# INITIAL STATEMENT OF REASONS

Medi-Cal, California's Medicaid program is administered by the Department of Health Care Services (Department). Medi-Cal provides health care services for low-income individuals including, but not limited to, families with children, seniors, persons with disabilities, children in foster care, and pregnant women.

The Department operates the Medi-Cal managed care program under the authority of California's Medicaid Section 1115 (of the Social Security Act) Demonstration Waiver, titled "California's Bridge to Reform" (1115 Waiver). The 1115 Waiver approves variations in the single comprehensive medical care program for eligible low-income individuals required by Title XIX of the Social Security Act in the following sections:

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|---|---|---|
| (a) | 1902(a)(1) | Statewideness |
| (b) | 1902(a)(5) | Single State Agency |
| (c) | 1902(a)(10)(B) | Amount, Duration, and Scope of Services and Comparability |
| (d) | 1902(a)(23) | Freedom of Choice |
| (e) | 1902(a)(30) | Basis for Payment |
| (f) | 1902(a)(13) | Payment to Providers |

Welfare and Institutions Code (W&I Code) Articles 2.7 (commencing with Section 14087.3), 2.8 (commencing with Section 14087.5), 2.81 (commencing with Section 14087.96), 2.9 (commencing with Section 14088), and 2.91 (commencing with Section 14089) of Chapter 7 and Articles 1 (commencing with Section 14200) and 7 (commencing with Section 14490) of Chapter 8 of Part 3 of Division 9, establish the statutory authority for the Department to contract with Medi-Cal managed care health plans (MCPs) to provide Medi-Cal and case management services.

Title 22, California Code of Regulations (CCR), Division 3, Chapters 4 (commencing with Section 53000), 4.1 (commencing with Section 53800), 4.5 (commencing with Section 53900), and 6 (commencing with Section 56000), contain the regulations that specifically implement the Medi-Cal managed care program.

## REGULATORY AUTHORITY

W&I Code Sections 10725, 14105, and 14124.5 authorize the director of the Department to adopt, amend, or repeal regulations as necessary and proper to carry out the purpose and intent of the statutes governing the Medi-Cal Program.

## PROGRAM BACKGROUND

The Department's Medi-Cal Managed Care Division (MMCD) provides high-quality, accessible, and cost-effective health care through managed care delivery systems. MMCD contracts for health care services through established networks of organized systems of care, which emphasize primary and preventive care. MCPs are a cost-

effective use of health care resources that improve health care access and assure quality of care for Medi-Cal beneficiaries. Approximately 5.2 million Medi-Cal beneficiaries in 30 counties receive their health care through three models of managed care: Two-Plan Model, County Organized Health Systems, and Geographic Managed Care.

As a result of the enabling legislation, Assembly Bill (AB) 1467 (Chapter 23, Statutes of 2012), Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012), SB 1036 (Chapter 45, Statutes of 2012), AB 1494 (Chapter 28, Statutes of 2012), and the 1115 Waiver, Medi-Cal managed care is continuing to expand into additional counties and will soon be serving several more transitioning populations.

W&I Code Section 14000 states that the intent of Chapter 7, of Division 9, Part 3, is to provide qualifying individuals with health care services, to the extent practicable, in the same manner as the public employs generally, with an emphasis on organized managed care plans. Section 14087.3, authorizes the Department to contract with any qualified individual, organization, or entity to provide services to, arrange for, or case manage the care of Medi-Cal beneficiaries. This section also allows, at the director's discretion, the contract to be exclusive or nonexclusive, statewide or on a more limited geographic basis.

## SUMMARY OF PROPOSAL

This regulatory proposal supports the goals of W&I Code Sections 14000 and 14087.3, and the proper and efficient administration of the Medi-Cal Program in accordance with federal and state laws governing the program's participation and funding rules. The proposed regulatory amendments will authorize the Department, in counties designated by the Department as operating under the Two-Plan Model, to contract with an Alternate Health Care Service Plan (AHCSP) to provide medical services to beneficiaries who demonstrate a specific linkage to the AHCSP.

This proposal will allow the Department to address the issue of how to enable beneficiaries transitioning into the Medi-Cal managed care program to maintain access to their existing AHCSP plans and providers. Situations arise where beneficiaries would not have the ability to maintain that access because an AHCSP does not subcontract with one of the two contracted Medi-Cal managed care plans. Beneficiaries would benefit if the Department is given the authority to contract with an AHCSP because if the Department does contract with an AHCSP, the beneficiaries would then be able to choose whether they wish to continue receiving health care services through that AHCSP, which preserves provider access and maintains existing physician-patient relationships. These beneficiaries could include a significant number of people transitioning from the Healthy Families Program into the Medi-Cal Program.

The specific purpose and rationale for the proposed amendments under the affected CCR sections are discussed below.

Section 53800

Subsection (a) provides that beneficiaries in designated counties shall receive health care services through two prepaid health plans. This regulatory proposal amends subsection (a) to include an exception provided by a newly added subsection (c). Non-substantial amendments are also included under subsection (a) to allow for the addition of the exception language and to offer further clarity.

Additional non-substantial amendments are specified under subsection (b). Specifically: correcting designations under (b)(2)(C)1. – 3.; updating cross references to subsections, due to other proposed amendments; changing terminology for consistency throughout the regulations (i.e. changing "subsection" to "Section" and removing the term "Medi-Cal," which is not part of the definition of a "traditional provider"); and including (b) in two references to subsections, for clarity.

Proposed subsection (c) authorizes the Department to contract directly with an AHCSP in addition to the Commercial Plan and the Local Initiative currently operating in such designated counties. This authorization allows the Department to take action to enable continuity of care, access to providers, and maintenance of physician-patient relationships that would not otherwise be available to beneficiaries. These amendments would directly benefit Medi-Cal beneficiaries with linkage to an AHCSP that contracts directly with the Department, which could include a significant number of the individuals transitioning from the Healthy Families Program into the Medi-Cal Program. W&I Code Section 14087.3(a) allows the Department to contract with this additional plan.

Subsection (c)(1) is being proposed to establish the criteria a beneficiary must meet to be eligible for voluntary enrollment into an AHCSP that contracts directly with the Department.

- Subsection (c)(1)(A) specifies that an existing member of the AHCSP transitioning into Medi-Cal is eligible to remain in the AHCSP. This provision is proposed so the beneficiary can preserve existing physician-patient relationships and maintain continuity of care.

- Subsection (c)(1)(B) specifies that a beneficiary who has been enrolled in the AHCSP at any time during the twelve (12) months immediately prior to Medi-Cal eligibility is eligible to enroll in the AHCSP. This provision is proposed for the purposes of re-establishing physician-patient relationships that may have recently (within the past 12 months) been lost due to eligibility issues and to preserve access to providers.

- Subsection (c)(1)(C) specifies a beneficiary with an AHCSP family member linkage shall be eligible to enroll in the AHCSP. This provision is proposed for those beneficiaries who do not meet the criteria in paragraphs (A) or (B), but do have AHCSP family member linkage, as defined in Section 53810(c). The rationale is that transportation to and communications with the same health care

provider location for multiple family members would be beneficial and contribute to better health care outcomes. Often Medi-Cal beneficiaries are among the most vulnerable populations with limited access to transportation and communication. This provision promotes easier access to health care services by allowing family members to receive their health care from the same health care plan.

Subsection (c)(2) is proposed to specify what happens if an eligible beneficiary chooses not to enroll in an AHCSP that directly contracts with the Department. AHCSP enrollment is voluntary; therefore, if a beneficiary is eligible for enrollment in the AHCSP as specified in subsection (c)(1), but chooses not to enroll in the AHSCP, the beneficiary is subject to the existing conditions for Medi-Cal managed care enrollment in the Two-Plan Model.

Subsection (c)(3) is proposed to specify that an AHCSP which contracts directly with the Department will not receive any default beneficiary assignments. AHCSP enrollment will be the result of a voluntary choice made by those beneficiaries who are eligible under the terms of subsection (c)(1).

Subsection (c)(4) is proposed to indicate that an AHCSP contracting directly with the Department must adhere to all applicable requirements of this chapter (Chapter 4.1). This is to ensure the AHCSP is in compliance with all the standards and requirements set forth by the Department for providing quality health care services to Medi-Cal beneficiaries in the Two-Plan Model.

Section 53810

Subsection (b) is amended to add the definition of AHCSP. The rationale for this definition is to identify providers that serve a meaningful number of beneficiaries through a unique health care model that has established a quality cost-effective health care delivery system. The definition has been drafted to provide the Department with the flexibility it needs to contract with the various complex business structures that would qualify as an AHCSP throughout the state. Wholly owned subsidiary is part of this definition to allow the Department to directly contract with either a parent company or a subsidiary of that parent company. Existing subsection (b) is re-designated to subsection (d).

Subsection (c) is amended to add the definition of AHCSP family member linkage. The purpose for this definition is to establish what is considered a family member linkage to an AHCSP contracting directly with the Department. The family make-up in California is very diverse and this definition reflects that diversity. The rationale for establishing this linkage is to allow all family members to receive their health care from the same health care plan. Often Medi-Cal beneficiaries are among the most vulnerable at-risk populations with limited access to transportation and communication. Establishing an AHCSP family member linkage will allow for transportation to and communication with the same health care provider location for multiple family members, which in turn

promotes easier access to health care services and contributes to better health care outcomes. Existing subsection (c) is re-designated to subsection (e).

The following existing subsections have been deleted because the terms are specific to Sections 53820 and 53830, which are proposed for repeal in this regulatory action:

- (h) defining “Commercial plan enrollment maximum”,
- (j) defining ”Contract maximum”,
- (w) defining “Local initiative enrollment”,
- (y) defining “Maximum enrollment”, and
- (kk) defining “Transition period.”

As necessary, some additional subsections of Section 53810 have been re-designated to accommodate the proposed amendments to this section:

- (d) has been re-designated to (f)
- (e) has been re-designated to (g)
- (f) has been re-designated to (h)
- (g) has been re-designated to (i)
- (i) has been re-designated to (j)
- (k) no change
- (l) no change
- (m) – (q) no change
- (r) no change
- (s) – (v) no change
- (x) has been re-designated to (w)
- (z) has been re-designated to (x)
- (aa) has been re-designated to (y)
- (bb) has been re-designated to (z)
- (cc) has been re-designated to (aa)
- (dd) has been re-designated to (bb)
- (ee) has been re-designated to (cc)
- (ff) has been re-designated to (dd)
- (gg) has been re-designated to (ee)
- (hh) has been re-designated to (ff)
- (ii) has been re-designated to (gg)
- (jj) has been re-designated to (hh)
- (ll) has been re-designated to (ii)

Subsection (l) has been amended to include the term “Care” in the definition of the “Department.”

Subsection (r) the definition of “Federally qualified health centers” has been amended to correct a transposition of words, removing “means.”

Current subsection (ll) “Two-plan model,” which has been re-designated subsection (ii), is amended to reflect that it is defined by Section 53800.

Article 3 and Section 53820

Article 3 and Section 53820 "Maximum Enrollment Levels," are being repealed. The purpose of this section was to explain the factors the Department would consider when establishing the Commercial Plan maximum enrollment levels. This section is no longer necessary because the Department's managed care model has evolved since this regulation section was added. While the original intent was to indirectly protect safety-net providers that contracted with the Local Initiatives, this protection is no longer necessary because safety-net providers are now contracted through both the Commercial Plans and the Local Initiatives. Currently, the Department annually re-determines the ratio of default enrollment assignments by using various nationally approved plan performance measures.

Article 4 and Section 53830

Article 4 and Section 53830 "Prepaid Health Plan and Primary Care Case Management Plan Enrollment Growth during the Transition Period," are being repealed. This section is no longer necessary to implement the Two-Plan Model. The original intent of this section was to detail maximum enrollment levels during the conversion of a prepaid health plan or primary care case management plan into a Two-Plan Model. This section is no longer needed because the conversion has been completed.

## STATEMENTS OF DETERMINATION

### (a) ALTERNATIVES CONSIDERED

The Department has determined that no reasonable alternative considered by the Department or that has otherwise been identified and brought to the attention of the Department would be more effective in carrying out the purpose for which this regulatory action was taken, would be as effective and less burdensome to affected private persons than the regulatory action, or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

### (b) LOCAL MANDATE DETERMINATION

The Department has determined that the proposed regulations would not impose a mandate on local agencies or school districts, nor are there any costs for which reimbursement is required by Government Code, Division 4, Part 7 (commencing with Section 17500).

## (c) ECONOMIC IMPACT ANALYSIS

The Department has made an initial determination that the proposed regulations will not have a significant statewide adverse economic impact directly affecting businesses, including the ability of California businesses to compete with businesses in other states.

The Department has determined that the proposed regulations would not significantly affect the following:

- The creation or elimination of jobs within the State of California.
- The creation of new businesses or the elimination of existing businesses within the State of California.
- The expansion of businesses currently doing business within the State of California.

Medi-Cal is a voluntary program for service providers. It is also voluntary for an individual to apply to participate in Medi-Cal. These proposed regulations will affect only those health care plans that voluntarily choose to participate in the Medi-Cal managed care program and the beneficiaries who are offered services through the program.

The Department has determined that the proposed regulations will not affect worker safety or the State's environment. However, the proposed regulations will benefit the health and welfare of California residents by maintaining the continuity of the Medi-Cal managed care program through the provision of comprehensive health care services at low cost to low-income individuals such as families with children, seniors, persons with disabilities, children in foster care and pregnant women.

## (d) EFFECT ON SMALL BUSINESSES

The Department has determined that the regulations would potentially affect small businesses that voluntarily choose to be Medi-Cal providers, in the situation when a beneficiary may choose to enroll and receive services through an AHCSP contracting directly with the Department.

## (e) HOUSING COSTS DETERMINATION

The Department has made the determination that the proposed regulations would have no impact on housing costs.