

**Assembly Bill No. 1181**

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Passed the Assembly April 23, 1998

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*Chief Clerk of the Assembly*

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Passed the Senate April 2, 1998

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*Secretary of the Senate*

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This bill was received by the Governor this \_\_\_\_ day  
of \_\_\_\_\_, 1998, at \_\_\_\_ o'clock \_\_M.

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*Private Secretary of the Governor*

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## CHAPTER \_\_\_\_

An act to add Section 1374.16 to the Health and Safety Code, and to add Section 14450.5 to the Welfare and Institutions Code, relating to health care.

## LEGISLATIVE COUNSEL'S DIGEST

AB 1181, Escutia. Health care coverage.

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 Commissioner of Corporations and makes the willful violation of these provisions subject to criminal sanction.

This bill would require every health care service plan, except a specialized health care service plan, to establish and implement procedures by which an enrollee could receive a standing referral, as defined by the bill, to a specialist and by which an enrollee with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling could receive a referral to a specialist who, or a specialty care center, as defined, that, has expertise in treating the condition or disease for the purpose of having the specialist, or the specialty care center, coordinate the enrollee's health care. Because the bill would change the definition of an existing crime, it would impose a state-mandated local program.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Services, pursuant to which benefits are provided to public assistance recipients and certain other low-income persons.

Existing law prohibits approval or renewal of a contract between the department and a prepaid health plan, unless the providers and the facilities of the prepaid health plan meet the Medi-Cal program standards for participation as established by the director, and the prepaid health plan meets certain standards under the Knox-Keene Health Care Service Plan Act of 1975,



standards specifically required by federal law, and other prescribed requirements.

This bill would, similarly, prohibit approval or renewal of contracts between the department and a prepaid health plan that is contracting with, or that is governed, owned, or operated by, a county board of supervisors, unless the standards set forth in this bill are met, and would require that the treatment plan developed pursuant to these provisions be consistent with federal and state medicaid requirements. The bill would provide that nothing in those provisions is intended to alter or abrogate any other requirements of federal or state law with regard to medicaid.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

SECTION 1. Section 1374.16 is added to the Health and Safety Code, to read:

1374.16. (a) Every health care service plan, except a specialized health care service plan, shall establish and implement a procedure by which an enrollee may receive a standing referral to a specialist. The procedure shall provide for a standing referral to a specialist if the primary care physician determines in consultation with the specialist, if any, and the plan medical director or his or her designee, that an enrollee needs continuing care from a specialist. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, the specialist, and the enrollee, if a treatment plan is deemed necessary to describe the course of the care. A treatment plan may be deemed to be not necessary provided that a current standing referral to a specialist is approved by the plan or its contracting provider, medical group, or



independent practice association. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the primary care physician with regular reports on the health care provided to the enrollee.

(b) Every health care service plan, except a specialized health care service plan, shall establish and implement a procedure by which an enrollee with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling may receive a referral to a specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the specialist coordinate the enrollee's health care. The referral shall be made if the primary care physician, in consultation with the specialist or specialty care center if any, and the plan medical director or his or her designee determines that this specialized medical care is medically necessary for the enrollee. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, specialist or specialty care center, and enrollee, if a treatment plan is deemed necessary to describe the course of care. A treatment plan may be deemed to be not necessary provided that the appropriate referral to a specialist or specialty care center is approved by the plan or its contracting provider, medical group, or independent practice association. After the referral is made, the specialist shall be authorized to provide health care services that are within the specialist's area of expertise and training to the enrollee in the same manner as the enrollee's primary care physician, subject to the terms of the treatment plan.

(c) The determinations described in subdivisions (a) and (b) shall be made within three business days of the date the request for the determination is made by the enrollee or the enrollee's primary care physician and all appropriate medical records and other items of information necessary to make the determination are



provided. Once a determination is made, the referral shall be made within four business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or his or her designee.

(d) Subdivisions (a) and (b) do not require a health care service plan to refer to a specialist who, or to a specialty care center that, is not employed by or under contract with the health care service plan to provide health care services to its enrollees, unless there is no specialist within the plan network that is appropriate to provide treatment to the enrollee, as determined by the primary care physician in consultation with the plan medical director as documented in the treatment plan developed pursuant to subdivision (a) or (b).

(e) For the purposes of this section, “specialty care center” means a center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

(f) As used in this section, a “standing referral” means a referral by a primary care physician to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the primary care physician having to provide a specific referral for each visit.

SEC. 2. Section 14450.5 is added to the Welfare and Institutions Code, to read:

14450.5. (a) No contract between the department and a prepaid health plan that is contracting with, or that is governed, owned, or operated by, a county board of supervisors, shall be approved or renewed unless the standards set forth in Section 1374.16 of the Health and Safety Code are met. The treatment plan developed pursuant to Section 1374.16 of the Health and Safety Code shall be consistent with federal and state medicaid requirements. Nothing in Section 1374.16 of the Health and Safety Code is intended to alter or abrogate any other



requirements of federal or state law with regard to medicaid.

(b) The requirements of this section shall apply to all managed care plan contracts entered into under any of the following:

(1) The act that added this subdivision.

(2) Any of the following provisions of Chapter 7 (commencing with Section 14000).

(A) Article 2.7 (commencing with Section 14087.3).

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

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

(3) Article 7 of Chapter 8 (commencing with Section 14490).

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.



Approved \_\_\_\_\_, 1998

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*Governor*

