(1) Amend Section 53800 to read:

§ 53800. General Provisions.

(a) In regions designated by the department, ~~health care services to~~ eligible Medi-Cal beneficiaries shall receive health care services ~~be provided~~ through one of ~~no more than~~ two prepaid health plans, except as provided in subsection (c) below.

(b) The two prepaid health plans in the designated regions shall be selected as follows:

(1) The department shall award one contract through a competitive bid process.

(2) The department shall award one contract to a prepaid health plan which is:

(A) Organized by the county government(s) or by stakeholders of a region designated by the director under the Two-Plan Model, or

(B) Designated by the county government(s) or by stakeholders of a region designated by the director under the Two-Plan Model, and approved by the department at the department's sole discretion.

(C) As a condition of contract award, the prepaid health plan shall agree:

~~(~~1.~~)~~ To include in its health care delivery system under the contract any safety net provider as defined in ~~subs~~Section 53810(~~hh~~ff) physically located and operating within the designated region, as defined in ~~subs~~Section 53810(m), that is willing to agree to provide services under the same terms and conditions that the plan requires of any other similar provider to be included in the health care delivery system under the contract, and

~~(~~2.~~)~~ To establish participation standards for any provider of medical or hospital services, physically located and operating within the region, that will ensure the opportunity for substantial participation of traditional ~~Medi-Cal~~ providers, as defined in ~~subs~~Section 53810(~~jj~~hh), in the health care delivery system under the contract. Nothing in this subsection shall be construed to prevent federally qualified health centers from requesting cost-based reimbursement consistent with federal law in seeking to enter into a subcontracting relationship with a plan in a designated region.

~~(~~3.~~)~~ If no health care service plan is willing or able to contract with the department pursuant to subsection (b)(2), the department may award two contracts pursuant to subsection (b)(1). The two prepaid health plans shall agree to offer subcontracts to safety net providers physically located and operating within the designated region in accordance with policies developed by each prepaid health plan and approved by the department prior to commencement of plan operation.

(c) To promote continuity of care, preserve access to providers, and maintain physician-patient relationships, the department has the authority to contract with an Alternate Health Care Service Plan (AHCSP). To the extent allowable under the law, the department has the authority to enter into either one contract for all geographic areas where the AHCSP operates or enter into multiple contracts to serve the different geographic areas.

(1) The following beneficiaries enrolling in Medi-Cal managed care shall be eligible to enroll in an AHCSP which contracts with the department:

(A) An existing member of the AHCSP transitioning into Medi-Cal managed care;

(B) A beneficiary who has been enrolled in the AHCSP at any time during the twelve (12) months immediately prior to the beneficiary's Medi-Cal eligibility; or

(C) A beneficiary with an AHCSP family member linkage.

(2) A beneficiary who is eligible to enroll in the AHCSP but chooses not to enroll in the AHCSP, shall be assigned to a plan through the enrollment processes set forth in Sections 53845, 53882, and 53883, except as otherwise provided by law.

(3) The assignment system described in Section 53884 shall not apply to the AHCSP, except as otherwise provided by law.

(4) An AHCSP shall meet all of the requirements of this chapter.

Note: Authority cited: Section 20, Health and Safety Code; Sections 10725, 14105, 14124.5 and 14312, Welfare and Institutions Code. Reference: Sections 14087.3, 14087.4 and 14201, Welfare and Institutions Code.

(2) Amend Section 53810 to read:

Article 2. Definitions

§ 53810. Definitions.

The following definitions shall be used throughout this chapter unless the context requires otherwise.

(a) Affiliate means an organization or person that, directly or indirectly through one or more intermediaries, controls, or is controlled by or is under common control with, a plan, and that provides services to, or receives services from, a plan.

(b) Alternate Health Care Service Plan (AHCSP) means a prepaid health plan that is a non-profit health care service plan with at least 3.5 million enrollees statewide, that owns or operates its own pharmacies and that provides medical services to enrollees in specific geographic regions through an exclusive contract with a single medical group in each specific geographic region in which it operates. A wholly owned subsidiary of the AHCSP qualifies as an AHCSP.

(c) AHCSP family member linkage means a situation where a beneficiary's parent, guardian, minor child or minor sibling is enrolled in or has been enrolled in the AHCSP at any time during the twelve (12) months immediately prior to the beneficiary's Medi-Cal eligibility.

Previous subsection (b) has been redesignated to (d)

Previous subsection (c) has been redesignated to (e)

Previous subsection (d) has been redesignated to (f)

Previous subsection (e) has been redesignated to (g)

Previous subsection (f) has been redesignated to (h)

Previous subsection (g) has been redesignated to (i)

~~(h) Commercial plan enrollment maximum means the enrollment level established by the department pursuant to section 53820(b).~~

Previous subsection (i) has been redesignated to (j)

~~(j) Contract maximum means the maximum enrollment level established by the terms of a prepaid health plan or PCCM plan contract.~~

No change to subsection (k)

(l) Department means the Department of Health Care Services.

No changes to subsections (m) – (q)

(r) Federally qualified health ~~means~~ centers means an entity which:

(1) Is receiving a grant under section 330 of the Public Health Service Act; or

(2) Is receiving funding from such a grant under a contract with the recipient of such a grant, and meets the requirements to receive a grant under section 330 of such Act; or

(3) Based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary of Health and Human Services to meet the requirements for receiving such a grant; or

(4) Was treated by the Secretary, for purposes of Part B of title XVIII, as a comprehensive federally funded health center as of January 1, 1990; and

(5) May be an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638) or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary health services.

No changes to subsections (s) – (v)

~~(w) Local initiative enrollment minimum means the total number of Medi-Cal beneficiaries in the mandatory aid categories in the designated geographic area less the maximum enrollment level established pursuant to section 53820.~~

Previous subsection (x) has been redesignated to (w)

~~(y) Maximum enrollment means the maximum commercial plan enrollment level at which the commercial plan ceases to receive default assignment enrollments as provided under this Chapter.~~

Previous subsection (z) has been redesignated to (x)

Previous subsection (aa) has been redesignated to (y)

Previous subsection (bb) has been redesignated to (z)

Previous subsection (cc) has been redesignated to (aa)

Previous subsection (dd) has been redesignated to (bb)

Previous subsection (ee) has been redesignated to (cc)

Previous subsection (ff) has been redesignated to (dd)

Previous subsection (gg) has been redesignated to (ee)

Previous subsection (hh) has been redesignated to (ff)

Previous subsection (ii) has been redesignated to (gg)

Previous subsection (jj) has been redesignated to (hh)

~~(kk) Transition period means, for each designated region, the period beginning April 1, 1993 through the date the two-plan model becomes operational in the region.~~

(~~l~~li) Two-plan model means the health care delivery system described in section 53800~~ which will consist, in most cases, of a commercial plan and a local initiative~~.

Note: Authority cited: Section 20, Health and Safety Code; Sections 10725, 14105, 14124.5 and 14312, Welfare and Institutions Code. Reference: Sections 14087.3, 14087.4, 14105.98, 14201 and 17000, Welfare and Institutions Code.

(3) Repeal Article 3:

Article 3. Maximum Enrollment Levels

(4) Repeal Section 53820:

§ 53820. Maximum Enrollment Levels.

~~(a) The department shall implement the two-plan model in regions designated by the department, pursuant to section 53800.~~

~~(b) For each designated region, the department shall establish a maximum enrollment level of Medi-Cal beneficiaries in the mandatory aid categories for the commercial plan under the two-plan model, which will consider the following factors:~~

~~(1) The number of inpatient days qualifying for DSH supplemental payments as the surrogate measure for services provided by all safety net providers in the region.~~

~~(2) The impact of the enrollment of Medi-Cal beneficiaries in the commercial plan on supplemental DSH payments, to the extent that inpatient days provided to members of the commercial plan will be diverted from safety net providers.~~

~~(3) The number of acute inpatient hospital days attributable to the Medi-Cal beneficiaries not enrolled in prepaid health plans or PCCM plans.~~

~~(4) The acute inpatient hospital utilization rate for Medi-Cal beneficiaries in the mandatory aid categories.~~

~~(5) The enrollment levels of both plans of the two-plan model necessary to ensure true beneficiary choice between plans and among providers within the two plans.~~

~~(6) The hospital inpatient care contracts the commercial plan may have with disproportionate share hospitals.~~

~~(7) An agreement between a local initiative and commercial plan in a designated region regarding local initiative minimum and commercial plan maximum enrollment levels.~~

~~(c) The process for setting the maximum enrollment level for the commercial plan in any region shall include the following:~~

~~(1) The department shall notify the Board(s) of Supervisors of each county included within the region of the proposed maximum enrollment level and the rationale for the proposed level.~~

~~(2) The Board(s) of Supervisors shall have 30 days to submit written comments to the department on the proposed maximum enrollment level.~~

~~(3) The department shall review and consider any written comments received from the Board(s) of Supervisors within the 30 day comment period and may adjust the~~

~~maximum enrollment level, if the department determines that an adjustment is warranted, or may set the maximum enrollment level as originally proposed.~~

~~(d) The department shall reevaluate the maximum enrollment level at least every two years and revise the level, if appropriate.~~

~~(e) If the number of enrollees and the utilization patterns of the commercial plan have significantly reduced or will significantly reduce DSH supplemental payments in the region, the department shall require the commercial plan to contract with disproportionate share hospitals for inpatient care for members.~~

Note: Authority cited: Sections 10725, 14105, 14124.5 and 14312, Welfare and Institutions Code. Reference: Sections 14087.3, 14087.4, 14105.98 and 14201, Welfare and Institutions Code.

(5) Repeal Article 4:

Article 4. Prepaid Health Plan and Primary Care Case Management Plan Enrollment Growth During the Transition Period

(6) Repeal Section 53830:

53830. Prepaid Health Plan and Primary Care Case Management Plan Enrollment Growth During the Transition Period.

~~(a) Until the implementation of the two-plan model in a designated region, the aggregate enrollment level of all prepaid health plans and PCCM plans affiliated with either the local initiative or the commercial plan operating in the region shall not exceed the maximum enrollment level for the commercial plan established by the department under section 53820(b) unless an exemption has been granted by the department pursuant to subsection (e). If the maximum enrollment level for the commercial plan in the region is exceeded and if the sum of the prepaid health plan contract maximums in the region is greater than the maximum enrollment level for the commercial plan in the region, the department shall negotiate amendments to the prepaid health plan contracts to set contract maximums specified to the region that will assist in bringing the total enrollment level in conformance with the maximum enrollment level for the commercial plan.~~

~~(b) Until the implementation of the Two-Plan Model in a designated region, the total allowable enrollment growth for PCCM plans in a designated region shall be the maximum enrollment level for the commercial plan set by the department for the region in accordance with section 53820(b) less the aggregate contracted capacity of all prepaid health plans operating in the region and less the total enrollment level of all~~

~~PCCM plans operating in the region, unless an exemption has been granted by the department pursuant to subsection (e).~~

~~(1) If there is allowable enrollment growth in the region for PCCM plans, a PCCM plan's enrollment growth in a region shall not exceed the percentage growth in the caseload in the region, which shall be determined as follows:~~

~~(A) In June of each year, the department shall establish an aggregate caseload growth percentage factor for the subsequent six-month period in each region. The department shall recalculate and apply this factor in December of each year.~~

~~(B) Each PCCM plan's enrollment level in each region as of July 1 in each year shall be multiplied by the caseload growth percentage factor calculated in June for that region. The product of this calculation shall be the PCCM plan's maximum enrollment growth for the six-month period ending December 31 of that year. Each PCCM plan's maximum enrollment growth for the six-month period ending June 30 in each year shall be calculated in the same manner by the department, using the PCCM plan's enrollment level in each region as of January 1.~~

~~(C) Once a PCCM plan achieves its six-month maximum enrollment growth in a region, enrollments in that region shall not be accepted by the department for the remainder of the six-month period except as necessary to allow the PCCM plan to~~

~~maintain its maximum enrollment level by replacing beneficiaries who disenroll from the PCCM plan.~~

~~(D) In calculating the aggregate caseload factor for each subsequent six-month period, the department may adjust this factor for any documented over- or underestimate of caseload growth in a region for the preceding caseload growth in a region for the preceding six-month period. Based on this adjustment, the department may further limit or increase PCCM maximum enrollment growth in the region for the succeeding six-month period.~~

~~(2) If the total allowable enrollment growth in the region is insufficient to allow all PCCM plans operating in a region to increase enrollment as provided in subsection (b)(1), the allowable increase shall be distributed equally among plans falling within the following priority categories, except that no plan may increase above the level provided by subsection (b)(1):~~

~~(A) Among PCCM plans whose most recent annual medical review by the department found no or only minor deficiencies in quality of care:~~

~~(i) First, PCCM plans whose most recent annual medical review by the department found a compliance level of 80 percent or better in the provision of Child Health and Disability Prevention services;~~

~~(ii) Second, PCCM plans whose most recent annual medical review by the department found a compliance level of 80 percent or better in the provision of adult preventive screens;~~

~~(iii) Third, all other PCCM plans whose most recent annual medical review by the department found no or only minor deficiencies in the quality of care; and then,~~

~~(B) All other PCCM plans in the region.~~

~~(c) If there is no allowable enrollment growth PCCM plans in a designated region, a PCCM plan's maximum enrollment level in that region shall be limited to its enrollment level as of the first month following the month in which the PCCM plan is notified to this effect.~~

~~(d) Until the department has established the commercial plan maximum enrollment level in a designated region as provided under section 53820(b), the maximum enrollment level for each PCCM plan in the designated region shall be capped at the plan's enrollment level as of July 1, 1993, unless an exemption has been granted by the department pursuant to subsection (e).~~

~~(e) The department may grant exemptions to the maximum enrollment level established for a PCCM plan pursuant to subsections (b) or (d) if special circumstances are established by the department. Special circumstances may specifically include, but~~

~~are not limited to, a county Board of Supervisors, with the stated intention of including the PCCM plan or plans or the additional enrollment in the provider network of the local initiative, requesting the department to allow a PCCM plan or PCCM plans to enroll Medi-Cal beneficiaries above the maximum enrollment level established pursuant to subsections (b) or (d).~~

~~(f) PCCM plan enrollment growth in nondesignated regions shall be limited to caseload growth as described in subsection (b)(1) unless special circumstances are established by the department. Special circumstances may include:~~

~~(1) A county board of Supervisors asks the department to allow a PCCM plan or PCCM plans operating in the county to enroll Medi-Cal beneficiaries at a rate greater than caseload growth.~~

~~(2) The department identifies a problem with access to care in a region that can be met by PCCM plans enrolling Medi-Cal beneficiaries at a rate greater than caseload growth.~~

~~(3) A county Board of Supervisors proposes to develop a health care delivery system both for Medi-Cal beneficiaries and for medically indigent persons covered by the county's responsibilities under 17000 of the Welfare and Institutions Code, and intends to use a PCCM plan or PCCM plans in this system.~~

~~(g) PCCM plans shall be permitted to open new service sites, enlarge existing service areas, and add new service areas in nondesignated regions to the extent that the plans do not exceed the enrollment level authorized by this section.~~

~~(h) The department shall publish a public notice of its intent to approve a new service area or enlargement of a service area for a PCCM plan in nondesignated regions at least 60 days prior to the action. The notice shall appear in at least two major newspapers of general distribution in the proposed service area and shall provide instruction for submission of comments.~~

~~(i) Nothing in this section precludes the department from applying appropriate sanctions as provided in section 56350 or 56408 against PCCM plans.~~

~~(j) Nothing in this section authorizes a PCCM plan to enroll embers in excess of the plan's capacity to provide services to members under the terms of the plan's contract and all applicable laws and regulations.~~

Note: Authority cited: Sections 10725, 14105, 14124.5 and 14312, Welfare and Institutions Code. Reference: Sections 14087.3, 14087.4, 14088, 14088.16, 14088.25 and 17000, Welfare and Institutions Code.