AMENDED IN ASSEMBLY APRIL 7, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 1327

Introduced by Assembly Member Portantino

February 18, 2011

~~An act to amend Section 1374.16 of, and to add Section 1374.18 to, the Health and Safety Code, and~~ *An act* to add Section 14087.309 to the Welfare and Institutions Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 1327, as amended, Portantino. ~~Health care: specialists.~~ *Medi-Cal services.*

~~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 violation of its provisions a crime. Under the act, a plan is required to provide a standing referral to a specialist if the enrollee's primary care physician, in consultation with designated persons, determines that the enrollee requires continuing care from the specialist.~~

~~This bill would expand the duty of a health care service plan to provide a standing referral to a specialist, requiring such a referral upon the enrollee's request, and would require the plan to ensure the availability, as specified, of HIV specialists to its enrollees. Because the bill would specify additional requirements under the act, the violation of which would be a crime, it would impose a state-mandated local program.~~

Existing law establishes the Medi-Cal program to provide qualifying individuals with health care services. Under existing law, the director of the State Department of Health Care Services is authorized to contract

with any qualified individual, organization, or entity to provide services to Medi-Cal beneficiaries.

This bill would require the State Department of Health Care Services to determine a per capita payment rate for services provided to Medi-Cal beneficiaries with HIV or AIDS and would specify its calculation method.

~~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.~~

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

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

~~SECTION 1. Section 1374.16 of the Health and Safety Code is amended 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 enrollee requests a referral or his or her 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 if 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 if 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 or, with respect to HIV specialists, no specialist is available within the distance parameters described in Section 1374.18, 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 or authorization for each visit.~~

~~(g) This section shall become operative on (1) January 1, 2004, or (2) the date of adoption of an accreditation or designation by an agency of the state or federal government or by a voluntary national health organization of an HIV or AIDS specialist, whichever date is earlier.~~

~~SEC. 2. Section 1374.18 is added to the Health and Safety Code, to read:~~

~~1374.18. (a) A group health care service plan that provides hospital, medical, or surgical expense benefits shall ensure that one HIV specialist per 500 of the plan's enrollees, as of January 1 of each year, is available on a full-time basis to treat enrollees referred pursuant to Section 1374.16. The plan shall ensure for its enrollees residing in an urban area that the HIV specialist's practice is within 15 miles of the enrollee's residential or business address or within one hour traveling time by motor vehicle from the enrollee's residential or business address. "Urban area" for this purpose means _____.~~

~~(b) An HIV specialist is a licensed physician and surgeon who meets the criteria of a medical expert as described by the HIV Academy of Medicine or by the HIV Medical Association of the Infectious Disease Society of America.~~

~~SEC. 3.~~

SECTION 1. Section 14087.309 is added to the Welfare and Institutions Code, to read:

14087.309. The department shall determine a per capita rate of payment to a managed care plan for services provided to Medi-Cal beneficiaries with HIV or AIDS. In developing the rate, the department shall use all of the coding elements of the definition of AIDS issued by the United States Centers for Disease Prevention

and Control and by the National Drug Code for antiretroviral medications. The rate shall be an average of medical treatment costs for the Medi-Cal beneficiary population with HIV and the Medi-Cal beneficiary population with AIDS. A managed care plan shall be reimbursed at this rate for a Medi-Cal beneficiary with HIV or AIDS.

~~SEC. 4. 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.~~

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