580-1

Federal regulations provide, in pertinent part, that:

(b) A state plan must—

(1) Specify a single State agency established or designated to administer or supervise the administration of the plan; and

(2) Include a certification by the State Attorney General, citing the legal authority for the single State agency to—

(i) Administer or supervise the administration of the plan; and

(ii) Make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan.

(c) Determination of eligibility. (1) The plan must specify whether the agency that determines eligibility for families and for individuals under 21 is—

(i) The Medicaid agency; or

(ii) The single State agency for the financial assistance program under Title IV-A (in the 50 States or the District of Columbia).

(2) The plan must specify whether the agency that determines eligibility for the aged, blind, or disabled is—

(i) The Medicaid agency;

(ii) The single State agency for the financial assistance program under Title IV-A (in the 50 States or the District of Columbia); or

(iii) The Federal agency administering the supplemental security income program under Title XVI (SSI). In this case, the plan must also specify whether the Medicaid agency or the Title IV-A agency determines eligibility for any groups whose eligibility is not determined by the Federal agency.

(e) Authority of the single State agency. In order for an agency to qualify as the Medicaid agency—

(1) The agency must not delegate, to other than its own officials, authority to—

(i) Exercise administrative discretion in the administration or supervision of the plan, or

(ii) Issue policies, rules, and regulations on program matters.

(2) The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State.

(3) If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.

(42 Code of Federal Regulations §431.10)

580-2 ADDED
8/14All managed care plans in California are subject to the Knox Keene Act which provides protections for enrollees. The provisions of the Knox Keene Act are set forth in California Health and Safety Code § 1340, et seq.and the regulations implementing these provisions are set for in Title 28 California Code of Regulations (CCR) §§ 1300.51 et seq.

580-2A ADDED
1/15Counties contracting with the Department of Health Care Services to operate county health systems (county-operated health systems or COHS) for provision of health care services to Medi-Cal beneficiaries pursuant to this article shall be exempt from the provisions of the Knox-Keene Health Care Service Plan Act, Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, for purposes of carrying out the contracts, unless the county seeks a contract with the federal Centers for Medicare and Medicaid Services to provide Medicare services as a Medicare Advantage program to persons who are eligible to receive medical benefits under Title 18 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.), in which case the county shall first obtain a license under the Knox-Keene Health Care Service Plan Act. (W&IC §§14087.95, 14087.54(b)(5) and (b)(3)(A) and (B))

580-3 ADDED
8/14All Knox-Keene-licensed health plans that provide physician services shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. Plans shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard. (28 CCR §1300.67.2.2(c)(1))

581-3A ADDED
10/15Students up to age 21, who are out of the home temporarily to attend college and are still claimed for their parents' income tax deductions, remain in the family's MFBU. When a family informs the county that the Medi-Cal beneficiary attends college outside of the family's residence county, the student's health plan in the family's county is discontinued and the student must choose a health plan in the new county. While the student is waiting to be enrolled in the new health plan, the student has fee-for-service Medi-Cal. If the student needs medical attention in the family's county during a break, the family must report to the county and the county must update the student's address to reflect the appropriate county in SAWS and MEDS. (Medi-Cal Eligibility Division Information Letter (MEDIL) No. I 15-32, October 20, 2015)

580-4 ADDED
8/14In addition to ensuring compliance with the clinical appropriateness standard set forth at subsection 1300.67.2.2 (c)(1), each Knox-Keene-licensed plan shall ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the following timeframes: Non-urgent appointments with specialist physicians: within fifteen business days of the request for appointment, except

where the referring or treating health care provider has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee, or where preventive care services or periodic follow-up care are scheduled in advance. (28 CCR §1300.67.2.2(c)(5)(D), (G) and (H))

580-5 ADDED
8/14A Knox-Keene-licensed plan operating in a service area that has a shortage of one or more types of providers shall ensure timely access to covered health care services as required by this section, including applicable time-elapsed standards, by referring enrollees to, or, in the case of a preferred provider network, by assisting enrollees to locate, available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs. Plans shall arrange for the provision of specialty services from specialists outside the plan's contracted network if unavailable within the network, when medically necessary for the enrollee's condition. Enrollee costs for medically necessary referrals to non-network providers shall not exceed applicable co-payments, co-insurance and deductibles. This requirement does not prohibit a plan or its delegated provider group from accommodating an enrollee's preference to wait for a later appointment from a specific contracted provider. (28 CCR §1300.67.2.2(c)(7)(B))

581-1

"Contract" means the written agreement entered into between a health care service plan (as defined in §1345, Health and Safety Code) and the Department and approved by appropriate state agencies to provide health care services to members under the provisions of the Waxman-Duffy Pre-paid Health Plan (PHP) Act, §14200, et seq., Welfare and Institutions Code. (§53108)

581-2

"Disenrollment" means the process by which a member's entitlement to receive services from a PHP is terminated. (§53114)

581-3

Except as provided in §53440, PHP membership shall continue indefinitely after enrollment. Membership shall be contingent upon the member's retention of Medi-Cal eligibility as well as eligibility for enrollment in the plan under the terms of the plan contract. (§53426)

581-4

Each prepaid health plan shall establish and maintain a procedure for submittal, processing and resolution of all member complaints. This section provides that such procedures shall be approved by the Department and shall provide for the processing of disenrollment requests through the grievance procedure. (§53260(a))

State law provides that the enrollment of a Medi-Cal beneficiary in a prepaid health plan shall not be terminated except for loss of eligibility, for good cause as determined by the Department, or at the request of the beneficiary. (Welfare and Institutions Code (W&IC) §14412(a))

581-2 ADDED

7/15A "dual eligible beneficiary" is a person age 21 or older who is enrolled for benefits under Medicare Part A (42 U.S.C. Sec. 1395c et seq.) or Medicare Part B (42 U.S.C. Sec. 1395j et seq.), or both, and is eligible for Medi-Cal. (W&I Code § 14182.16(b)(2))

"Coordinated Care Initiative (CCI) counties" means the Counties of Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. (W&I Code § 14182(b)(1))

All dual eligible beneficiaries in CCI counties must be enrolled in managed care plans. (W&I Code § 14182(a))

Welfare & Institutions Code section 14182(c)(1) provides the only exemptions from mandatory managed care enrollment for dual eligible beneficiaries in CCI counties:

- Except in counties with county organized health systems operating pursuant to Article 2.8 (commencing with Section 14087.5), the beneficiary has other health coverage providing the same benefits as the Medi-Cal program.
- The beneficiary receives services through a foster care program.
- The beneficiary is under 21 years of age.
- The beneficiary is not eligible for enrollment in managed care health plans for medically necessary reasons determined by the department.
- The beneficiary resides in one of the Veterans Homes of California.
- The beneficiary is enrolled in the PACE program pursuant to WIC Section 14591.
- The beneficiary is enrolled in a managed care organization licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) that has previously contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) of Chapter 7.

A dual eligible beneficiary who has been diagnosed with HIV/AIDS is not exempt from mandatory enrollment, but may opt out of managed care enrollment at the beginning of any month. (W&I Code § 14182(c)(2)

Welfare & Institutions Code section 14182(c) does not provide any exemption based on medical needs for continuity of care through a Medi-Cal fee-for-service provider.

582-1 ADDED
1/16Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012), SB 1036 (Chapter 45, Statutes of 2012), and SB 94 (Chapter 37, Statutes of 2013 authorized the implementation of the Coordinated Care Initiative (CCI). The CCI's purpose is to enhance health outcomes and beneficiary satisfaction for low-income Seniors and Persons with Disabilities (SPDs) by shifting service delivery away from institutional care to home and community-based settings. (Dual Plan Letter (DPL) 15-01, August 17, 2015)

The three major components of the CCI are: (1) a three-year Duals Demonstration Project (Cal MediConnect) for dual eligible (individuals eligible for Medicare and Medicaid) beneficiaries (Duals) that combines the full continuum of acute, primary, institutional, and home and community-based services into a single benefit package, delivered through an organized service delivery system; (2) mandatory Medi-Cal managed care enrollment for Duals; and (3) the inclusion of Long-Term Services and Supports (LTSS) as a Medi-Cal managed care benefit

for SPD beneficiaries who are eligible for Medi-Cal only, and for SPD Duals. (Dual Plan Letter (DPL) 15-01, August 17, 2015)

The seven CCI counties participating in Cal MediConnect are Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. (Dual Plan Letter (DPL) 15-01, August 17, 2015)

Under the CCI, all Medicare-Medi-Cal managed care plans (MMPs) must provide continuity of care for dual eligible enrolled in the Coordinated Care initiative. Two tools of continuity of care are the Risk Stratification and Health Risk Assessment (HRA). (Dual Plan Letter (DPL) 15-01, August 17, 2015)
(Welfare and Institutions Code (W&IC) §14182)

582-2 ADDED
1/16Medicare Medicaid Plans are required to establish a risk stratification mechanism designed for the purpose of identifying new enrollees who are considered to be higher or lower risk. Higher risk for risk stratification purposes means an enrollee who is at increased risk of having an adverse health outcome or worsening of his or her health status if he or she does not receive his or her initial contact by the Medicare Medicaid Plan within 45 calendar days of enrollment.

After analyzing the historical data, each Medicare Medicaid Plan must identify an enrollee as higher risk if he or she, at a minimum, meets any one of the following criteria:

- Has been on oxygen within the past 90 calendar days;
- Has been hospitalized within the last 90 calendar days, or has had three or more voluntary and/or involuntary hospitalizations within the past year;
- Has had three or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g. multiple prescriptions consistent with the diagnoses of chronic diseases);
- Has IHSS greater than or equal to 195 hours/month. Higher risk IHSS beneficiaries can be identified in the IHSS assessment files;
- Is enrolled in MSSP;
- Is receiving Community Based Adult Services;
- Has End Stage Renal Disease, Acquired Immunodeficiency Syndrome, and/or a recent organ transplant;
- Has cancer and is currently being treated;
- Has been prescribed anti-psychotic medication within the past 90 calendar days;
- Has been prescribed 15 or more medications in the past 90 calendar days; or
- Has other conditions as determined by the Medicare Medicaid Plan, based on local resources.

New enrollees who have no historical data must be stratified as higher risk.

(Dual Plan Letter (DPL) 15-01, August 17, 2015)

582-3 ADDED
1/16Medicare Medicaid Plans are required to develop a health risk assessment survey tool to assess an enrollee’s current health risk within 45 calendar days of enrollment for those enrollees identified through the risk stratification as higher risk, and within 90 calendar days of coverage for those identified as lower risk.

As part of the health risk assessment, the Medicare Medicaid Plan must ask the enrollee if there are any upcoming health care appointments or treatments scheduled and assist the enrollee at that time in initiating the continuity of care process if the enrollee chooses to do so.

Health risk reassessments must be conducted at least annually, within 12 months of completing the last health risk assessment, or as often as the health and/or functional status of the enrollee requires.
(Dual Plan Letter (DPL) 15-01, August 17, 2015)

583-1

State law permits the Director of the CDHS to designate any benefit or service included in the Medi-Cal Program, at state option under federal Medicaid rules, as a covered benefit only when provided by a Medi-Cal managed care plan to a Medi-Cal enrollee of the plan. (Welfare and Institutions Code (W&IC) §14131.15(a))

Where benefits and services have been designated by the Director under the above paragraph, beneficiaries who are eligible to enroll in and reside in the service area of a managed care plan, and who desire coverage for such benefits and services, must enroll in a Medi-Cal managed care plan to receive them. These beneficiaries shall, to the maximum extent permitted under federal law, remain enrolled in the plan. (W&IC §14131.15(b))

583-2
Under a federal waiver, effective 2011, managed care is mandatory for disabled and senior Medi-Cal recipients who do not have a share of cost. To ensure continuity of care, Seniors and Persons with Disabilities (SPDs) subject to mandatory enrollment in managed care will be given the opportunity to work with their health plan and continue to see their current provider out of network for up to 12 months from the date of enrollment in the health plan. (ACDWLs 11-24, 11-24e)

584-1

Enrollment in GMC is mandatory for eligible beneficiaries who meet all of the following criteria:

1. Are eligible for full scope Medi-Cal;

2. Have a zero SOC;

3. Do not qualify to select an alternative to GMC, under §53923.5;

4. Are eligible for AFDC, or linked to AFDC, to Foster Care, or to the MI program for children under age 21.

(§53906(a))

584-1A ADDED
8/14
REVISED 4/16

Geographic Managed Care (GMC) plan means a Prepaid Health Plan (PHP), Primary Care Case Management (PCCM) plan, or dental plan that has entered into a GMC contract with the Department of Health Care Services (DHCS). (§53902(j))

584-2

The CDHS or the GMC enrollment contractor shall mail an enrollment form and GMC plan information to each eligible beneficiary described in §53906(a). The mailing shall include GMC options presentation information and instructions to enroll in a GMC plan within thirty days of the postmark date on the mailing envelope. (§53921(c)) Each eligible beneficiary described in §53906(a) shall enroll in a GMC plan within thirty days of receipt of an enrollment form with instructions from the department or the GMC enrollment contractor to select a GMC plan. Under Subsection (1), in the event an eligible beneficiary described in §53906(a) does not enroll in a GMC plan within thirty days, the GMC enrollment contractor shall assign the eligible beneficiary to a GMC plan, in accordance with §53921.5. (§53921(d))

584-3

Each eligible beneficiary, prior to or upon either signing an enrollment application or being assigned to a GMC plan in accordance with §53921.5, shall be informed in writing by the department or the GMC enrollment contractor of at least the following:

(1) There will be a 15 to 45 day processing time between the date of application and the effective date of enrollment in a GMC plan.

(2) Until GMC plan enrollment is effective, the beneficiary may receive Medi-Cal covered health care services from any Medi-Cal provider licensed to provide the services.

(3) An alternative to GMC plan enrollment exists.

(4) Disenrollment from certain GMC plans, specified in §53925.5, is restricted during the second through sixth month of enrollment.

(§53926.5(a))

584-4

Each GMC plan shall provide in writing, in addition to those items of information required by W&IC §14406, the following to each member within seven days after the effective date of enrollment in the plan:

(1) The effective date of enrollment.

(2) A description of all available services and an explanation of any applicable service limitations, exclusions from coverage or charges for services.

(3) The name, telephone number and service site address of the primary care provider selected by the member or instructions to select a primary care provider within thirty days or be assigned to one.

(4) An enrollment/disenrollment form and an explanation that it must be used to disenroll from the GMC plan, in the event disenrollment is requested by the member.

(5) Information concerning non-medical transportation available to the beneficiary under the Medi-Cal program, or offered by the GMC plan, if applicable, and how to receive it.

(§53926.5(b))

584-5

Each eligible beneficiary enrolling in a GMC plan shall enroll in one dental plan and either one PHP or one PCCM plan. (§53921(e))

584-6

The GMC enrollment contractor shall assign an eligible beneficiary described in §53906(a) to a GMC plan, from which to receive health care services, in the following situations:

(1) In the event the eligible beneficiary does not select a PHP or PCCM plan and a dental plan within thirty days of receiving an enrollment form pursuant to §53921(c).

(2) In the event a member requests and is granted disenrollment from a GMC plan (pursuant to §53925.5) but does not select a different GMC plan (pursuant to §53925.5) in which to enroll: Unless that member was granted approval by the GMC enrollment contractor to receive health care services through the fee-for-service Medi-Cal program (pursuant to §53923.5).

(§53921.5(a))

584-7

No member who is assigned to a GMC plan under §53921.5 shall be denied a request for disenrollment if all primary health care services through that assigned GMC plan are more than 10 miles from the beneficiary's residence. (§53922.5(a))

584-8

An eligible beneficiary specified in §53906(a) who meets the requirements of (a) or (b) may request from the GMC enrollment contractor an alternative to GMC plan enrollment.

(a) An eligible beneficiary who is an Indian, is a member of an Indian household, or has written acceptance from an Indian Health Service program facility to receive health care services through that facility, may, as an alternative to GMC plan enrollment and upon request, choose to receive health care services through an Indian Health Service program facility.

(b) An eligible beneficiary who is receiving treatment or services for a complex medical situation from a physician who is participating in the Medi-Cal program, but is not a contracted provider of any GMC plan, may request continued fee-for-service Medi-Cal for the purposes of continuity of care. The department may approve continued treatment under the fee-for-service Medi-Cal program for any eligible beneficiary whose diagnosis or treatment needs are verified in writing by the beneficiary's Medi-Cal provider and who meets one of the criteria below in 1 though 3 for

continued fee-for-service Medi-Cal.

(1) The eligible beneficiary is under the care of a physician specialist:

(A) For treatment of a condition that is within the specialist's scope of practice, pursuant to the Business and Professions Code;

(B) That specialty is not practiced by any physician within the available providers of any GMC plan; and

(C) That specialist is a participating Medi-Cal provider, but is not a contracted provider of any GMC plan.

(2) The eligible beneficiary is in a complex, high risk medical treatment plan:

(A) Under the supervision of a physician who is a participating Medi-Cal provider, but is not a contracted provider of any GMC plan; and

(B) May experience deleterious medical effects if that treatment were to be disrupted by leaving the care of that physician to begin receiving care from a GMC plan physician.

(3) The eligible beneficiary is a woman who is pregnant and under the care of a physician who is a participating Medi-Cal provider, but is not a contracted provider of any GMC plan.

(c) Any eligible beneficiary granted continued fee-for-service Medi-Cal under (b)(1) or (2) may remain with that fee-for-service physician only until the medical condition has stabilized to a level that would enable the eligible beneficiary to change physicians and begin receiving care from a GMC plan physician without deleterious medical effects. An eligible beneficiary granted continued fee-for-service Medi-Cal under (b)(3) may remain with that physician through delivery and the end of the month in which ninety days post-partum occurs.

(§53923.5)

584-8A ADDED
1/16Managed Care Plans are required to consider a request for exemption from Managed Care Plan enrollment that is denied as a request to complete a course of treatment with an existing fee for service or nonparticipating health plan provider under H&S Code § 1373.96, and in compliance with the Managed Care Plan's contract with Department of Health Care Services and any other Department of Health Care Services continuity of care All Plan Letter. Managed Care Plans must ensure that all beneficiaries continue to receive medically necessary Medi-Cal services and ensure new enrollees are entitled to receive continuity of care with their existing providers for the completion of those services to the extent authorized by law. The beneficiary's existing provider is identified by the National Provider Identifier on the Medical Exemption Request. Managed Care Plans must meet the continuity of care timeframes that are specified in H&S Code § 1373.96. This continuity of care policy is in addition to the extended continuity of care policy for Seniors and Persons with Disabilities established under All Plan Letter 11-019, Duals Plan Letter (DPL) 14-004 on continuity of care, All Plan Letter 14-021 on continuity of care for Medi-Cal beneficiaries who transition into managed care, and other continuity of care All Plan Letters and DPLs.
(All Plan Letter 15-001, January 14, 2015)

584-9

State regulations require that:

(a) Each GMC plan shall have a mechanism in place and approved in writing by the department to ensure that each member is assigned to a primary care provider, by either:

(1) Allowing each member to select a primary care provider from the GMC plan's network of affiliated providers, if the member chooses to do so; or

(2) Assigning a primary care provider to each member within forty days from the effective date of enrollment, if the member does not select one within the first thirty days of the effective date of enrollment in the GMC plan.

(A) Assignment conducted pursuant to (a)(2) shall meet both 1 and 2:

1. The member shall be assigned to a primary care provider no more than 10 miles from the beneficiary's residence.

2. If available within the GMC plan, the member shall be assigned to a primary care provider who is or has office staff who are linguistically and culturally competent to communicate with the member or have the ability to interpret in the provision of health care services and related activities during the member's office visits or contacts, if the language or cultural needs of the member are known to the GMC plan.

(b) Any member dissatisfied with the primary care provider selected or assigned shall be allowed to select or be assigned to another primary care provider. Each GMC plan shall assist its members in changing primary care providers if that change is requested by the member. Any GMC plan physician or dentist dissatisfied with the professional relationship with any member may request that the member select or be assigned to another primary care provider.

(§53925)

584-10 ADDED
8/14Each GMC plan shall, among other things, agree to provide or arrange for the provision of, to the extent allowed by state and federal law, the scope of Medi-Cal program benefits set forth by GMC contract to eligible beneficiaries who either select or are assigned to that GMC plan. (§53904(a)(1))

584-11 ADDED
8/14Each GMC plan shall provide readily available and accessible health care services and utilize preventive health care programs to improve the health status of its members. (§53904(a)(3))

584-12 ADDED
8/14Each GMC plan shall provide or arrange for the provision of the full scope of Medi-Cal services set forth in 22 CCR, Chapter 3, Article 4, beginning with Section 51301 (Schedule of Benefits covered by Medi-Cal), unless services are specifically included or excluded under the terms of the GMC contract, and four additional specified categories of service. (§53910.5(a)

(GMC Scope of Services), referring to §53210 (Prepaid Health Plan Scope of Services), referring to §§51301 et seq.)

584-13 ADDED
8/14Each GMC plan shall have the organizational and administrative ability to carry out is obligations as a Knox-Keene licensee. (§53200(a)(1))