan's ~~Internet Web site.~~ *internet website.*

3 (g) The provider directory or directories shall include the
4 following disclosures informing enrollees that they are entitled to
5 both of the following:

6 (1) Language interpreter services, at no cost to the enrollee,
7 including how to obtain interpretation services in accordance with
8 Section 1367.04.

9 (2) Full and equal access to covered services, including enrollees
10 with disabilities as required under the federal Americans with
11 Disabilities Act of 1990 and Section 504 of the Rehabilitation Act
12 of 1973.

13 (h) A full service health care service plan and a specialized
14 mental health plan shall include all of the following information
15 in the provider directory or directories:

16 (1) The provider's name, practice location or locations, and
17 contact information.

18 (2) Type of practitioner.

19 (3) National Provider Identifier number.

20 (4) California license number and type of license.

21 (5) The area of specialty, including board certification, if any.

22 (6) The provider's office email address, if available.

23 (7) The name of each affiliated provider group currently under
24 contract with the plan through which the provider sees enrollees.

25 (8) A listing for each of the following providers that are under
26 contract with the plan:

27 (A) For physicians and surgeons, the provider group, and
28 admitting privileges, if any, at hospitals contracted with the plan.

29 (B) Nurse practitioners, physician assistants, psychologists,
30 acupuncturists, optometrists, podiatrists, chiropractors, licensed
31 clinical social workers, marriage and family therapists, professional
32 clinical counselors, qualified autism service providers, as defined
33 in ~~Section 1374.73, 4999.200 of the Business and Professions~~
34 *Code*, nurse midwives, and dentists.

35 (C) For federally qualified health centers or primary care clinics,
36 the name of the federally qualified health center or clinic.

37 (D) For ~~any~~ a provider described in subparagraph (A) or (B)
38 who is employed by a federally qualified health center or primary
39 care clinic, and to the extent their services may be accessed and
40 are covered through the contract with the plan, the name of the

1 provider, and the name of the federally qualified health center or
2 clinic.

3 (E) Facilities, including, but not limited to, general acute care
4 hospitals, skilled nursing facilities, urgent care clinics, ambulatory
5 surgery centers, inpatient hospice, residential care facilities, and
6 inpatient rehabilitation facilities.

7 (F) Pharmacies, clinical laboratories, imaging centers, and other
8 facilities providing contracted health care services.

9 (9) The provider directory or directories may note that
10 authorization or referral may be required to access some providers.

11 (10) Non-English language, if any, spoken by a health care
12 provider or other medical professional as well as non-English
13 language spoken by a qualified medical interpreter, in accordance
14 with Section 1367.04, if any, on the provider's staff.

15 (11) Identification of providers who no longer accept new
16 patients for some or all of the plan's products.

17 (12) The network tier to which the provider is assigned, if the
18 provider is not in the lowest tier, as applicable. Nothing in this
19 section shall be construed to require the use of network tiers other
20 than contract and noncontracting tiers.

21 (13) All other information necessary to conduct a search
22 pursuant to paragraph (2) of subdivision (c).

23 (i) A vision, dental, or other specialized health care service plan,
24 except for a specialized mental health plan, shall include all of the
25 following information for each provider directory or directories
26 used by the plan for its networks:

27 (1) The provider's name, practice location or locations, and
28 contact information.

29 (2) Type of practitioner.

30 (3) National Provider Identifier number.

31 (4) California license number and type of license, if applicable.

32 (5) The area of specialty, including board certification, or other
33 accreditation, if any.

34 (6) The provider's office email address, if available.

35 (7) The name of each affiliated provider group or specialty plan
36 practice group currently under contract with the plan through which
37 the provider sees enrollees.

38 (8) The names of each allied health care professional to the
39 extent there is a direct contract for those services covered through
40 a contract with the plan.

(9) The non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a qualified medical interpreter, in accordance with Section 1367.04, if any, on the provider's staff.

(10) Identification of providers who no longer accept new patients for some or all of the plan's products.

(11) All other applicable information necessary to conduct a provider search pursuant to paragraph (2) of subdivision (c).

(j) (1) The contract between the plan and a provider shall include a requirement that the provider inform the plan within five business days when either of the following occurs:

(A) The provider is not accepting new patients.

(B) If the provider had previously not accepted new patients, the provider is currently accepting new patients.

(2) If a provider who is not accepting new patients is contacted by an enrollee or potential enrollee seeking to become a new patient, the provider shall direct the enrollee or potential enrollee to both the plan for additional assistance in finding a provider and to the department to report any inaccuracy with the plan's directory or directories.

(3) If an enrollee or potential enrollee informs a plan of a possible inaccuracy in the provider directory or directories, the plan shall promptly investigate, and, if necessary, undertake corrective action within 30 business days to ensure the accuracy of the directory or directories.

(k) (1) On or before December 31, 2016, the department shall develop uniform provider directory standards to permit consistency in accordance with subdivision (b) and paragraph (2) of subdivision (c) and development of a multiplan directory by another entity. Those standards shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), until January 1, 2021. No more than two revisions of those standards shall be exempt from the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) pursuant to this subdivision.

(2) In developing the standards under this subdivision, the department shall seek input from interested parties throughout the process of developing the standards and shall hold at least one public meeting. The department shall take into consideration any

1 requirements for provider directories established by the federal
2 Centers for Medicare and Medicaid Services and the State
3 Department of Health Care Services.

4 (3) By July 31, 2017, or 12 months after the date provider
5 directory standards are developed under this subdivision, whichever
6 occurs later, a plan shall use the standards developed by the
7 department for each product offered by the plan.

8 (l) (1) A plan shall take appropriate steps to ensure the accuracy
9 of the information concerning each provider listed in the plan's
10 provider directory or directories in accordance with this section,
11 and shall, at least annually, review and update the entire provider
12 directory or directories for each product offered. Each calendar
13 year the plan shall notify all contracted providers described in
14 subdivisions (h) and (i) as follows:

15 (A) For individual providers who are not affiliated with a
16 provider group described in subparagraph (A) or (B) of paragraph
17 (8) of subdivision (h) and providers described in subdivision (i),
18 the plan shall notify each provider at least once every six months.

19 (B) For all other providers described in subdivision (h) who are
20 not subject to the requirements of subparagraph (A), the plan shall
21 notify its contracted providers to ensure that all of the providers
22 are contacted by the plan at least once annually.

23 (2) The notification shall include all of the following:

24 (A) The information the plan has in its directory or directories
25 regarding the provider or provider group, including a list of
26 networks and plan products that include the contracted provider
27 or provider group.

28 (B) A statement that the failure to respond to the notification
29 may result in a delay of payment or reimbursement of a claim
30 pursuant to subdivision (p).

31 (C) Instructions on how the provider or provider group can
32 update the information in the provider directory or directories using
33 the online interface developed pursuant to subdivision (m).

34 (3) The plan shall require an affirmative response from the
35 provider or provider group acknowledging that the notification
36 was received. The provider or provider group shall confirm that
37 the information in the provider directory or directories is current
38 and accurate or update the information required to be in the
39 directory or directories pursuant to this section, including whether

1 or not the provider or provider group is accepting new patients for
2 each plan product.

3 (4) If the plan does not receive an affirmative response and
4 confirmation from the provider that the information is current and
5 accurate or, as an alternative, updates any information required to
6 be in the directory or directories pursuant to this section, within
7 30 business days, the plan shall take no more than 15 business
8 days to verify whether the provider's information is correct or
9 requires updates. The plan shall document the receipt and outcome
10 of each attempt to verify the information. If the plan is unable to
11 verify whether the provider's information is correct or requires
12 updates, the plan shall notify the provider 10 business days in
13 advance of removal that the provider will be removed from the
14 provider directory or directories. The provider shall be removed
15 from the provider directory or directories at the next required
16 update of the provider directory or directories after the
17 10-business-day notice period. A provider shall not be removed
18 from the provider directory or directories if ~~he or she responds~~
19 *they respond* before the end of the 10-business-day notice period.

20 (5) General acute care hospitals shall be exempt from the
21 requirements in paragraphs (3) and (4).

22 (m) A plan shall establish policies and procedures with regard
23 to the regular updating of its provider directory or directories,
24 including the weekly, quarterly, and annual updates required
25 pursuant to this section, or more frequently, if required by federal
26 law or guidance.

27 (1) The policies and procedures described under this subdivision
28 shall be submitted by a plan annually to the department for
29 approval and in a format described by the department pursuant to
30 Section 1367.035.

31 (2) Every health care service plan shall ensure processes are in
32 place to allow providers to promptly verify or submit changes to
33 the information required to be in the directory or directories
34 pursuant to this section. Those processes shall, at a minimum,
35 include an online interface for providers to submit verification or
36 changes electronically and shall generate an acknowledgment of
37 receipt from the health care service plan. Providers shall verify or
38 submit changes to information required to be in the directory or
39 directories pursuant to this section using the process required by
40 the health care service plan.

(3) The plan shall establish and maintain a process for enrollees, potential enrollees, other providers, and the public to identify and report possible inaccurate, incomplete, or misleading information currently listed in the plan's provider directory or directories. This process shall, at a minimum, include a telephone number and a dedicated email address at which the plan will accept these reports, as well as a hyperlink on the plan's provider directory-Internet Web site *internet website* linking to a form where the information can be reported directly to the plan through its-Internet Web site-*internet website*.

(n) (1) This section does not prohibit a plan from requiring its provider groups or contracting specialized health care service plans to provide information to the plan that is required by the plan to satisfy the requirements of this section for each of the providers that contract with the provider group or contracting specialized health care service plan. This responsibility shall be specifically documented in a written contract between the plan and the provider group or contracting specialized health care service plan.

(2) If a plan requires its contracting provider groups or contracting specialized health care service plans to provide the plan with information described in paragraph (1), the plan shall continue to retain responsibility for ensuring that the requirements of this section are satisfied.

(3) A provider group may terminate a contract with a provider for a pattern or repeated failure of the provider to update the information required to be in the directory or directories pursuant to this section.

(4) A provider group is not subject to the payment delay described in subdivision (p) if all of the following occurs:

(A) A provider does not respond to the provider group's attempt to verify the provider's information. As used in this paragraph, "verify" means to contact the provider in writing, electronically, and by telephone to confirm whether the provider's information is correct or requires updates.

(B) The provider group documents its efforts to verify the provider's information.

(C) The provider group reports to the plan that the provider should be deleted from the provider group in the plan directory or directories.

1 (5) Section 1375.7, known as the Health Care Providers' Bill
2 of Rights, applies to any material change to a provider contract
3 pursuant to this section.

4 (o) (1) Whenever a health care service plan receives a report
5 indicating that information listed in its provider directory or
6 directories is inaccurate, the plan shall promptly investigate the
7 reported inaccuracy and, no later than 30 business days following
8 receipt of the report, either verify the accuracy of the information
9 or update the information in its provider directory or directories,
10 as applicable.

11 (2) When investigating a report regarding its provider directory
12 or directories, the plan shall, at a minimum, do the following:

13 (A) Contact the affected provider no later than five business
14 days following receipt of the report.

15 (B) Document the receipt and outcome of each report. The
16 documentation shall include the provider's name, location, and a
17 description of the plan's investigation, the outcome of the
18 investigation, and any changes or updates made to its provider
19 directory or directories.

20 (C) If changes to a plan's provider directory or directories are
21 required as a result of the plan's investigation, the changes to the
22 online provider directory or directories shall be made no later than
23 the next scheduled weekly update, or the update immediately
24 following that update, or sooner if required by federal law or
25 regulations. For printed provider directories, the change shall be
26 made no later than the next required update, or sooner if required
27 by federal law or regulations.

28 (p) (1) Notwithstanding Sections 1371 and 1371.35, a plan may
29 delay payment or reimbursement owed to a provider or provider
30 group as specified in subparagraph (A) or (B), if the provider or
31 provider group fails to respond to the plan's attempts to verify the
32 provider's or provider group's information as required under
33 subdivision (l). The plan shall not delay payment unless it has
34 attempted to verify the provider's or provider group's information.
35 As used in this subdivision, "verify" means to contact the provider
36 or provider group in writing, electronically, and by telephone to
37 confirm whether the provider's or provider group's information
38 is correct or requires updates. A plan may seek to delay payment
39 or reimbursement owed to a provider or provider group only after

1 the 10-business day notice period described in paragraph (4) of
2 subdivision (l) has lapsed.

3 (A) For a provider or provider group that receives compensation
4 on a capitated or prepaid basis, the plan may delay no more than
5 50 percent of the next scheduled capitation payment for up to one
6 calendar month.

7 (B) For any claims payment made to a provider or provider
8 group, the plan may delay the claims payment for up to one
9 calendar month beginning on the first day of the following month.

10 (2) A plan shall notify the provider or provider group 10
11 business days before it seeks to delay payment or reimbursement
12 to a provider or provider group pursuant to this subdivision. If the
13 plan delays a payment or reimbursement pursuant to this
14 subdivision, the plan shall reimburse the full amount of any
15 payment or reimbursement subject to delay to the provider or
16 provider group according to either of the following timelines, as
17 applicable:

18 (A) No later than three business days following the date on
19 which the plan receives the information required to be submitted
20 by the provider or provider group pursuant to subdivision (l).

21 (B) At the end of the one-calendar month delay described in
22 subparagraph (A) or (B) of paragraph (1), as applicable, if the
23 provider or provider group fails to provide the information required
24 to be submitted to the plan pursuant to subdivision (l).

25 (3) A plan may terminate a contract for a pattern or repeated
26 failure of the provider or provider group to alert the plan to a
27 change in the information required to be in the directory or
28 directories pursuant to this section.

29 (4) A plan that delays payment or reimbursement under this
30 subdivision shall document each instance a payment or
31 reimbursement was delayed and report this information to the
32 department in a format described by the department pursuant to
33 Section 1367.035. This information shall be submitted along with
34 the policies and procedures required to be submitted annually to
35 the department pursuant to paragraph (1) of subdivision (m).

36 (5) With respect to plans with Medi-Cal managed care contracts
37 with the State Department of Health Care Services pursuant to
38 Chapter 7 (commencing with Section 14000), Chapter 8
39 (commencing with Section 14200), or Chapter 8.75 (commencing
40 with Section 14591) of *Part 3 of Division 9* of the Welfare and

1 Institutions Code, this subdivision shall be implemented only to
2 the extent consistent with federal law and guidance.

3 (q) In circumstances where the department finds that an enrollee
4 reasonably relied upon materially inaccurate, incomplete, or
5 misleading information contained in a health plan's provider
6 directory or directories, the department may require the health plan
7 to provide coverage for all covered health care services provided
8 to the enrollee and to reimburse the enrollee for any amount beyond
9 what the enrollee would have paid, had the services been delivered
10 by an in-network provider under the enrollee's plan contract. Prior
11 to requiring reimbursement in these circumstances, the department
12 shall conclude that the services received by the enrollee were
13 covered services under the enrollee's plan contract. In those
14 circumstances, the fact that the services were rendered or delivered
15 by a noncontracting or out-of-plan provider shall not be used as a
16 basis to deny reimbursement to the enrollee.

17 (r) Whenever a plan determines as a result of this section that
18 there has been a 10 percent change in the network for a product
19 in a region, the plan shall file an amendment to the plan application
20 with the department consistent with subdivision (f) of Section
21 1300.52 of Title 28 of the California Code of Regulations.

22 (s) This section applies to plans with Medi-Cal managed care
23 contracts with the State Department of Health Care Services
24 pursuant to Chapter 7 (commencing with Section 14000), Chapter
25 8 (commencing with Section 14200), or Chapter 8.75 (commencing
26 with Section 14591) of *Part 3 of Division 9* of the Welfare and
27 Institutions Code to the extent consistent with federal law and
28 guidance and state law guidance issued after January 1, 2016.
29 Notwithstanding any other provision to the contrary in a plan
30 contract with the State Department of Health Care Services, and
31 to the extent consistent with federal law and guidance and state
32 guidance issued after January 1, 2016, a Medi-Cal managed care
33 plan that complies with the requirements of this section shall not
34 be required to distribute a printed provider directory or directories,
35 except as required by paragraph (1) of subdivision (d).

36 (t) A health plan that contracts with multiple employer welfare
37 agreements regulated pursuant to Article 4.7 (commencing with
38 Section 742.20) of Chapter 1 of Part 2 of Division 1 of the
39 Insurance Code shall meet the requirements of this section.

1 (u) This section shall not be construed to alter a provider's
2 obligation to provide health care services to an enrollee pursuant
3 to the provider's contract with the plan.

4 (v) As part of the department's routine examination of the fiscal
5 and administrative affairs of a health care service plan pursuant to
6 Section 1382, the department shall include a review of the health
7 care service plan's compliance with subdivision (p).

8 (w) For purposes of this section, "provider group" means a
9 medical group, independent practice association, or other similar
10 group of providers.

11 SEC. 4. Section 1374.72 of the Health and Safety Code is
12 amended to read:

13 1374.72. (a) (1) Every health care service plan contract issued,
14 amended, or renewed on or after January 1, 2021, that provides
15 hospital, medical, or surgical coverage shall provide coverage for
16 medically necessary treatment of mental health and substance use
17 disorders, under the same terms and conditions applied to other
18 medical conditions as specified in subdivision (c).

19 (2) For purposes of this section, "mental health and substance
20 use disorders" means a mental health condition or substance use
21 disorder that falls under any of the diagnostic categories listed in
22 the mental and behavioral disorders chapter of the most recent
23 edition of the International Classification of Diseases or that is
24 listed in the most recent version of the Diagnostic and Statistical
25 Manual of Mental Disorders. Changes in terminology, organization,
26 or classification of mental health and substance use disorders in
27 future versions of the American Psychiatric Association's
28 Diagnostic and Statistical Manual of Mental Disorders or the World
29 Health Organization's International Statistical Classification of
30 Diseases and Related Health Problems shall not affect the
31 conditions covered by this section as long as a condition is
32 commonly understood to be a mental health or substance use
33 disorder by health care providers practicing in relevant clinical
34 specialties.

35 (3) (A) For purposes of this section, "medically necessary
36 treatment of a mental health or substance use disorder" means a
37 service or product addressing the specific needs of that patient, for
38 the purpose of preventing, diagnosing, or treating an illness, injury,
39 condition, or its symptoms, including minimizing the progression

1 of that illness, injury, condition, or its symptoms, in a manner that
2 is all of the following:

3 (i) In accordance with the generally accepted standards of mental
4 health and substance use disorder care.

5 (ii) Clinically appropriate in terms of type, frequency, extent,
6 site, and duration.

7 (iii) Not primarily for the economic benefit of the health care
8 service plan and subscribers or for the convenience of the patient,
9 treating physician, or other health care provider.

10 (B) This paragraph does not limit in any way the independent
11 medical review rights of an enrollee or subscriber under this
12 chapter.

13 (4) For purposes of this section, “health care provider” means
14 any of the following:

15 (A) A person who is licensed under Division 2 (commencing
16 with Section 500) of the Business and Professions Code.

17 (B) An associate marriage and family therapist or marriage and
18 family therapist trainee functioning pursuant to Section 4980.43.3
19 of the Business and Professions Code.

20 (C) A qualified autism service provider ~~or qualified autism~~
21 ~~service professional~~ certified by a national entity ~~pursuant to~~
22 ~~Section 10144.51 of the Insurance Code and Section 1374.73; as~~
23 *defined in Section 4999.200 of the Business and Professions Code*
24 *or a qualified autism service professional as defined in Section*
25 *4999.201 of the Business and Professions Code.*

26 (D) An associate clinical social worker functioning pursuant to
27 Section 4996.23.2 of the Business and Professions Code.

28 (E) An associate professional clinical counselor or professional
29 clinical counselor trainee functioning pursuant to Section 4999.46.3
30 of the Business and Professions Code.

31 (F) A registered psychologist, as described in Section 2909.5
32 of the Business and Professions Code.

33 (G) A registered psychological associate, as described in Section
34 2913 of the Business and Professions Code.

35 (H) A psychology trainee or person supervised as set forth in
36 Section 2910 or 2911 of, or subdivision (d) of Section 2914 of,
37 the Business and Professions Code.

38 (5) For purposes of this section, “generally accepted standards
39 of mental health and substance use disorder care” has the same

1 meaning as defined in paragraph (1) of subdivision (f) of Section
2 1374.721.

3 (6) A health care service plan shall not limit benefits or coverage
4 for mental health and substance use disorders to short-term or acute
5 treatment.

6 (7) All medical necessity determinations by the health care
7 service plan concerning service intensity, level of care placement,
8 continued stay, and transfer or discharge of enrollees diagnosed
9 with mental health and substance use disorders shall be conducted
10 in accordance with the requirements of Section 1374.721. This
11 paragraph does not deprive an enrollee of the other protections of
12 this chapter, including, but not limited to, grievances, appeals,
13 independent medical review, discharge, transfer, and continuity
14 of care.

15 (8) A health care service plan that authorizes a specific type of
16 treatment by a provider pursuant to this section shall not rescind
17 or modify the authorization after the provider renders the health
18 care service in good faith and pursuant to this authorization for
19 any reason, including, but not limited to, the plan's subsequent
20 rescission, cancellation, or modification of the enrollee's or
21 subscriber's contract, or the plan's subsequent determination that
22 it did not make an accurate determination of the enrollee's or
23 subscriber's eligibility. This section shall not be construed to
24 expand or alter the benefits available to the enrollee or subscriber
25 under a plan.

26 (b) The benefits that shall be covered pursuant to this section
27 shall include, but not be limited to, the following:

28 (1) Basic health care services, as defined in subdivision (b) of
29 Section 1345.

30 (2) Intermediate services, including the full range of levels of
31 care, including, but not limited to, residential treatment, partial
32 hospitalization, and intensive outpatient treatment.

33 (3) Prescription drugs, if the plan contract includes coverage
34 for prescription drugs.

35 (c) The terms and conditions applied to the benefits required
36 by this section, that shall be applied equally to all benefits under
37 the plan contract, shall include, but not be limited to, all of the
38 following patient financial responsibilities:

39 (1) Maximum annual and lifetime benefits, if not prohibited by
40 applicable law.

- 1 (2) Copayments and coinsurance.
- 2 (3) Individual and family deductibles.
- 3 (4) Out-of-pocket maximums.

4 (d) If services for the medically necessary treatment of a mental
5 health or substance use disorder are not available in network within
6 the geographic and timely access standards set by law or regulation,
7 the health care service plan shall arrange coverage to ensure the
8 delivery of medically necessary out-of-network services and any
9 medically necessary followup services that, to the maximum extent
10 possible, meet those geographic and timely access standards. As
11 used in this subdivision, to “arrange coverage to ensure the delivery
12 of medically necessary out-of-network services” includes, but is
13 not limited to, providing services to secure medically necessary
14 out-of-network options that are available to the enrollee within
15 geographic and timely access standards. The enrollee shall pay no
16 more than the same cost sharing that the enrollee would pay for
17 the same covered services received from an in-network provider.

18 (e) This section shall not apply to contracts entered into pursuant
19 to Chapter 7 (commencing with Section 14000) or Chapter 8
20 (commencing with Section 14200) of Part 3 of Division 9 of the
21 Welfare and Institutions Code, between the State Department of
22 Health Care Services and a health care service plan for enrolled
23 Medi-Cal beneficiaries.

24 (f) (1) For the purpose of compliance with this section, a health
25 care service plan may provide coverage for all or part of the mental
26 health and substance use disorder services required by this section
27 through a separate specialized health care service plan or mental
28 health plan, and shall not be required to obtain an additional or
29 specialized license for this purpose.

30 (2) A health care service plan shall provide the mental health
31 and substance use disorder coverage required by this section in its
32 entire service area and in emergency situations as may be required
33 by applicable laws and regulations. For purposes of this section,
34 health care service plan contracts that provide benefits to enrollees
35 through preferred provider contracting arrangements are not
36 precluded from requiring enrollees who reside or work in
37 geographic areas served by specialized health care service plans
38 or mental health plans to secure all or part of their mental health
39 services within those geographic areas served by specialized health
40 care service plans or mental health plans, provided that all

1 appropriate mental health or substance use disorder services are
2 actually available within those geographic service areas within
3 timeliness standards.

4 (3) Notwithstanding any other law, in the provision of benefits
5 required by this section, a health care service plan may utilize case
6 management, network providers, utilization review techniques,
7 prior authorization, copayments, or other cost sharing, provided
8 that these practices are consistent with Section 1374.76 of this
9 code, and Section 2052 of the Business and Professions Code.

10 (g) This section shall not be construed to deny or restrict in any
11 way the department's authority to ensure plan compliance with
12 this chapter.

13 (h) A health care service plan shall not limit benefits or coverage
14 for medically necessary services on the basis that those services
15 should be or could be covered by a public entitlement program,
16 including, but not limited to, special education or an individualized
17 education program, Medicaid, Medicare, Supplemental Security
18 Income, or Social Security Disability Insurance, and shall not
19 include or enforce a contract term that excludes otherwise covered
20 benefits on the basis that those services should be or could be
21 covered by a public entitlement program.

22 (i) A health care service plan shall not adopt, impose, or enforce
23 terms in its plan contracts or provider agreements, in writing or in
24 operation, that undermine, alter, or conflict with the requirements
25 of this section.

26 SEC. 5. Section 1374.73 of the Health and Safety Code is
27 amended to read:

28 1374.73. (a) (1) Every health care service plan contract that
29 provides hospital, medical, or surgical coverage shall also provide
30 coverage for behavioral health treatment for pervasive
31 developmental disorder or autism no later than July 1, 2012. The
32 coverage shall be provided in the same manner and ~~shall be~~ *is*
33 subject to the same requirements as provided in Section 1374.72.

34 (2) Notwithstanding paragraph (1), as of the date that proposed
35 final rulemaking for essential health benefits is issued, this section
36 does not require any benefits to be provided that exceed the
37 essential health benefits that all health plans will be required by
38 federal regulations to provide under Section 1302(b) of the federal
39 Patient Protection and Affordable Care Act (Public Law 111-148),

1 as amended by the federal Health Care and Education
2 Reconciliation Act of 2010 (Public Law 111-152).

3 (3) This section ~~shall~~ *does* not affect services for which an
4 individual is eligible pursuant to Division 4.5 (commencing with
5 Section 4500) of the Welfare and Institutions Code or Title 14
6 (commencing with Section 95000) of the Government Code.

7 (4) This section ~~shall~~ *does* not affect or reduce any obligation
8 to provide services under an individualized education program, as
9 defined in Section 56032 of the Education Code, or an individual
10 service plan, as described in Section 5600.4 of the Welfare and
11 Institutions Code, or under the federal Individuals with Disabilities
12 Education Act (20 U.S.C. Sec. 1400 et seq.) and its implementing
13 regulations.

14 (b) Every health care service plan subject to this section shall
15 maintain an adequate network that includes qualified autism service
16 providers who supervise or employ qualified autism service
17 professionals or paraprofessionals who provide and administer
18 behavioral health treatment. A health care service plan is not
19 prevented from selectively contracting with providers within these
20 requirements.

21 (c) For the purposes of this section, the following definitions
22 shall apply:

23 (1) “Behavioral health treatment” means professional services
24 and treatment programs, including applied behavior analysis and
25 evidence-based behavior intervention programs, that develop or
26 restore, to the maximum extent practicable, the functioning of an
27 individual with pervasive developmental disorder or autism and
28 that meet all of the following criteria:

29 (A) The treatment is prescribed by a physician and surgeon
30 licensed pursuant to Chapter 5 (commencing with Section 2000)
31 of, or is developed by a psychologist licensed pursuant to Chapter
32 6.6 (commencing with Section 2900) of, Division 2 of the Business
33 and Professions Code.

34 (B) The treatment is provided under a treatment plan prescribed
35 by a qualified autism service provider and is administered by one
36 of the following:

37 (i) A qualified autism service provider.

38 (ii) A qualified autism service professional supervised by the
39 qualified autism service provider.

1 (iii) A qualified autism service paraprofessional supervised by
2 a qualified autism service provider or qualified autism service
3 professional.

4 (C) The treatment plan has measurable goals over a specific
5 timeline that is developed and approved by the qualified autism
6 service provider for the specific patient being treated. The treatment
7 plan shall be reviewed no less than once every six months by the
8 qualified autism service provider and modified whenever
9 appropriate, and shall be consistent with Section 4686.2 of the
10 Welfare and Institutions Code pursuant to which the qualified
11 autism service provider does all of the following:

12 (i) Describes the patient's behavioral health impairments or
13 developmental challenges that are to be treated.

14 (ii) Designs an intervention plan that includes the service type,
15 number of hours, and parent participation needed to achieve the
16 plan's goal and objectives, and the frequency at which the patient's
17 progress is evaluated and reported.

18 (iii) Provides intervention plans that utilize evidence-based
19 practices, with demonstrated clinical efficacy in treating pervasive
20 developmental disorder or autism.

21 (iv) Discontinues intensive behavioral intervention services
22 when the treatment goals and objectives are achieved or no longer
23 appropriate.

24 (D) The treatment plan is not used for purposes of providing or
25 for the reimbursement of respite, day care, or educational services
26 and is not used to reimburse a parent for participating in the
27 treatment program. The treatment plan shall be made available to
28 the health care service plan upon request.

29 ~~(2) "Pervasive developmental disorder or autism" shall have~~
30 ~~the same meaning and interpretation as used in Section 1374.72.~~

31 ~~(3) "Qualified autism service provider" means either of the~~
32 ~~following:~~

33 ~~(A) A person who is certified by a national entity, such as the~~
34 ~~Behavior Analyst Certification Board, with a certification that is~~
35 ~~accredited by the National Commission for Certifying Agencies,~~
36 ~~and who designs, supervises, or provides treatment for pervasive~~
37 ~~developmental disorder or autism, provided the services are within~~
38 ~~the experience and competence of the person who is nationally~~
39 ~~certified.~~

~~(B) A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.~~

~~(4) “Qualified autism service professional” means an individual who meets all of the following criteria:~~

~~(A) Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider.~~

~~(B) Is supervised by a qualified autism service provider.~~

~~(C) Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service provider.~~

~~(D) Is either of the following:~~

~~(i) A behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program.~~

~~(ii) A psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology.~~

~~(E) (i) Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.~~

~~(ii) If an individual meets the requirement described in clause (ii) of subparagraph (D), the individual shall also meet the criteria set forth in the regulations adopted pursuant to Section 4686.4 of the Welfare and Institutions Code for a Behavioral Health Professional.~~

1 ~~(F) Is employed by the qualified autism service provider or an~~
2 ~~entity or group that employs qualified autism service providers~~
3 ~~responsible for the autism treatment plan.~~

4 ~~(5) “Qualified autism service paraprofessional” means an~~
5 ~~unlicensed and uncertified individual who meets all of the~~
6 ~~following criteria:~~

7 ~~(A) Is supervised by a qualified autism service provider or~~
8 ~~qualified autism service professional at a level of clinical~~
9 ~~supervision that meets professionally recognized standards of~~
10 ~~practice.~~

11 ~~(B) Provides treatment and implements services pursuant to a~~
12 ~~treatment plan developed and approved by the qualified autism~~
13 ~~service provider.~~

14 ~~(C) Meets the education and training qualifications described~~
15 ~~in Section 54342 of Title 17 of the California Code of Regulations.~~

16 ~~(D) Has adequate education, training, and experience, as~~
17 ~~certified by a qualified autism service provider or an entity or~~
18 ~~group that employs qualified autism service providers.~~

19 ~~(E) Is employed by the qualified autism service provider or an~~
20 ~~entity or group that employs qualified autism service providers~~
21 ~~responsible for the autism treatment plan.~~

22 ~~(2) “Qualified autism service provider” means an individual~~
23 ~~described in Section 4999.200 of the Business and Professions~~
24 ~~Code.~~

25 ~~(3) “Qualified autism service professional” means an individual~~
26 ~~who meets all of the criteria set forth in Section 4999.201 of the~~
27 ~~Business and Professions Code.~~

28 ~~(4) “Qualified autism service paraprofessional” means an~~
29 ~~unlicensed and uncertified individual who meets all of the criteria~~
30 ~~set forth in Section 4999.202 of the Business and Professions Code.~~

31 ~~(d) This section shall does not apply to any of the following:~~

32 ~~(1) A specialized health care service plan that does not deliver~~
33 ~~mental health or behavioral health services to enrollees.~~

34 ~~(2) A health care service plan contract in the Medi-Cal program~~
35 ~~(Chapter 7 (commencing with Section 14000) of Part 3 of Division~~
36 ~~9 of the Welfare and Institutions Code).~~

37 ~~(e) This section does not limit the obligation to provide services~~
38 ~~under Section 1374.72.~~

39 ~~(f) As provided in Section 1374.72 and in paragraph (1) of~~
40 ~~subdivision (a), in the provision of benefits required by this section,~~

1 a health care service plan may utilize case management, network
2 providers, utilization review techniques, prior authorization,
3 copayments, or other cost sharing.

4 SEC. 6. Section 10133.15 of the Insurance Code is amended
5 to read:

6 10133.15. (a) Commencing July 1, 2016, a health insurer that
7 contracts with providers for alternative rates of payment pursuant
8 to Section 10133 shall publish and maintain provider directory or
9 directories with information on contracting providers that deliver
10 health care services to the insurer's insureds, including those that
11 accept new patients. A provider directory shall not list or include
12 information on a provider that is not currently under contract with
13 the insurer.

14 (b) An insurer shall provide the online directory or directories
15 for the specific network offered for each product using a consistent
16 method of network and product naming, numbering, or other
17 classification method that ensures the public, insureds, potential
18 insureds, the department, and other state or federal agencies can
19 easily identify the networks and insurer products in which a
20 provider participates. By July 31, 2017, or 12 months after the date
21 provider directory standards are developed under subdivision (k),
22 whichever occurs later, an insurer shall use the naming, numbering,
23 or classification method developed by the department pursuant to
24 subdivision (k).

25 (c) (1) An online provider directory or directories shall be
26 available on the insurer's ~~Internet Web site~~ *internet website* to the
27 public, potential insureds, insureds, and providers without any
28 restrictions or limitations. The directory or directories shall be
29 accessible without any requirement that an individual seeking the
30 directory information demonstrate coverage with the insurer,
31 indicate interest in obtaining coverage with the insurer, provide a
32 member identification or policy number, provide any other
33 identifying information, or create or access an account.

34 (2) The online provider directory or directories shall be
35 accessible on the insurer's public ~~Internet Web site~~ *internet website*
36 through an identifiable link or tab and in a manner that is accessible
37 and searchable by insureds, potential insureds, the public, and
38 providers. By July 1, 2017, or 12 months after the date provider
39 directory standards are developed under subdivision (k), whichever
40 occurs later, the insurer's public ~~Internet Web site~~ *internet website*

1 shall allow provider searches by, at a minimum, name, practice
2 address, city, ZIP Code, California license number, National
3 Provider Identifier number, admitting privileges to an identified
4 hospital, product, tier, provider language or languages, provider
5 group, hospital name, facility name, or clinic name, as appropriate.

6 (d) (1) An insurer shall allow insureds, potential insureds,
7 providers, and members of the public to request a printed copy of
8 the provider directory or directories by contacting the insurer
9 through the insurer's toll-free telephone number, electronically,
10 or in writing. A printed copy of the provider directory or directories
11 shall include the information required in subdivisions (h) and (i).
12 The printed copy of the provider directory or directories shall be
13 provided to the requester by mail postmarked no later than five
14 business days following the date of the request and may be limited
15 to the geographic region in which the requester resides or works
16 or intends to reside or work.

17 (2) An insurer shall update its printed provider directory or
18 directories at least quarterly, or more frequently, if required by
19 federal law.

20 (e) (1) The insurer shall update the online provider directory
21 or directories, at least weekly, or more frequently, if required by
22 federal law, when informed of and upon confirmation by the insurer
23 of any of the following:

24 (A) A contracting provider is no longer accepting new patients
25 for that product, or an individual provider within a provider group
26 is no longer accepting new patients.

27 (B) A contracted provider is no longer under contract for a
28 particular product.

29 (C) A provider's practice location or other information required
30 under subdivision (h) or (i) has changed.

31 (D) Upon the completion of the investigation described in
32 subdivision (o), a change is necessary based on an insured
33 complaint that a provider was not accepting new patients, was
34 otherwise not available, or whose contact information was listed
35 incorrectly.

36 (E) Any other information that affects the content or accuracy
37 of the provider directory or directories.

38 (2) Upon confirmation of any of the following, the insurer shall
39 delete a provider from the directory or directories when:

40 (A) A provider has retired or otherwise has ceased to practice.

1 (B) A provider or provider group is no longer under contract
2 with the insurer for any reason.

3 (C) The contracting provider group has informed the insurer
4 that the provider is no longer associated with the provider group
5 and is no longer under contract with the insurer.

6 (f) The provider directory or directories shall include both an
7 email address and a telephone number for members of the public
8 and providers to notify the insurer if the provider directory
9 information appears to be inaccurate. This information shall be
10 disclosed prominently in the directory or directories and on the
11 insurer's ~~Internet Web site~~. *internet website*.

12 (g) The provider directory or directories shall include the
13 following disclosures informing insureds that they are entitled to
14 both of the following:

15 (1) Language interpreter services, at no cost to the insured,
16 including how to obtain interpretation services in accordance with
17 Section 10133.8.

18 (2) Full and equal access to covered services, including insureds
19 with disabilities as required under the federal Americans with
20 Disabilities Act of 1990 and Section 504 of the Rehabilitation Act
21 of 1973.

22 (h) The insurer and a specialized mental health insurer shall
23 include all of the following information in the provider directory
24 or directories:

25 (1) The provider's name, practice location or locations, and
26 contact information.

27 (2) Type of practitioner.

28 (3) National Provider Identifier number.

29 (4) California license number and type of license.

30 (5) The area of specialty, including board certification, if any.

31 (6) The provider's office email address, if available.

32 (7) The name of each affiliated provider group currently under
33 contract with the insurer through which the provider sees enrollees.

34 (8) A listing for each of the following providers that are under
35 contract with the insurer:

36 (A) For physicians and surgeons, the provider group, and
37 admitting privileges, if any, at hospitals contracted with the insurer.

38 (B) Nurse practitioners, physician assistants, psychologists,
39 acupuncturists, optometrists, podiatrists, chiropractors, licensed
40 clinical social workers, marriage and family therapists, professional

1 clinical counselors, qualified autism service providers, as defined
2 in Section ~~10144.51~~, 4999.200 of the *Business and Professions*
3 *Code*, nurse midwives, and dentists.

4 (C) For federally qualified health centers or primary care clinics,
5 the name of the federally qualified health center or clinic.

6 (D) For ~~any~~ a provider described in subparagraph (A) or (B)
7 who is employed by a federally qualified health center or primary
8 care clinic, and to the extent their services may be accessed and
9 are covered through the contract with the insurer, the name of the
10 provider, and the name of the federally qualified health center or
11 clinic.

12 (E) Facilities, including, but not limited to, general acute care
13 hospitals, skilled nursing facilities, urgent care clinics, ambulatory
14 surgery centers, inpatient hospice, residential care facilities, and
15 inpatient rehabilitation facilities.

16 (F) Pharmacies, clinical laboratories, imaging centers, and other
17 facilities providing contracted health care services.

18 (9) The provider directory or directories may note that
19 authorization or referral may be required to access some providers.

20 (10) Non-English language, if any, spoken by a health care
21 provider or other medical professional as well as non-English
22 language spoken by a qualified medical interpreter, in accordance
23 with Section 10133.8, if any, on the provider's staff.

24 (11) Identification of providers who no longer accept new
25 patients for some or all of the insurer's products.

26 (12) The network tier to which the provider is assigned, if the
27 provider is not in the lowest tier, as applicable. Nothing in this
28 section shall be construed to require the use of network tiers other
29 than contract and noncontracting tiers.

30 (13) All other information necessary to conduct a search
31 pursuant to paragraph (2) of subdivision (c).

32 (i) A vision, dental, or other specialized insurer, except for a
33 specialized mental health insurer, shall include all of the following
34 information for each provider directory or directories used by the
35 insurer for its networks:

36 (1) The provider's name, practice location or locations, and
37 contact information.

38 (2) Type of practitioner.

39 (3) National Provider Identifier number.

40 (4) California license number and type of license, if applicable.

1 (5) The area of specialty, including board certification, or other
2 accreditation, if any.

3 (6) The provider's office email address, if available.

4 (7) The name of each affiliated provider group or specialty
5 insurer practice group currently under contract with the insurer
6 through which the provider sees insureds.

7 (8) The names of each allied health care professional to the
8 extent there is a direct contract for those services covered through
9 a contract with the insurer.

10 (9) The non-English language, if any, spoken by a health care
11 provider or other medical professional as well as non-English
12 language spoken by a qualified medical interpreter, in accordance
13 with Section 10133.8, if any, on the provider's staff.

14 (10) Identification of providers who no longer accept new
15 patients for some or all of the insurer's products.

16 (11) All other applicable information necessary to conduct a
17 provider search pursuant to paragraph (2) of subdivision (c).

18 (j) (1) The contract between the insurer and a provider shall
19 include a requirement that the provider inform the insurer within
20 five business days when either of the following occurs:

21 (A) The provider is not accepting new patients.

22 (B) If the provider had previously not accepted new patients,
23 the provider is currently accepting new patients.

24 (2) If a provider who is not accepting new patients is contacted
25 by an insured or potential insured seeking to become a new patient,
26 the provider shall direct the insurer or potential insured to both the
27 insurer for additional assistance in finding a provider and to the
28 department to report any inaccuracy with the insurer's directory
29 or directories.

30 (3) If an insured or potential insured informs an insurer of a
31 possible inaccuracy in the provider directory or directories, the
32 insurer shall promptly investigate and, if necessary, undertake
33 corrective action within 30 business days to ensure the accuracy
34 of the directory or directories.

35 (k) (1) On or before December 31, 2016, the department shall
36 develop uniform provider directory standards to permit consistency
37 in accordance with subdivision (b) and paragraph (2) of subdivision
38 (c) and development of a multiplan directory by another entity.
39 Those standards shall not be subject to the Administrative
40 Procedure Act (Chapter 3.5 (commencing with Section 11340) of

1 Part 1 of Division 3 of Title 2 of the Government Code), until
2 January 1, 2021. No more than two revisions of those standards
3 shall be exempt from the Administrative Procedure Act (Chapter
4 3.5 (commencing with Section 11340) of Part 1 of Division 3 of
5 Title 2 of the Government Code) pursuant to this subdivision.

6 (2) In developing the standards under this subdivision, the
7 department shall seek input from interested parties throughout the
8 process of developing the standards and shall hold at least one
9 public meeting. The department shall take into consideration any
10 requirements for provider directories established by the federal
11 Centers for Medicare and Medicaid Services and the State
12 Department of Health Care Services.

13 (3) By July 31, 2017, or 12 months after the date provider
14 directory standards are developed under this subdivision, whichever
15 occurs later, an insurer shall use the standards developed by the
16 department for each product offered by the insurer.

17 (l) (1) An insurer shall take appropriate steps to ensure the
18 accuracy of the information concerning each provider listed in the
19 insurer's provider directory or directories in accordance with this
20 section, and shall, at least annually, review and update the entire
21 provider directory or directories for each product offered. Each
22 calendar year the insurer shall notify all contracted providers
23 described in subdivisions (h) and (i) as follows:

24 (A) For individual providers who are not affiliated with a
25 provider group described in subparagraph (A) or (B) of paragraph
26 (8) of subdivision (h) and providers described in subdivision (i),
27 the insurer shall notify each provider at least once every six months.

28 (B) For all other providers described in subdivision (h) who are
29 not subject to the requirements of subparagraph (A), the insurer
30 shall notify its contracted providers to ensure that all of the
31 providers are contacted by the insurer at least once annually.

32 (2) The notification shall include all of the following:

33 (A) The information the insurer has in its directory or directories
34 regarding the provider or provider group, including a list of
35 networks and products that include the contracted provider or
36 provider group.

37 (B) A statement that the failure to respond to the notification
38 may result in a delay of payment or reimbursement of a claim
39 pursuant to subdivision (p).

1 (C) Instructions on how the provider or provider group can
2 update the information in the provider directory or directories using
3 the online interface developed pursuant to subdivision (m).

4 (3) The insurer shall require an affirmative response from the
5 provider or provider group acknowledging that the notification
6 was received. The provider or provider group shall confirm that
7 the information in the provider directory or directories is current
8 and accurate or update the information required to be in the
9 directory or directories pursuant to this section, including whether
10 or not the provider group is accepting new patients for each
11 product.

12 (4) If the insurer does not receive an affirmative response and
13 confirmation from the provider that the information is current and
14 accurate or, as an alternative, updates any information required to
15 be in the directory or directories pursuant to this section, within
16 30 business days, the insurer shall take no more than 15 business
17 days to verify whether the provider's information is correct or
18 requires updates. The insurer shall document the receipt and
19 outcome of each attempt to verify the information. If the insurer
20 is unable to verify whether the provider's information is correct
21 or requires updates, the insurer shall notify the provider 10 business
22 days in advance of removal that the provider will be removed from
23 the directory or directories. The provider shall be removed from
24 the directory or directories at the next required update of the
25 provider directory or directories after the 10-business day notice
26 period. A provider shall not be removed from the provider directory
27 or directories if ~~he or she responds~~ *they respond* before the end of
28 the 10-business day notice period.

29 (5) General acute care hospitals shall be exempt from the
30 requirements in paragraphs (3) and (4).

31 (m) An insurer shall establish policies and procedures with
32 regard to the regular updating of its provider directory or
33 directories, including the weekly, quarterly, and annual updates
34 required pursuant to this section, or more frequently, if required
35 by federal law or guidance.

36 (1) The policies and procedures described under this subdivision
37 shall be submitted by an insurer annually to the department for
38 approval and in a format described by the department.

39 (2) Every insurer shall ensure processes are in place to allow
40 providers to promptly verify or submit changes to the information

1 required to be in the directory or directories pursuant to this section.
2 Those processes shall, at a minimum, include an online interface
3 for providers to submit verification or changes electronically and
4 shall generate an acknowledgment of receipt from the insurer.
5 Providers shall verify or submit changes to information required
6 to be in the directory or directories pursuant to this section using
7 the process required by the insurer.

8 (3) The insurer shall establish and maintain a process for
9 insureds, potential insureds, other providers, and the public to
10 identify and report possible inaccurate, incomplete, or misleading
11 information currently listed in the insurer's provider directory or
12 directories. This process shall, at a minimum, include a telephone
13 number and a dedicated email address at which the insurer will
14 accept these reports, as well as a hyperlink on the insurer's provider
15 directory ~~Internet Web site~~ *internet website* linking to a form where
16 the information can be reported directly to the insurer through its
17 ~~Internet Web site~~ *internet website*.

18 (n) (1) This section does not prohibit an insurer from requiring
19 its provider groups or contracting specialized health insurers to
20 provide information to the insurer that is required by the insurer
21 to satisfy the requirements of this section for each of the providers
22 that contract with the provider group or contracting specialized
23 health insurer. This responsibility shall be specifically documented
24 in a written contract between the insurer and the provider group
25 or contracting specialized health insurer.

26 (2) If an insurer requires its contracting provider groups or
27 contracting specialized health insurers to provide the insurer with
28 information described in paragraph (1), the insurer shall continue
29 to retain responsibility for ensuring that the requirements of this
30 section are satisfied.

31 (3) A provider group may terminate a contract with a provider
32 for a pattern or repeated failure of the provider to update the
33 information required to be in the directory or directories pursuant
34 to this section.

35 (4) A provider group is not subject to the payment delay
36 described in subdivision (p) if all of the following occurs:

37 (A) A provider does not respond to the provider group's attempt
38 to verify the provider's information. As used in this paragraph,
39 "verify" means to contact the provider in writing, electronically,

1 and by telephone to confirm whether the provider's information
2 is correct or requires updates.

3 (B) The provider group documents its efforts to verify the
4 provider's information.

5 (C) The provider group reports to the insurer that the provider
6 should be deleted from the provider group in the insurer's provider
7 directory or directories.

8 (5) Section 10133.65, known as the Health Care Providers' Bill
9 of Rights, applies to any material change to a provider contract
10 pursuant to this section.

11 (o) (1) Whenever an insurer receives a report indicating that
12 information listed in its provider directory or directories is
13 inaccurate, the insurer shall promptly investigate the reported
14 inaccuracy and, no later than 30 business days following receipt
15 of the report, either verify the accuracy of the information or update
16 the information in its provider directory or directories, as
17 applicable.

18 (2) When investigating a report regarding its provider directory
19 or directories, the insurer shall, at a minimum, do the following:

20 (A) Contact the affected provider no later than five business
21 days following receipt of the report.

22 (B) Document the receipt and outcome of each report. The
23 documentation shall include the provider's name, location, and a
24 description of the insurer's investigation, the outcome of the
25 investigation, and any changes or updates made to its provider
26 directory or directories.

27 (C) If changes to an insurer's provider directory or directories
28 are required as a result of the insurer's investigation, the changes
29 to the online provider directory or directories shall be made no
30 later than the next scheduled weekly update, or the update
31 immediately following that update, or sooner if required by federal
32 law or regulations. For printed provider directories, the change
33 shall be made no later than the next required update, or sooner if
34 required by federal law or regulations.

35 (p) (1) Notwithstanding Sections 10123.13 and 10123.147, an
36 insurer may delay payment or reimbursement owed to a provider
37 or provider group for any claims payment made to a provider or
38 provider group for up to one calendar month beginning on the first
39 day of the following month, if the provider or provider group fails
40 to respond to the insurer's attempts to verify the provider's

information as required under subdivision (l). The insurer shall not delay payment unless it has attempted to verify the provider's or provider group's information. As used in this subdivision, "verify" means to contact the provider or provider group in writing, electronically, and by telephone to confirm whether the provider's or provider group's information is correct or requires updates. An insurer may seek to delay payment or reimbursement owed to a provider or provider group only after the 10-business day notice period described in paragraph (4) of subdivision (l) has lapsed.

(2) An insurer shall notify the provider or provider group 10 days before it seeks to delay payment or reimbursement to a provider or provider group pursuant to this subdivision. If the insurer delays a payment or reimbursement pursuant to this subdivision, the insurer shall reimburse the full amount of any payment or reimbursement subject to delay to the provider or provider group according to either of the following timelines, as applicable:

(A) No later than three business days following the date on which the insurer receives the information required to be submitted by the provider or provider group pursuant to subdivision (l).

(B) At the end of the one-calendar-month delay described in paragraph (1), if the provider or provider group fails to provide the information required to be submitted to the insurer pursuant to subdivision (l).

(3) An insurer may terminate a contract for a pattern or repeated failure of the provider or provider group to alert the insurer to a change in the information required to be in the directory or directories pursuant to this section.

(4) An insurer that delays payment or reimbursement under this subdivision shall document each instance a payment or reimbursement was delayed and report this information to the department in a format described by the department. This information shall be submitted along with the policies and procedures required to be submitted annually to the department pursuant to paragraph (1) of subdivision (m).

(q) In circumstances where the department finds that an insured reasonably relied upon materially inaccurate, incomplete, or misleading information contained in an insurer's provider directory or directories, the department may require the insurer to provide coverage for all covered health care services provided to the insured

1 and to reimburse the insured for any amount beyond what the
2 insured would have paid, had the services been delivered by an
3 in-network provider under the insured's health insurance policy.
4 Prior to requiring reimbursement in these circumstances, the
5 department shall conclude that the services received by the insured
6 were covered services under the insured's health insurance policy.
7 In those circumstances, the fact that the services were rendered or
8 delivered by a noncontracting or out-of-network provider shall not
9 be used as a basis to deny reimbursement to the insured.

10 (r) Whenever an insurer determines as a result of this section
11 that there has been a 10-percent change in the network for a product
12 in a region, the insurer shall file a statement with the commissioner.

13 (s) An insurer that contracts with multiple employer welfare
14 agreements regulated pursuant to Article 4.7 (commencing with
15 Section 742.20) of Chapter 1 of Part 2 of Division 1 shall meet the
16 requirements of this section.

17 (t) This section shall not be construed to alter a provider's
18 obligation to provide health care services to an insured pursuant
19 to the provider's contract with the insurer.

20 (u) As part of the department's routine examination of a health
21 insurer pursuant to Section 730, the department shall include a
22 review of the health insurer's compliance with subdivision (p).

23 (v) For purposes of this section, "provider group" means a
24 medical group, independent practice association, or other similar
25 group of providers.

26 SEC. 7. Section 10144.5 of the Insurance Code is amended to
27 read:

28 10144.5. (a) (1) Every disability insurance policy issued,
29 amended, or renewed on or after January 1, 2021, that provides
30 hospital, medical, or surgical coverage shall provide coverage for
31 medically necessary treatment of mental health and substance use
32 disorders, under the same terms and conditions applied to other
33 medical conditions as specified in subdivision (c).

34 (2) For purposes of this section, "mental health and substance
35 use disorders" means a mental health condition or substance use
36 disorder that falls under any of the diagnostic categories listed in
37 the mental and behavioral disorders chapter of the most recent
38 edition of the World Health Organization's International Statistical
39 Classification of Diseases and Related Health Problems, or that is
40 listed in the most recent version of the American Psychiatric

Association’s Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization’s International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

(3) (A) For purposes of this section, “medically necessary treatment of a mental health or substance use disorder” means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the generally accepted standards of mental health and substance use disorder care.

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(iii) Not primarily for the economic benefit of the disability insurer and insureds or for the convenience of the patient, treating physician, or other health care provider.

(B) This paragraph does not limit in any way the independent medical review rights of an insured or policyholder under this chapter.

(4) “Health care provider” means any of the following:

(A) A person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

(B) An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3 of the Business and Professions Code.

(C) A qualified autism service provider ~~or qualified autism service professional~~ certified by a national entity ~~pursuant to Section 1374.73 of the Health and Safety Code and Section 10144.51~~, as defined in Section 4999.200 of the Business and Professions Code or a qualified autism service professional as defined in Section 4999.201 of the Business and Professions Code.

1 (D) An associate clinical social worker functioning pursuant to
2 Section 4996.23.2 of the Business and Professions Code.

3 (E) An associate professional clinical counselor or professional
4 clinical counselor trainee functioning pursuant to Section 4999.46.3
5 of the Business and Professions Code.

6 (F) A registered psychologist, as described in Section 2909.5
7 of the Business and Professions Code.

8 (G) A registered psychological assistant, as described in Section
9 2913 of the Business and Professions Code.

10 (H) A psychology trainee or person supervised as set forth in
11 Section 2910 or 2911 of, or subdivision (d) of Section 2914 of,
12 the Business and Professions Code.

13 (5) For purposes of this section, “generally accepted standards
14 of mental health and substance use disorder care” has the same
15 meaning as defined in paragraph (1) of subdivision (f) of Section
16 10144.52.

17 (6) A disability insurer shall not limit benefits or coverage for
18 mental health and substance use disorders to short-term or acute
19 treatment.

20 (7) All medical necessity determinations made by the disability
21 insurer concerning service intensity, level of care placement,
22 continued stay, and transfer or discharge of insureds diagnosed
23 with mental health and substance use disorders shall be conducted
24 in accordance with the requirements of Section 10144.52.

25 (8) A disability insurer that authorizes a specific type of
26 treatment by a provider pursuant to this section shall not rescind
27 or modify the authorization after the provider renders the health
28 care service in good faith and pursuant to this authorization for
29 any reason, including, but not limited to, the insurer’s subsequent
30 rescission, cancellation, or modification of the insured’s or
31 policyholder’s contract, or the insurer’s subsequent determination
32 that it did not make an accurate determination of the insured’s or
33 policyholder’s eligibility. This section shall not be construed to
34 expand or alter the benefits available to the insured or policyholder
35 under an insurance policy.

36 (b) The benefits that shall be covered pursuant to this section
37 shall include, but not be limited to, the following:

38 (1) Basic health care services, as defined in subdivision (b) of
39 Section 1345 of the Health and Safety Code.

1 (2) Intermediate services, including the full range of levels of
2 care, including, but not limited to, residential treatment, partial
3 hospitalization, and intensive outpatient treatment.

4 (3) Prescription drugs, if the policy includes coverage for
5 prescription drugs.

6 (c) The terms and conditions applied to the benefits required
7 by this section, that shall be applied equally to all benefits under
8 the disability insurance policy shall include, but not be limited to,
9 all of the following patient financial responsibilities:

10 (1) Maximum and annual lifetime benefits, if not prohibited by
11 applicable law.

12 (2) Copayments and coinsurance.

13 (3) Individual and family deductibles.

14 (4) Out-of-pocket maximums.

15 (d) If services for the medically necessary treatment of a mental
16 health or substance use disorder are not available in network within
17 the geographic and timely access standards set by law or regulation,
18 the disability insurer shall arrange coverage to ensure the delivery
19 of medically necessary out-of-network services and any medically
20 necessary followup services that, to the maximum extent possible,
21 meet those geographic and timely access standards. As used in
22 this subdivision, to “arrange coverage to ensure the delivery of
23 medically necessary out-of-network services” includes, but is not
24 limited to, providing services to secure medically necessary
25 out-of-network options that are available to the insured within
26 geographic and timely access standards. The insured shall pay no
27 more than the same cost sharing that the insured would pay for the
28 same covered services received from an in-network provider.

29 (e) This section shall not apply to accident-only, specified
30 disease, hospital indemnity, Medicare supplement, dental-only, or
31 vision-only insurance policies.

32 (f) (1) For the purpose of compliance with this section, a
33 disability insurer may provide coverage for all or part of the mental
34 health and substance use disorder services required by this section
35 through a separate specialized health insurance policy or mental
36 health policy. This paragraph shall not apply to policies that are
37 subject to Section 10112.27.

38 (2) A disability insurer shall provide the mental health and
39 substance use disorder coverage required by this section in its
40 entire service area and in emergency situations as may be required

1 by applicable laws and regulations. For purposes of this section,
2 disability insurance policies that provide benefits to insureds
3 through preferred provider contracting arrangements are not
4 precluded from requiring insureds who reside or work in
5 geographic areas served by specialized health insurance policies
6 or mental health insurance policies to secure all or part of their
7 mental health services within those geographic areas served by
8 specialized health insurance policies or mental health insurance
9 policies, provided that all appropriate mental health or substance
10 use disorder services are actually available within those geographic
11 service areas within timeliness standards.

12 (3) Notwithstanding any other law, in the provision of benefits
13 required by this section, a disability insurer may utilize case
14 management, network providers, utilization review techniques,
15 prior authorization, copayments, or other cost sharing, provided
16 that these practices are consistent with Section 10144.4 of this
17 code, and Section 2052 of the Business and Professions Code.

18 (g) This section shall not be construed to deny or restrict in any
19 way the department's authority to ensure a disability insurer's
20 compliance with this code.

21 (h) A disability insurer shall not limit benefits or coverage for
22 medically necessary services on the basis that those services should
23 be or could be covered by a public entitlement program, including,
24 but not limited to, special education or an individualized education
25 program, Medicaid, Medicare, Supplemental Security Income, or
26 Social Security Disability Insurance, and shall not include or
27 enforce a contract term that excludes otherwise covered benefits
28 on the basis that those services should be or could be covered by
29 a public entitlement program.

30 (i) A disability insurer shall not adopt, impose, or enforce terms
31 in its policies or provider agreements, in writing or in operation,
32 that undermine, alter, or conflict with the requirements of this
33 section.

34 (j) If the commissioner determines that a disability insurer has
35 violated this section, the commissioner may, after appropriate
36 notice and opportunity for hearing in accordance with the
37 Administrative Procedure Act (Chapter 5 (commencing with
38 Section 11500) of Part 1 of Division 3 of Title 2 of the Government
39 Code), by order, assess a civil penalty not to exceed five thousand
40 dollars (\$5,000) for each violation, or, if a violation was willful,

1 a civil penalty not to exceed ten thousand dollars (\$10,000) for
2 each violation.

3 SEC. 8. Section 10144.51 of the Insurance Code is amended
4 to read:

5 10144.51. (a) (1) Every health insurance policy shall also
6 provide coverage for behavioral health treatment for pervasive
7 developmental disorder or autism no later than July 1, 2012. The
8 coverage shall be provided in the same manner and ~~shall be~~ *is*
9 subject to the same requirements as provided in Section 10144.5.

10 (2) Notwithstanding paragraph (1), as of the date that proposed
11 final rulemaking for essential health benefits is issued, this section
12 does not require any benefits to be provided that exceed the
13 essential health benefits that all health insurers will be required by
14 federal regulations to provide under Section 1302(b) of the federal
15 Patient Protection and Affordable Care Act (Public Law 111-148),
16 as amended by the federal Health Care and Education
17 Reconciliation Act of 2010 (Public Law 111-152).

18 (3) This section ~~shall~~ *does* not affect services for which an
19 individual is eligible pursuant to Division 4.5 (commencing with
20 Section 4500) of the Welfare and Institutions Code or Title 14
21 (commencing with Section 95000) of the Government Code.

22 (4) This section ~~shall~~ *does* not affect or reduce any obligation
23 to provide services under an individualized education program, as
24 defined in Section 56032 of the Education Code, or an individual
25 service plan, as described in Section 5600.4 of the Welfare and
26 Institutions Code, or under the federal Individuals with Disabilities
27 Education Act (20 U.S.C. Sec. 1400 et seq.) and its implementing
28 regulations.

29 (b) Pursuant to Article 6 (commencing with Section 2240) of
30 Subchapter 2 of Chapter 5 of Title 10 of the California Code of
31 Regulations, every health insurer subject to this section shall
32 maintain an adequate network that includes qualified autism service
33 providers who supervise or employ qualified autism service
34 professionals or paraprofessionals who provide and administer
35 behavioral health treatment. A health insurer is not prevented from
36 selectively contracting with providers within these requirements.

37 (c) For the purposes of this section, the following definitions
38 shall apply:

39 (1) "Behavioral health treatment" means professional services
40 and treatment programs, including applied behavior analysis and

1 evidence-based behavior intervention programs, that develop or
2 restore, to the maximum extent practicable, the functioning of an
3 individual with pervasive developmental disorder or autism, and
4 that meet all of the following criteria:

5 (A) The treatment is prescribed by a physician and surgeon
6 licensed pursuant to Chapter 5 (commencing with Section 2000)
7 of, or is developed by a psychologist licensed pursuant to Chapter
8 6.6 (commencing with Section 2900) of, Division 2 of the Business
9 and Professions Code.

10 (B) The treatment is provided under a treatment plan prescribed
11 by a qualified autism service provider and is administered by one
12 of the following:

13 (i) A qualified autism service provider.

14 (ii) A qualified autism service professional supervised by the
15 qualified autism service provider.

16 (iii) A qualified autism service paraprofessional supervised by
17 a qualified autism service provider or qualified autism service
18 professional.

19 (C) The treatment plan has measurable goals over a specific
20 timeline that is developed and approved by the qualified autism
21 service provider for the specific patient being treated. The treatment
22 plan shall be reviewed no less than once every six months by the
23 qualified autism service provider and modified whenever
24 appropriate, and shall be consistent with Section 4686.2 of the
25 Welfare and Institutions Code pursuant to which the qualified
26 autism service provider does all of the following:

27 (i) Describes the patient's behavioral health impairments or
28 developmental challenges that are to be treated.

29 (ii) Designs an intervention plan that includes the service type,
30 number of hours, and parent participation needed to achieve the
31 plan's goal and objectives, and the frequency at which the patient's
32 progress is evaluated and reported.

33 (iii) Provides intervention plans that utilize evidence-based
34 practices, with demonstrated clinical efficacy in treating pervasive
35 developmental disorder or autism.

36 (iv) Discontinues intensive behavioral intervention services
37 when the treatment goals and objectives are achieved or no longer
38 appropriate.

39 (D) The treatment plan is not used for purposes of providing or
40 for the reimbursement of respite, day care, or educational services

1 and is not used to reimburse a parent for participating in the
2 treatment program. The treatment plan shall be made available to
3 the insurer upon request.

4 ~~(2) “Pervasive developmental disorder or autism” shall have~~
5 ~~the same meaning and interpretation as used in Section 10144.5.~~

6 ~~(3) “Qualified autism service provider” means either of the~~
7 ~~following:~~

8 ~~(A) A person who is certified by a national entity, such as the~~
9 ~~Behavior Analyst Certification Board, with a certification that is~~
10 ~~accredited by the National Commission for Certifying Agencies,~~
11 ~~and who designs, supervises, or provides treatment for pervasive~~
12 ~~developmental disorder or autism, provided the services are within~~
13 ~~the experience and competence of the person who is nationally~~
14 ~~certified.~~

15 ~~(B) A person licensed as a physician and surgeon, physical~~
16 ~~therapist, occupational therapist, psychologist, marriage and family~~
17 ~~therapist, educational psychologist, clinical social worker,~~
18 ~~professional clinical counselor, speech-language pathologist, or~~
19 ~~audiologist pursuant to Division 2 (commencing with Section 500)~~
20 ~~of the Business and Professions Code, who designs, supervises,~~
21 ~~or provides treatment for pervasive developmental disorder or~~
22 ~~autism, provided the services are within the experience and~~
23 ~~competence of the licensee.~~

24 ~~(4) “Qualified autism service professional” means an individual~~
25 ~~who meets all of the following criteria:~~

26 ~~(A) Provides behavioral health treatment, which may include~~
27 ~~clinical case management and case supervision under the direction~~
28 ~~and supervision of a qualified autism service provider.~~

29 ~~(B) Is supervised by a qualified autism service provider.~~

30 ~~(C) Provides treatment pursuant to a treatment plan developed~~
31 ~~and approved by the qualified autism service provider.~~

32 ~~(D) Is either of the following:~~

33 ~~(i) A behavioral service provider who meets the education and~~
34 ~~experience qualifications described in Section 54342 of Title 17~~
35 ~~of the California Code of Regulations for an Associate Behavior~~
36 ~~Analyst, Behavior Analyst, Behavior Management Assistant,~~
37 ~~Behavior Management Consultant, or Behavior Management~~
38 ~~Program.~~

39 ~~(ii) A psychological associate, an associate marriage and family~~
40 ~~therapist, an associate clinical social worker, or an associate~~

1 professional clinical counselor, as defined and regulated by the
2 Board of Behavioral Sciences or the Board of Psychology.

3 (E) (i) ~~Has training and experience in providing services for~~
4 ~~pervasive developmental disorder or autism pursuant to Division~~
5 ~~4.5 (commencing with Section 4500) of the Welfare and~~
6 ~~Institutions Code or Title 14 (commencing with Section 95000)~~
7 ~~of the Government Code.~~

8 (ii) ~~If an individual meets the requirement described in clause~~
9 ~~(ii) of subparagraph (D), the individual shall also meet the criteria~~
10 ~~set forth in the regulations adopted pursuant to Section 4686.4 of~~
11 ~~the Welfare and Institutions Code for a Behavioral Health~~
12 ~~Professional.~~

13 (F) ~~Is employed by the qualified autism service provider or an~~
14 ~~entity or group that employs qualified autism service providers~~
15 ~~responsible for the autism treatment plan.~~

16 (5) ~~“Qualified autism service paraprofessional” means an~~
17 ~~unlicensed and uncertified individual who meets all of the~~
18 ~~following criteria:~~

19 (A) ~~Is supervised by a qualified autism service provider or~~
20 ~~qualified autism service professional at a level of clinical~~
21 ~~supervision that meets professionally recognized standards of~~
22 ~~practice.~~

23 (B) ~~Provides treatment and implements services pursuant to a~~
24 ~~treatment plan developed and approved by the qualified autism~~
25 ~~service provider.~~

26 (C) ~~Meets the education and training qualifications described~~
27 ~~in Section 54342 of Title 17 of the California Code of Regulations.~~

28 (D) ~~Has adequate education, training, and experience, as~~
29 ~~certified by a qualified autism service provider or an entity or~~
30 ~~group that employs qualified autism service providers.~~

31 (E) ~~Is employed by the qualified autism service provider or an~~
32 ~~entity or group that employs qualified autism service providers~~
33 ~~responsible for the autism treatment plan.~~

34 (2) *“Qualified autism service provider” means an individual*
35 *described in Section 4999.200 of the Business and Professions*
36 *Code.*

37 (3) *“Qualified autism service professional” means an individual*
38 *who meets all of the criteria set forth in Section 4999.201 of the*
39 *Business and Professions Code.*

1 (4) “*Qualified autism service paraprofessional*” means an
2 *unlicensed and uncertified individual who meets all of the criteria*
3 *set forth in Section 4999.202 of the Business and Professions Code.*

4 (d) This section ~~shall~~ does not apply to any the following:

5 (1) A specialized health insurance policy that does not cover
6 mental health or behavioral health services or an accident only,
7 specified disease, hospital indemnity, or Medicare supplement
8 policy.

9 (2) A health insurance policy in the Medi-Cal program (Chapter
10 7 (commencing with Section 14000) of Part 3 of Division 9 of the
11 Welfare and Institutions Code).

12 (e) This section does not limit the obligation to provide services
13 under Section 10144.5.

14 (f) As provided in Section 10144.5 and in paragraph (1) of
15 subdivision (a), in the provision of benefits required by this section,
16 a health insurer may utilize case management, network providers,
17 utilization review techniques, prior authorization, copayments, or
18 other cost sharing.

19 SEC. 9. Section 11165.7 of the Penal Code is amended to read:

20 11165.7. (a) As used in this article, “mandated reporter” is
21 defined as any of the following:

22 (1) A teacher.

23 (2) An instructional aide.

24 (3) A teacher’s aide or teacher’s assistant employed by a public
25 or private school.

26 (4) A classified employee of a public school.

27 (5) An administrative officer or supervisor of child welfare and
28 attendance, or a certificated pupil personnel employee of a public
29 or private school.

30 (6) An administrator of a public or private day camp.

31 (7) An administrator or employee of a public or private youth
32 center, youth recreation program, or youth organization.

33 (8) An administrator, board member, or employee of a public
34 or private organization whose duties require direct contact and
35 supervision of children, including a foster family agency.

36 (9) An employee of a county office of education or the State
37 Department of Education whose duties bring the employee into
38 contact with children on a regular basis.

39 (10) A licensee, an administrator, or an employee of a licensed
40 community care or child daycare facility.

- 1 (11) A Head Start program teacher.
- 2 (12) A licensing worker or licensing evaluator employed by a
- 3 licensing agency, as defined in Section 11165.11.
- 4 (13) A public assistance worker.
- 5 (14) An employee of a childcare institution, including, but not
- 6 limited to, foster parents, group home personnel, and personnel of
- 7 residential care facilities.
- 8 (15) A social worker, probation officer, or parole officer.
- 9 (16) An employee of a school district police or security
- 10 department.
- 11 (17) A person who is an administrator or presenter of, or a
- 12 counselor in, a child abuse prevention program in a public or
- 13 private school.
- 14 (18) A district attorney investigator, inspector, or local child
- 15 support agency caseworker, unless the investigator, inspector, or
- 16 caseworker is working with an attorney appointed pursuant to
- 17 Section 317 of the Welfare and Institutions Code to represent a
- 18 minor.
- 19 (19) A peace officer, as defined in Chapter 4.5 (commencing
- 20 with Section 830) of Title 3 of Part 2, who is not otherwise
- 21 described in this section.
- 22 (20) A firefighter, except for volunteer firefighters.
- 23 (21) A physician and surgeon, psychiatrist, psychologist, dentist,
- 24 resident, intern, podiatrist, chiropractor, licensed nurse, dental
- 25 hygienist, optometrist, marriage and family therapist, clinical social
- 26 worker, professional clinical counselor, or any other person who
- 27 is currently licensed under Division 2 (commencing with Section
- 28 500) of the Business and Professions Code.
- 29 (22) An emergency medical technician I or II, paramedic, or
- 30 other person certified pursuant to Division 2.5 (commencing with
- 31 Section 1797) of the Health and Safety Code.
- 32 (23) A psychological assistant registered pursuant to Section
- 33 2913 of the Business and Professions Code.
- 34 (24) A marriage and family therapist trainee, as defined in
- 35 subdivision (c) of Section 4980.03 of the Business and Professions
- 36 Code.
- 37 (25) An unlicensed associate marriage and family therapist
- 38 registered under Section 4980.44 of the Business and Professions
- 39 Code.

1 (26) A state or county public health employee who treats a minor
2 for venereal disease or any other condition.

3 (27) A coroner.

4 (28) A medical examiner or other person who performs
5 autopsies.

6 (29) A commercial film and photographic print or image
7 processor as specified in subdivision (e) of Section 11166. As used
8 in this article, “commercial film and photographic print or image
9 processor” means a person who develops exposed photographic
10 film into negatives, slides, or prints, or who makes prints from
11 negatives or slides, or who prepares, publishes, produces, develops,
12 duplicates, or prints any representation of information, data, or an
13 image, including, but not limited to, any film, filmstrip, photograph,
14 negative, slide, photocopy, videotape, video laser disc, computer
15 hardware, computer software, computer floppy disk, data storage
16 medium, CD-ROM, computer-generated equipment, or
17 computer-generated image, for compensation. The term includes
18 any employee of that person; it does not include a person who
19 develops film or makes prints or images for a public agency.

20 (30) A child visitation monitor. As used in this article, “child
21 visitation monitor” means a person who, for financial
22 compensation, acts as a monitor of a visit between a child and
23 another person when the monitoring of that visit has been ordered
24 by a court of law.

25 (31) An animal control officer or humane society officer. For
26 the purposes of this article, the following terms have the following
27 meanings:

28 (A) “Animal control officer” means a person employed by a
29 city, county, or city and county for the purpose of enforcing animal
30 control laws or regulations.

31 (B) “Humane society officer” means a person appointed or
32 employed by a public or private entity as a humane officer who is
33 qualified pursuant to Section 14502 or 14503 of the Corporations
34 Code.

35 (32) A clergy member, as specified in subdivision (d) of Section
36 11166. As used in this article, “clergy member” means a priest,
37 minister, rabbi, religious practitioner, or similar functionary of a
38 church, temple, or recognized denomination or organization.

39 (33) Any custodian of records of a clergy member, as specified
40 in this section and subdivision (d) of Section 11166.

1 (34) An employee of any police department, county sheriff's
2 department, county probation department, or county welfare
3 department.

4 (35) An employee or volunteer of a Court Appointed Special
5 Advocate program, as defined in Rule 5.655 of the California Rules
6 of Court.

7 (36) A custodial officer, as defined in Section 831.5.

8 (37) A person providing services to a minor child under Section
9 12300 or 12300.1 of the Welfare and Institutions Code.

10 (38) An alcohol and drug counselor. As used in this article, an
11 "alcohol and drug counselor" is a person providing counseling,
12 therapy, or other clinical services for a state licensed or certified
13 drug, alcohol, or drug and alcohol treatment program. However,
14 alcohol or drug abuse, or both alcohol and drug abuse, is not, in
15 and of itself, a sufficient basis for reporting child abuse or neglect.

16 (39) A clinical counselor trainee, as defined in subdivision (g)
17 of Section 4999.12 of the Business and Professions Code.

18 (40) An associate professional clinical counselor registered
19 under Section 4999.42 of the Business and Professions Code.

20 (41) An employee or administrator of a public or private
21 postsecondary educational institution, whose duties bring the
22 administrator or employee into contact with children on a regular
23 basis, or who supervises those whose duties bring the administrator
24 or employee into contact with children on a regular basis, as to
25 child abuse or neglect occurring on that institution's premises or
26 at an official activity of, or program conducted by, the institution.
27 Nothing in this paragraph shall be construed as altering the
28 lawyer-client privilege as set forth in Article 3 (commencing with
29 Section 950) of Chapter 4 of Division 8 of the Evidence Code.

30 (42) An athletic coach, athletic administrator, or athletic director
31 employed by any public or private school that provides any
32 combination of instruction for kindergarten, or grades 1 to 12,
33 inclusive.

34 (43) (A) A commercial computer technician as specified in
35 subdivision (e) of Section 11166. As used in this article,
36 "commercial computer technician" means a person who works for
37 a company that is in the business of repairing, installing, or
38 otherwise servicing a computer or computer component, including,
39 but not limited to, a computer part, device, memory storage or
40 recording mechanism, auxiliary storage recording or memory

1 capacity, or any other material relating to the operation and
2 maintenance of a computer or computer network system, for a fee.
3 An employer who provides an electronic communications service
4 or a remote computing service to the public shall be deemed to
5 comply with this article if that employer complies with Section
6 2258A of Title 18 of the United States Code.

7 (B) An employer of a commercial computer technician may
8 implement internal procedures for facilitating reporting consistent
9 with this article. These procedures may direct employees who are
10 mandated reporters under this paragraph to report materials
11 described in subdivision (e) of Section 11166 to an employee who
12 is designated by the employer to receive the reports. An employee
13 who is designated to receive reports under this subparagraph shall
14 be a commercial computer technician for purposes of this article.
15 A commercial computer technician who makes a report to the
16 designated employee pursuant to this subparagraph shall be deemed
17 to have complied with the requirements of this article and shall be
18 subject to the protections afforded to mandated reporters, including,
19 but not limited to, those protections afforded by Section 11172.

20 (44) Any athletic coach, including, but not limited to, an
21 assistant coach or a graduate assistant involved in coaching, at
22 public or private postsecondary educational institutions.

23 (45) An individual certified by a licensed foster family agency
24 as a certified family home, as defined in Section 1506 of the Health
25 and Safety Code.

26 (46) An individual approved as a resource family, as defined in
27 Section 1517 of the Health and Safety Code and Section 16519.5
28 of the Welfare and Institutions Code.

29 (47) A qualified autism service provider, a qualified autism
30 service professional, or a qualified autism service ~~paraprofessional,~~
31 ~~as defined in Section 1374.73 of the Health and Safety Code and~~
32 ~~Section 10144.51 of the Insurance Code.~~ *paraprofessional as*
33 *defined in Chapter 17 (commencing with Section 4999.200) of*
34 *Division 2 of the Business and Professions Code.*

35 (48) A human resource employee of a business subject to Part
36 2.8 (commencing with Section 12900) of Division 3 of Title 2 of
37 the Government Code that employs minors. For purposes of this
38 section, a “human resource employee” is the employee or
39 employees designated by the employer to accept any complaints
40 of misconduct as required by Chapter 6 (commencing with Section

1 12940) of Part 2.8 of Division 3 of Title 2 of the Government
2 Code.

3 (49) An adult person whose duties require direct contact with
4 and supervision of minors in the performance of the minors' duties
5 in the workplace of a business subject to Part 2.8 (commencing
6 with Section 12900) of Division 3 of Title 2 of the Government
7 Code is a mandated reporter of sexual abuse, as defined in Section
8 11165.1. Nothing in this paragraph shall be construed to modify
9 or limit the person's duty to report known or suspected child abuse
10 or neglect when the person is acting in some other capacity that
11 would otherwise make the person a mandated reporter.

12 (b) Except as provided in paragraph (35) of subdivision (a),
13 volunteers of public or private organizations whose duties require
14 direct contact with and supervision of children are not mandated
15 reporters but are encouraged to obtain training in the identification
16 and reporting of child abuse and neglect and are further encouraged
17 to report known or suspected instances of child abuse or neglect
18 to an agency specified in Section 11165.9.

19 (c) (1) Except as provided in subdivision (d) and paragraph (2),
20 employers are strongly encouraged to provide their employees
21 who are mandated reporters with training in the duties imposed
22 by this article. This training shall include training in child abuse
23 and neglect identification and training in child abuse and neglect
24 reporting. Whether or not employers provide their employees with
25 training in child abuse and neglect identification and reporting,
26 the employers shall provide their employees who are mandated
27 reporters with the statement required pursuant to subdivision (a)
28 of Section 11166.5.

29 (2) Employers subject to paragraphs (48) and (49) of subdivision
30 (a) shall provide their employees who are mandated reporters with
31 training in the duties imposed by this article. This training shall
32 include training in child abuse and neglect identification and
33 training in child abuse and neglect reporting. The training
34 requirement may be met by completing the general online training
35 for mandated reporters offered by the Office of Child Abuse
36 Prevention in the State Department of Social Services.

37 (d) Pursuant to Section 44691 of the Education Code, school
38 districts, county offices of education, state special schools and
39 diagnostic centers operated by the State Department of Education,
40 and charter schools shall annually train their employees and persons

1 working on their behalf specified in subdivision (a) in the duties
2 of mandated reporters under the child abuse reporting laws. The
3 training shall include, but not necessarily be limited to, training in
4 child abuse and neglect identification and child abuse and neglect
5 reporting.

6 (e) (1) On and after January 1, 2018, pursuant to Section
7 1596.8662 of the Health and Safety Code, a childcare licensee
8 applicant shall take training in the duties of mandated reporters
9 under the child abuse reporting laws as a condition of licensure,
10 and a childcare administrator or an employee of a licensed child
11 daycare facility shall take training in the duties of mandated
12 reporters during the first 90 days when that administrator or
13 employee is employed by the facility.

14 (2) A person specified in paragraph (1) who becomes a licensee,
15 administrator, or employee of a licensed child daycare facility shall
16 take renewal mandated reporter training every two years following
17 the date on which that person completed the initial mandated
18 reporter training. The training shall include, but not necessarily be
19 limited to, training in child abuse and neglect identification and
20 child abuse and neglect reporting.

21 (f) Unless otherwise specifically provided, the absence of
22 training shall not excuse a mandated reporter from the duties
23 imposed by this article.

24 (g) Public and private organizations are encouraged to provide
25 their volunteers whose duties require direct contact with and
26 supervision of children with training in the identification and
27 reporting of child abuse and neglect.