

DEPARTMENT OF HEALTH SERVICES

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December 30, 1998

MMCD Policy Letter 98- 12

- TO:
- County Organized Health Systems Plans
 - Geographic Managed Care Plans
 - Prepaid Health Plans
 - Primary Care Case Management Plans

SUBJECT: PRIMARY CARE PHYSICIAN SELECTION AND ASSIGNMENT
POLICY

A

GOALS

To assure that all members of contracting Medi-Cal managed care plans are afforded timely assignment to an appropriate primary care physician to whom they have adequate and continuous access.

To assure that all medically necessary services delivered to plan members are actively and continuously case managed by the member's primary care physician of record.

POLICY

All Medi-Cal managed care plans (County Organized Health Systems [COHS], Prepaid Health Plans [PHP], Geographic Managed Care [GMC], Two-Plan Model, and Primary Care Case Management [PCCM], hereafter referred to as the Plans) are contractually required to implement and maintain written policies and procedures governing member selection or Plan assignment of primary care physicians (PCP).

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- I. **The Plans must ensure that each member has a primary care physician of record.**
 - A. The Plans must ensure that each **full** scope Medi-Cal member, regardless of share-of-cost considerations or service carve-out arrangements, has a PCP. The PCP serves as the medical home for members, especially children. The medical home is where care is accessible, continuous, comprehensive, and culturally competent.
 - B. The Plans must ensure that each member is provided sufficient information to make an informed selection of a PCP within 30 days of **the** effective date of enrollment in the Plan. For Two-Plan Model and GMC, the effective date of enrollment is the first day of the month following notification by the Medi-Cal Eligibility Data System (**MEDS**) tape that a beneficiary is eligible to receive services from the plan and **capitation** will be paid, that is, that the member is not on "hold" status. For **COHSs**, the effective date of enrollment is the date the COHS receives notification from the State of the eligibility of a beneficiary to receive Medi-Cal services from the COHS. Members may select **PCPs** outside of the contractually stipulated time and distance standards.
 - C. If a member does not select a PCP within 30 days, the Plan must assign the member to an appropriate PCP within 40 days of the effective date of member enrollment. The Plans must assign **PCPs** in accordance with contractually stipulated time and distance standards and member cultural and linguistic needs.
 - D. The Plans must assure that all foster care children within the plan and members in long-term care facilities, including those in out-of-county placements, have a PCP. The PCP must provide and/or arrange for all medically necessary services, care coordination and case management activities. The Plans are responsible for reimbursement of all medically necessary services delivered to these populations, and must have procedures for coordination of care with providers in the county of placement.
 - E. The Plans are not required to assign **PCPs** to members who have permanently changed their county of residence, but for whom necessary

changes in the MEDS system have not as yet been made. The Plans are responsible for reimbursement of all medically necessary services delivered to these members until they can access services through the Medi-Cal system of their new county of residence. The Plans are encouraged to assure effective transition of care from one county to the other for these members through the transfer of medical information from the Plan to the member's new PCP.

- F. With the exception of pregnant women, COHSs are not required to assign a PCP to members with certain restricted aid codes, which limit the services to which the member is entitled. Plan procedures must clearly state the circumstances under which members will not be assigned a PCP. COHSs must assign a PCP to all pregnant women, for continuous care during the perinatal period, regardless of aid code designation or coverage.
- G. The PCP must be a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). An OB/GYN may serve as both a PCP and a specialist within the Plan's provider network, if the OB/GYN specialist meets the requirements enumerated in IV below for approval of specialists as PCPs. The PCP assures the provision of the initial health assessment and subsequent primary care services, and is responsible for coordination of the care provided to the member and participation in all medical case management functions.
- H. On occasion, the Plans may need to 'reassign the member to another PCP. For Two-Plan Model and GMC in the event of a breakdown in contractor/member relationship as described in Plan contracts, except in cases of violent behavior or fraud, the Plans must make significant efforts to resolve the problem. This effort may include reassignment of PCP as long as the Plan assures an effective transition of care. COHS contracts require that written procedures for changing the designation of a PCP must also address the above situations. PCCM should refer to their contracts for the specific language governing reassignment and/or case management options in the above situations.
- I. Plan procedures must assure continuity of PCP coverage. In the event that a PCP of record becomes unavailable to the member, for whatever reason, the Plans must inform the member and assist him or her to select another available PCP from the Plan's provider network. If a member is receiving

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primary care services from a primary care clinic (see II below), the member has the right to remain at the clinic site and to select, or have assigned, another PCP from the staff of the clinic. The member may also elect to continue with his or her current PCP, if the PCP remains in the plan's provider network. In all circumstances, the Plans must assure the effective transition of care to the new PCP.

Recently enacted legislation (Chapter 180, Statutes of 1998) requires that the Plans, at the request of the member, arrange for continuation of services for an acute condition or a serious chronic condition, for a high-risk pregnancy, or for a pregnancy that has reached the second or third trimester, by a provider or provider group whose contract has been terminated or not renewed by the plan for reasons other than cause. This statute covers continuation of PCP or specialist services and stipulates timelines for the continuation of services. A copy of the relevant section of this legislation is provided for your information as Enclosure 1.

- II. **The Plans must allow members to choose nonphysician medical practitioners (NPMPs), primary care physicians-in-training (residents), and primary care clinics as their providers of primary care services. (These health care providers will be referred to in this policy letter as providers of primary care services, to distinguish them from the member's PCP.)**
- A. NPMPs are nurse practitioners (NP), certified nurse midwives (CNM) or physician assistants.(
- B. Prior to enrollment in a plan, members may have received primary care services from an NPMP, resident or primary care clinic, such as a licensed community health center, community health clinic, or a teaching clinic which is operated by or associated with an approved postgraduate medical training institution. The Plan must honor a member's decision to establish or continue an existing relationship with any of these providers of primary care services, who are available as network providers. The Plan should assist the member to continue the relationship by assuring that the member is assigned to a PCP who:
- has a consultative, collaborative or supervisory relationship, consistent with federal and State statutes or regulations, with the

NPMP identified by the member as his or her provider of primary care services, or

- is in regular attendance at the primary care clinic selected by the member for the provision of primary care services, or
- is responsible for the supervision of residents involved in the provision of primary care services to the member.

C. Federal law requires the Plans to provide access to CNM and NP services. The Plans are not required to have **CNMs** or **NPs** available within the Plan provider network, but need to be aware of the following requirements:

- If at least one of the managed care plans in a county or geographic area includes **CNMs** and **NPs** in its network of providers, and the member has chosen to enroll in a plan without these provider categories, the member does not have the right to access services of these providers out-of-plan. The selected Plan is not obligated to reimburse out-of-plan CNM or NP services provided to members unless the services have been authorized by the Plan.
- If none of the Plans in the county or geographic area includes **CNMs** and/or **NPs** in its provider network, all **Plans** in that county or geographic area must inform members that they have the right to access services from **CNMs** and/or **NPs** outside of the Plan and that the Plan will pay for such services. Reimbursement is at the applicable managed care fee-for-service rate.
- The Plans remain responsible for the reimbursement of those out-of-plan services which members may obtain without prior authorization, such as those for family planning, which may be provided by **NPs** or **CNMs**, regardless of the regulations discussed above.

D. The Plans may choose to have PA available within their provider network as providers of primary care services, subject to physician supervision consistent with existing regulations, but are not required to offer this option.

- E. CNMs, NPs, and PAs are subject to all laws, regulations, and contract provisions governing supervision of their activities by any California licensed physician.' It is the Plan's responsibility to ascertain an NPMP's capabilities to serve as a primary care provider for its members and to assure that all NPMPs are operating within their respective scope of practice. The Plans must assure that the member's assigned PCP provides the legally required collaboration, consultation or supervision of the NP, CNM, or PA. In all cases, the PCP is responsible for overall case management and coordination of care for the member.

The Plans must submit their policies and procedures regarding supervision of NPMPs to MMCD for approval., These policies and procedures must include, but should not be limited to, methods for:

- The continuing evaluation of the competence of CNMs and NPs and the periodic review of the written standardized procedures under which network CNMs and NPs are authorized to perform their medical functions;
- Assuring that appropriate written delegation of service agreements have been developed for medical services which may be provided by PAs, and that written supervisory guidelines are in place and are being appropriately utilized for supervision of PAs. A reprint of the July 1998 Medical Board of California Action Report article entitled, "Supervision of Physician Assistants" is provided for information purposes as Enclosure 2.
- Assuring compliance with Title 22, California Code of Regulations (CCR), Sections 5 1240 and 5 1241 which require the following full-time equivalent (FTE) physician to NPMP assignment ratios:

N P S	1:4
CNMs	1:3
PAs	1:2

Four NPMPs in any combination that does not include more than three CNMs or two PAs.

- Two-Plan Model Plans must implement a procedure to comply with the contract requirement of one FTE NPMP to 1,000 patients caseload ratio.

III. The Plans must develop and implement procedures to ensure that each member's PCP is available at his or her designated service site(s) for sufficient time each week to allow all assigned members timely access based upon member's request or medical necessity, and to provide continuous and effective case management of the health care services delivered to the member.

- A. The Plans may stipulate the minimum number of hours a given PCP should be present at designated primary care service sites in order to meet member health care needs. If on-site hours are stipulated, the Plan may allow alternative arrangements for service sites located in rural or urban settings with documented lack of access to physician providers or for other reasons stipulated in the Plan's procedures.
- B. The Plans must continuously monitor and assess the adequacy of their provider networks to assure that they meet the required one FTE PCP per 2,000 members ratio. This ratio is calculated on the Plan's PCP network as a whole and is not applied to any individual PCP. The continuous assessment of PCP network adequacy must take into consideration time and distance access standards, current availability of PCPs accepting new members, and threshold language capabilities in the provider network system.

IV. The Plans may elect to allow a specialist to act as a member's PCP. The Plans which elect this option, must establish eligibility criteria which specialists must meet in order to serve as PCPs.

The criteria established must include, but are not limited to, the following:

- The specialist has received appropriate training and/or has relevant recent experience in the provision of primary care services.

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- The specialist agrees to provide both primary care and specialty services for assigned members, and to comply with all primary care and preventive services guidelines.

V. The Plans must assure the timely availability of specialists to assist the PCP in delivering appropriate services to members with chronic and complex medical conditions.

- A. The Plan must have procedures which describe how a member's need for specialists and/or specialty care centers for the ongoing care of chronic and complex medical conditions are to be identified upon enrollment of the member into the Plan. These needs must be met by continuing existing relationships, to the extent that these specialty resources are available as part of the Plan's provider network, or by assuring that comparable services are provided by network specialty providers. The Plans must assure that families of children with special needs have access to appropriate pediatric medical and surgical specialists on referral from PCPs as needed and that these specialists are available to assist the PCP in the management of members under the age of 21 years who have chronic and complex medical conditions. The Plans must assure that any member's need for specialized care is facilitated by such means, including standing referrals to specialists, as are deemed necessary, in accordance with Assembly Bill 118 1 (Chapter 3 1, Statutes of 1998). See Enclosure 3.
- B. The Plan procedures must allow women direct access to any OB/GYN or family practitioner contracted to provide OB/GYN services within the Plan's provider network. The Plans should assure that medical information from these self-referrals is available to the member's PCP if the PCP is other than the physician providing the OB/GYN services.

VI. The Plans must provide the information necessary to assist members to make an informed decision regarding selection of an appropriate PCP or other provider of primary care services.

- A. The Plans must provide health care options or the local county agency responsible for making Medi-Cal eligibility determinations, certain materials to be included with the enrollment packet. These materials must

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include a provider directory, which lists all physicians currently available for member choice as a PCP. Potential enrollees must be able to select any listed physician as his or her PCP, unless it is clearly indicated that the provider is not accepting new members. Two-Plan Model and GMC must ensure that the selection of a PCP made by the member prior to the effective date of Plan enrollment is honored. COHSs must coordinate their member informing efforts with the local county agency responsible for Medi-Cal eligibility determinations to assure that a member's selection of an appropriate PCP is facilitated.

- B. No later than seven days after the member's effective date of enrollment, the Plan will distribute its Membership Services Guide to the member. Information provided with this Guide will include the name, telephone number, and service site address of the PCP selected by the member. If the Plan assigns a PCP during this period in the absence of information on member selection of a PCP, the name, telephone number, and service site address of the PCP assigned to the member must also be provided.
- C. Member informing material must include procedures for selecting or requesting a change in PCP, and must be provided in an appropriate threshold language and reading level. In order to enable the member to make an informed decision concerning selection of a PCP, the Plan procedures must also ensure that members are informed:
- Of the important role of the PCP in managing and coordinating the medical care services delivered to the member.
 - That, upon enrollment, they have the right to continue an established relationship with a PCP if the PCP is in the Plan provider network.
 - That they have the right to request to be seen by their PCP for advice or consultation at any time, and the Plan procedures must assure that this request is honored.
 - That they may receive health care from providers of primary care other than a PCP, as defined in the contract and this policy letter. Members must be informed of the Plan procedures concerning

access to these providers, including continuation of existing service relationships with such providers, to the extent possible. Members will always have an assigned PCP to whom they have a right of access:

- That they are entitled to access covered services prior to the selection and/or assignment of a PCP and the procedures for doing so must be explained.
- That they may request a change of **PCPs** at any time and the procedures for doing so must be explained. Members must be allowed to change **PCPs** upon request pursuant to the following requirements: Title 22, CCR, Section 53890 (c), for the Two-Plan Model and 53925 for **GMCs** and provisions of COHS, PHP, and PCCM contracts.
- Of the reason for which their selection of a PCP could not be honored, and that they have the right to select another network PCP who is accepting new members.
- Of the PCP provider sites where threshold languages are spoken, and that interpreter services must be provided should the member select a PCP who does not speak the member's language. A member's request for or refusal of assignment to a PCP site with specific language capability should be documented.
- That the selection of a PCP who belongs to a medical group or independent practice association (**IPA**) may result in a limitation of access only to those providers, including specialists who, are also members of the **PCP's** medical group or **IPA**.
- That they may select any Plan PCP accepting new members without regard to time or distance standards. The Plans should emphasize to the member the expectation that all PCP services are to be provided by the physician selected, even if the member's selected PCP is located beyond the usual time and distance standards.

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- That they have a responsibility to provide accurate information to professional staff, to cooperate in the treatment plan to the extent possible, and to use the services available in an appropriate manner.

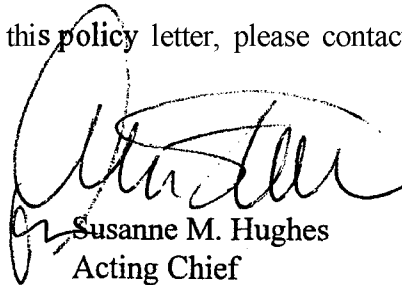
VII. The Plans are responsible for assuring that network PCPs are instructed regarding their responsibilities for service provision, coordination of care, case management, and supervision of other providers of primary care services.

- A. The Plans should emphasize the importance of the PCP onsite presence at designated service sites for a sufficient amount of time per week to guarantee their timely availability for members and other provider staff, and for care coordination and case management activities.
- B. Training must include:
- Explanation of the roles and responsibilities of the PCP and other providers of primary care services.
 - Discussion of the Plan's policies and procedures regarding initial health assessment, care coordination, and case management.

VIII. The Plans must maintain a current listing of each member's PCP of record.

The Plans are encouraged to list the PCP on the member's identification card. The Plans, which elect to do so, may also elect to list other providers of primary care services on the identification card.

If there are any questions regarding this policy letter, please contact your contract manager.



Susanne M. Hughes
Acting Chief
Medi-Cal Managed Care Division

Enclosures

(i) Subdivision (b) shall not apply to any coverage provided by a plan for the Medi-Cal program or the Medicare program pursuant to Title XVIII and Title XIX of the Social Security Act.

SEC 3. Section 1373.96 is added to the Health and Safety Code, immediately following Section 1373.95, to read:

1373.96. (a) Every health care service plan shall, at the request of, an enrollee, arrange for the continuation of covered services rendered by a terminated provider to an enrollee who is undergoing a course of treatment from a terminated provider for: an acute condition, serious chronic condition, or 8 pregnancy covered by subdivision (b), at the time of the contract termination, subject to the provisions of this section.

(b) Subject to subdivisions (c) and (d), the plan shall, at the request of an enrollee, provide for continuity of care for the enrollee by a terminated provider who has been providing care for an acute condition or a serious chronic condition, for a high-risk pregnancy, or for a pregnancy that has reached the second or third trimester. In cases involving an acute condition or a serious chronic condition, the plan shall furnish the enrollee with health care services on a timely and appropriate basis from the terminated provider for up to 90 days or a longer period if necessary for a safe transfer to another provider as determined by the plan in consultation with the terminated provider, consistent with good professional practice. In the case of a pregnancy, the plan shall furnish the enrollee with health care services on a timely and appropriate basis from the terminated provider until postpartum services related to the delivery are completed or for a longer period if necessary for a safe transfer to another provider as determined by the plan in consultation with the terminated provider, consistent with good professional practice.

(c) The plan may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, there shall be no obligation on the part of the plan to continue the provider's services beyond the contract termination date. Further, if the terminated provider or provider group voluntarily leaves the plan, there shall be no obligation on the part of the provider or the plan to continue the provider's services beyond the contract termination date.

(d) Unless otherwise agreed upon between the terminated provider and the plan or between the provider and the provider group, the agreement shall be construed to require a rate and method of payment to the terminated provider, for the services

rendered pursuant to this section, similar to rates and methods of payment used by the plan or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the terminated provider. The plan or the provider group shall not be obligated to continue the services of a terminated provider if the provider does not accept the payment rates provided for in this section.

(e) A description as to how an enrollee may request continuity of care pursuant to this section shall be provided in any plan evidence of coverage and disclosure form issued after July 1, 1999. A plan shall provide a written copy of this information to its contracting providers and provider groups. A plan shall also provide a copy to its enrollees upon request.

(f) The payment of copayments, deductibles, or other cost sharing components by the enrollee during the period of continuation of care with a terminated provider shall be the same copayments, deductibles, or other cost sharing components that would be paid by the enrollee when receiving care from a provider currently contracting with or employed by the plan.

(g) If a plan delegates the responsibility of complying with this section to its contracting providers or contracting provider groups, the plan shall ensure that the requirements of this section are met.

(h) For the purposes of this section:

(1) "Provider" means a person who is a licentiate, as defined in Section 805 of the Business and Professions Code or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code.

(2) "Terminated provider" means a provider whose contract to provide services to plan enrollees is terminated or not renewed by the plan or one of the plan's contracting provider groups. A terminated provider is not a provider who voluntarily leaves the plan or contracting provider group.

(3) "Provider group" includes a medical group, independent practice association, or any other similar group of providers.

(4) "Acute condition" means a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

(5) "Serious chronic condition" means a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following:

(A) Persists without full cure or worsens over an extended period of time.

(B) Requires ongoing treatment to maintain remission or prevent deterioration.

(i) This section shall not require a plan or provider group to provide for continuity of care by a provider whose contract with the plan or group has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Profession Code, or fraud or other criminal activity,

(j) This section shall not require a plan to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract.

(k) The provisions contained in this section are in addition to any other responsibilities of health care service plans to provide continuity of care pursuant to this chapter. Nothing in this section shall preclude a plan from providing continuity of care beyond the requirements of this section.

SEC 4. Section 10133.56 is added to the Insurance Code; to read:

-10133.56. (a) Disability insurers who provide, hospital, medical, or surgical coverage and that negotiate and enter into contracts with professional or institutional providers to provide services at alternative rates of payment pursuant to Section 10133, shall, at the request of an insured, arrange for the continuation of covered services rendered by a terminated provider to an insured who is undergoing a course of treatment from a terminated provider for an acute condition, serious chronic condition, or a pregnancy covered by subdivision (b), at the time of the contract termination, subject to the provisions of this section.

(b) Subject to subdivisions (c) and (d), the insurer shall, at the request of an insured, provide for continuity of care for the insured by a terminated provider who has been providing care for an acute condition or a serious chronic condition, for a high-risk pregnancy, or for a pregnancy that has reached the second or third trimester. Continuity of care for an acute or serious chronic condition shall be provided for up to 90 days or a longer period if necessary to ensure a safe transfer to another provider, as determined by the insurer, in consultation with the terminated provider, consistent with good professional practice. In the case of pregnancy, continuity of care shall be provided through the course of the pregnancy and during the postpartum period. After the required period of continuity of care has expired pursuant to this section, coverage shall be provided pursuant to the general terms and conditions of the insured's policy.

(c) The insurer may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the terminated provider does not agree to comply or does not comply with these contractual terms

Supervision of Physician Assistants

by Ray E. Dale, Executive Officer, Physician Assistant Examining Committee

Several hundred physicians this year will contact the Medical Board of California seeking their initial approval to use physician assistants (PAs). Those who are granted approval accept significant supervisory duties and responsibilities. According to California law, all care given to a patient by a physician assistant is the ultimate responsibility of the supervising physician.

Current law limits physicians to supervising no more than two **PAs** at any moment in time. A supervising physician must be available in person or by electronic communication at all times when a physician assistant is caring for patients.

Before authorizing a PA to perform any medical procedure, the physician is responsible for evaluating their education, experience, knowledge and **ability** to perform the procedure safely and correctly. The **physician must also** verify that a PA possesses a current license to practice in California from the Physician Assistant Examining Committee (PAEC).

For the mutual benefit and protection of patients, physicians and their **PAs**, the PA regulations require that the physician delegate in writing, for each supervised physician assistant, those medical services which the PA may provide. That **document** is often referred to as a Delegation of Services **Agreement**. Medical tasks which are delegated by an approved supervising physician may only be those which are **usual** and customary to the physician's personal practice.

Another one of the many important responsibilities of supervising physicians is the establishment of a signed and dated written statement which explains how, where and when they will review the **activities** of the **PAs** they supervise. The statement, often called a "written supervisory guideline," must be made available to the PA and to staff of the **Medical** Board of California or Osteopathic Medical Board on request.

In addition, if **PAs** are to be utilized in a hospital, the supervisory guideline and often the delegation of services agreement should be made available to the hospital's medical staff executive committee. Unless specifically delegated the authority by the medical staff, the granting of hospital privileges for physician assistants and their supervising physicians does not fall within the review of the hospital's committee on interdisciplinary practice. If physicians plan to utilize **PAs** in nursing homes, hospices, jails, prisons, or similar settings, they should first make arrangements with the facility's medical director.

There are four methods for providing legally adequate supervision outlined in Section 1399.545 of the Physician Assistant Regulations:

1. The physician may see the patients the same day that they are treated by the PA.
2. The physician may review, sign and date the medical record of every patient treated by the physician assistant within thirty days of the treatment.

3. The physician may adopt written protocols which specifically guide the actions of the PA. The physician must select, review, sign, and date at least 10% of the medical records of patients treated by the physician assistant according to those protocols.
4. Or, in special circumstances, the physician may provide supervision through additional methods which must be approved in advance by the PAEC.

To fulfill the required supervisor obligation, the physician must utilize one, or a combination of, the four authorized supervision methods.

To ensure that a PA's actions involving the prescribing or administration of drugs is in strict accordance with the directions of the physician, every time a PA administers a drug or transmits a drug order, a physician supervisor must sign and date the patient's medical record or drug chart within seven days.

There is no current law that authorizes a PA to orally issue a prescription, write or complete pre-signed prescription blanks, or sign a prescription for drugs or medical devices. Current law does not authorize the delegation of prescribing authority to **PAs**. However, Business and Professions Code section 3500 et seq. permits physician assistants to write and sign prescription "transmittal orders" when authorized to do so by their supervising physicians. Business and Professions Code section 4000 et seq. authorizes licensed pharmacists to dispense drugs or devices based on a PA transmittal order.

In the event there is a problem or violation involving a PA, the complaint process is comparable to that for the supervising physician. The PAEC processes the complaint and Medical Board investigators are used to conduct any investigation that may be required.

For physicians interested in utilizing physician assistants and who would like to know more about the benefits and requirements, several publications are available from the PAEC, including:

- California Laws and Regulations regarding the use of **PAs**
- Guidelines for Delegation of Services Agreements
- Written Transmittal Orders (information bulletin)
- Application for Approval to Supervise a PA
- Patient Information Brochures (English and Spanish)
- **PAEC Update** (newsletter)

To request **publications** or verify physician assistant licensing information, contact:

Physician Assistant Examining Committee
1424 Howe Avenue, Suite 35, Sacramento, CA 95825-3237

Telephone: (916) 263-2670 / (800) 555-8038
Fax: (916) 263-2671

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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.

Thk 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