SENATE BILL No. 1516

Introduced by Senator Leno

February 24, 2012

An act to amend Section 14131.07 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 1516, as introduced, Leno. Medi-Cal: physician office and clinic visits.

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income individuals. Existing law states that there is a limit on the total number of physician office and clinic visits for physician services provided by a physician, or under the direction of a physician, that are a covered benefit under the Medi-Cal program of 7 visits per beneficiary per fiscal year, except as specified.

This bill would make a technical, nonsubstantive change to these provisions.

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

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

SECTION 1. Section 14131.07 of the Welfare and Institutions Code is amended to read:

14131.07. (a) Notwithstanding any other provision of this chapter or Chapter 8 (commencing with Section 14200), the total number of physician office and clinic visits for physician services provided by a physician, or under the direction of a physician, that

are a covered benefit under the Medi-Cal program shall be limited to seven visits per beneficiary per fiscal year, excepting visits that meet the conditions ~~set forth~~ *described* in subdivision (b). For purposes of this limit, a visit shall include physician services provided at any federally qualified health center, rural health clinic, community clinic, outpatient clinic, and hospital outpatient department. The department may seek input from consumer organizations and the provider community, as applicable, prior to implementation.

(b) (1) Visits exceeding seven per beneficiary per fiscal year shall be required to be certified by the physician, or other medical professional under the supervision of a physician, attesting that one or more of the following circumstances is applicable:

(A) The services will prevent deterioration in a beneficiary's condition that would otherwise foreseeably result in admission to the emergency department.

(B) The services will prevent deterioration in the beneficiary's condition that would otherwise result in inpatient admission.

(C) The services will prevent disruption in ongoing medical therapy or surgical therapy, or both, including, but not limited to, medications, radiation, or wound management.

(D) The services constitute diagnostic workup in progress that would otherwise foreseeably result in inpatient or emergency department admission.

(E) The services are for the purpose of assessment and form completion for Medi-Cal recipients seeking or receiving in-home supportive services.

(2) The certification shall consist of a written declaration by the physician, or other medical professional under the supervision of the physician, that the visit meets the requirements of any one or more of the circumstances set forth in paragraph (1), and shall include a description of the services provided.

(3) The certification shall be maintained onsite at the physician's office or clinic location at which the medical records for the beneficiary are maintained and shall be subject to audit and inspection by the department.

(4) This subdivision does not authorize or direct a beneficiary to obtain services at a physician office or clinic visit for an emergency medical condition or that should properly be provided in the emergency department or as hospital inpatient services.

(c) Specialty mental health services furnished or arranged for the provision of mental health services to Medi-Cal beneficiaries pursuant to Part 2.5 (commencing with Section 5775) of Division 5, shall not be subject to the limit provided in subdivision (a).

(d) Any pregnancy-related visit, or any visit for the treatment of any other condition that might complicate a pregnancy, shall not be subject to the limit provided in subdivision (a).

(e) The limit on physician office and clinic visits provided in subdivision (a) shall not apply to any of the following:

(1) A beneficiary under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

(2) A beneficiary receiving long-term care in a nursing facility that is both of the following:

(A) A skilled nursing facility or intermediate care facility as defined in subdivisions (c), (d), (e), (g), and (h), respectively, of Section 1250 of the Health and Safety Code, and facilities providing continuous skilled nursing care to persons with developmental disabilities under the pilot project established pursuant to Section 14132.20.

(B) Licensed pursuant to subdivision (k) of Section 1250 of the Health and Safety Code.

(f) For managed health care plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200), except for Senior Care Action Network or AIDS Healthcare Foundation, payments shall be reduced by the actuarial equivalent amount of the benefit reductions resulting from the implementation of the benefit cap amounts specified in this section pursuant to contract amendments or change orders effective on July 1, 2011, or thereafter.

(g) This section shall be implemented only to the extent permitted by federal law.

(h) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of all-county letters, provider bulletins, or similar instructions, without taking regulatory action.

(i) This section shall be implemented on the first day of the first calendar month following 180 days after the effective date of the act that added this section, or on the first day of the calendar month following 60 days after the date the department secures all

necessary federal approvals to implement this section, whichever is later. If the implementation date occurs after July 1, 2011, then the benefit caps described in subdivision (a) for the first year of implementation shall be applied from the implementation date to June 30 of the state fiscal year in which implementation begins. Thereafter, the benefit caps shall apply on a state fiscal year basis.

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