WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 9. PUBLIC SOCIAL SERVICES [10000 - 18999.98] *(Division 9 added by Stats. 1965, Ch. 1784.)*

PART 3. AID AND MEDICAL ASSISTANCE [11000 - 15771] *(Part 3 added by Stats. 1965, Ch. 1784.)*

CHAPTER 8. Prepaid Plans [14200 - 14499.77] *(Chapter 8 added by Stats. 1972, Ch. 1366.)*

ARTICLE 2. Definitions [14250 - 14265] *(Article 2 added by Stats. 1972, Ch. 1366.)*

14250. Unless the context otherwise requires, the definitions set forth in this article govern the construction of this chapter.

(Added by Stats. 1972, Ch. 1366.)

14251. (a) (1) “Prepaid health plan” means a plan that meets all of the following criteria:

(A) Is licensed as a health care service plan by the Director of the Department of Managed Health Care pursuant to 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), other than a plan organized and operating pursuant to Section 10810 of the Corporations Code that substantially indemnifies subscribers or enrollees for the cost of provided services, or has an application for licensure pending and was registered under the Knox-Mills Health Plan Act prior to its repeal.

(B) Meets the requirements for participation in the Medicaid program (Title XIX of the Social Security Act) on an at-risk basis.

(C) Agrees with the State Department of Health Care Services to furnish directly or indirectly health services to Medi-Cal beneficiaries on a predetermined periodic rate basis.

(2) “Prepaid health plan” includes any organization that is licensed as a plan pursuant to the Knox-Keene Health Care Service Plan Act of 1975 and is subject to regulation by the Department of Managed Health Care pursuant to that act, and that contracts with the State Department of Health Care Services solely as a fiscal intermediary at risk.

(b) (1) Except for the requirement of licensure pursuant to the Knox-Keene Health Care Service Plan Act of 1975, the State Director of Health Care Services may waive any provision of this chapter that the director determines is inappropriate for a fiscal intermediary at risk. An exemption or waiver shall be set forth in the fiscal intermediary at-risk contract with the State Department of Health Care Services.

(2) “Fiscal intermediary at risk” means any entity that entered into a contract with the State Department of Health Care Services on a pilot basis pursuant to subdivision (f) of Section 14000, as in effect June 1, 1973, in accordance with which the entity received capitated payments from the state and reimbursed providers of health care services on a fee-for-service or other basis for at least the basic scope of health care services, as defined in Section 14256, provided to all beneficiaries covered by the contract residing within a specified geographic region of the state. The fiscal intermediary at risk shall be at risk for the cost of administration and utilization of services or the cost of services, or both, for at least the basic scope of health care services, as defined in Section 14256, provided to all beneficiaries covered by the contract residing within a specified geographic region of the state. The fiscal intermediary at risk may share the risk with providers or reinsuring agencies or both. Eligibility of beneficiaries shall be determined by the State Department of Health Care Services and capitation payments shall be based on the number of beneficiaries so determined.

(Amended by Stats. 2015, Ch. 455, Sec. 53. (SB 804) Effective January 1, 2016.)

14252. “Medi-Cal beneficiary” means a person who is eligible to receive benefits under Chapter 7 (commencing with Section 14000) of this part.

(Added by Stats. 1972, Ch. 1366.)

14253. “Subcontract” means an agreement entered into by the prepaid health plan with any of the following:

(a) A provider of health care services who agrees to furnish such services to Medi-Cal beneficiaries enrolled in the prepaid health plan.

(b) A marketing organization.

(c) Any other person or organization who agrees to perform any administrative function or service for the operation of the prepaid health plan specifically related to securing or fulfilling its contractual obligations with the department.

(Added by Stats. 1974, Ch. 983.)

14254. (a) “Primary care physician” is a physician who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. A primary care physician shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner.

(b) A nonphysician medical practitioner, as defined in subdivision (c) of Section 14088, who is supervised by a primary care physician, has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care.

(Amended by Stats. 2013, Ch. 684, Sec. 5. (SB 494) Effective January 1, 2014.)

14255. “Specialist” means a physician who is board certified or board eligible in the specialty of medical care provided.

(Amended by Stats. 1974, Ch. 983.)

14256. The “basic scope of health care benefits” means:

(a) Physician’s services;

(b) Hospital outpatient services;

(c) Laboratory and X-ray;

(d) Prescription drugs;

(e) Hospital inpatient care;

(f) Skilled nursing facility care.

(Amended by Stats. 1974, Ch. 1240.)

14257. Nothing in this act shall preclude the director from contracting with licensed specialized health care service plans which provide only dental, pharmaceutical, optometric, or psychological services in accordance with regulations issued by the department.

(Amended by Stats. 1977, Ch. 1036.)

14258. “Service area” means a geographical area designated by the department within which a prepaid health plan shall provide health care services and within which the Medi-Cal beneficiaries eligible for enrollment in the prepaid health plan reside.

(Added by Stats. 1974, Ch. 983.)

14259. “Director” means the State Director of Health Services.

(Amended by Stats. 1977, Ch. 1252.)

14260. “Department” means the State Department of Health Services.

(Amended by Stats. 1977, Ch. 1252.)

14261. “Vendor” means any person who provides services or supplies to a prepaid health plan or a subcontractor of a prepaid health plan and who does not have a subcontract as defined by Section 14253 with either the prepaid health plan or its subcontractors.

(Repealed and added by Stats. 1977, Ch. 1036.)

14263. “Marketing” means any activity conducted by or on behalf of a prepaid health plan where information regarding the services offered by a prepaid health plan is disseminated in order to persuade Medi-Cal beneficiaries to enroll or accept any application for

enrollment in the prepaid health plan. Marketing shall also include any similar activity to procure the endorsement of the prepaid health plan from any individual or organization.

(Amended by Stats. 1977, Ch. 1036.)

14264. "Marketing organization" means any subcontractor who agrees to provide marketing services for a prepaid health plan.

(Amended by Stats. 1977, Ch. 1036.)

14265. "Marketing representative" means any person who engages in marketing activities on behalf of a marketing organization or the prepaid health plan.

(Added by Stats. 1974, Ch. 983.)