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 5. Standards for Prepaid Health Plans [14450 - 14464] *(Article 5 added by Stats. 1974, Ch. 983.)*

14450. (a) No contract between the department and a prepaid health plan shall be approved or renewed unless the providers and the facilities of the prepaid health plan meet the Medi-Cal program standards for participation as established by the director. In addition, a prepaid health plan shall meet the standards required pursuant to the provisions of 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), standards specifically required by federal law, and the following requirements:

(1) Each prepaid health plan shall establish a grievance procedure under which enrollees may submit their grievances. The procedure shall be approved by the department prior to the approval of the contract. The department shall establish standards for the procedures to insure adequate consideration and rectification of enrollee grievances. A prepaid health plan shall make a finding of fact in the case of each grievance processed, a copy of which shall be transmitted to the enrollee. If the enrollee has an unresolved grievance, the fair hearing provided in Chapter 7 (commencing with Section 10950) of Part 2 shall be available to resolve all grievances regarding care and administration by the prepaid health plan. The findings and recommendations of the department, based on the decision of the hearing officer, shall be binding upon the prepaid health plan. Any changes in a proposed health plan's grievance procedure must be approved by the department before the changes take effect.

(2) (A) Medi-Cal enrollees shall have the same responsibilities and shall be entitled to the same rights as other enrollees with regard to any requirements for arbitration as a condition of membership in a health plan.

(B) Arbitration requirements shall be clearly disclosed in all of the contractor's Medi-Cal marketing presentations, materials and brochures, enrollment agreements, evidence of coverage, and disclosure forms.

(3) The prepaid health plan shall provide the director, for their approval, a plan for marketing its services to Medi-Cal beneficiaries which relates the proposed service to the need for services, and the size of the potential population to be served in the proposed service area.

(4) The prepaid health plan shall demonstrate to the department that it has adequate financial resources, administrative abilities and soundness of program design to carry out its contractual obligations.

(b) The requirements of this section shall apply to all managed care plan contracts entered into under any of the following:

(1) The act that added this subdivision.

(2) Any of the following provisions of Chapter 7 (commencing with Section 14000).

(A) Article 2.7 (commencing with Section 14087.3).

(B) Article 2.9 (commencing with Section 14088).

(C) Article 2.91 (commencing with Section 14490).

(3) Article 7 of Chapter 8 (commencing with Section 14490).

(Amended by Stats. 2023, Ch. 266, Sec. 4. (AB 614) Effective January 1, 2024.)

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 abrogate any other requirements of federal or state law with regard to medicaid.

(b) The requirements of this section shall apply to all managed care plan contracts entered into under any of the following:

(1) The act that added this subdivision.

(2) Any of the following provisions of Chapter 7 (commencing with Section 14000).

(A) Article 2.7 (commencing with Section 14087.3).

(B) Article 2.9 (commencing with Section 14088).

(C) Article 2.91 (commencing with Section 14089).

(3) Article 7 of Chapter 8 (commencing with Section 14490).

(Added by Stats. 1998, Ch. 31, Sec. 2. Effective January 1, 1999.)

14451. Services under a prepaid health plan contract shall be provided in accordance with the requirements of the Knox-Keene Health Care Service Plan Act of 1975.

(Amended by Stats. 2014, Ch. 442, Sec. 39. (SB 1465) Effective September 18, 2014.)

14451.5. (a) A prepaid health plan contractor may not enter into subcontracts when such an action would remove from the contractor his obligation to bear a significant portion of the risk encountered in providing the covered services.

(b) The prepaid health plan may obtain reinsurance for the cost of providing covered services. Such reinsurance shall not limit the contractor's liability below five thousand dollars ($5,000) per enrollee for any one 12-month period, except that the contractor may also obtain reinsurance for the total cost of services provided to enrollees by noncontractor emergency service providers, and for 90 percent of all costs exceeding 115 percent of its income during any contractor fiscal year.

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

14452. (a) (1) All subcontracts shall be entered into pursuant to the requirements of the Knox-Keene Health Care Service Plan Act of 1975 and federal law. All subcontracts shall be in writing, a copy of which shall be transmitted to the department.

(2) Each subcontract shall contain the amount of compensation or other consideration that the subcontractor will receive under the terms of the subcontract with the prepaid health plans. These provisions shall not apply to a provider who is employed or salaried by the prepaid health plan. Unless the department objects, a prepaid health plan may enter into a subcontract in which consideration is determined by a percentage of the primary contractor's payment from the department. This subdivision shall not be construed to prohibit any subcontract in which consideration is determined on a capitation basis.

(3) Subcontracts between a prepaid health plan and the subcontractor shall be public records on file with the department. The names of the officers and owners of the subcontractor, stockholders owning more than 10 percent of the stock issued by the subcontractor, and major creditors holding more than 5 percent of the debt of the subcontractor shall be submitted by each prepaid health plan to the department and shall be public records on file with the department.

(b) A prepaid health plan that is not a qualified health maintenance organization pursuant to Title XIII of the federal Public Health Service Act shall submit all provider and management subcontracts to the department for approval prior to the subcontract taking effect.

(c) Each subcontract shall require that the subcontractor make all of its books and records pertaining to the goods and services furnished under the terms of the subcontract available for inspection, examination, or copying by the department during normal working hours at the subcontractor's place of business, or another mutually agreeable location in California.

(Amended by Stats. 2023, Ch. 266, Sec. 5. (AB 614) Effective January 1, 2024.)

14452.3. Each prepaid health plan shall provide the services of an optometrist and ophthalmologist when the prepaid health plan contract requires the provision of vision care services.

Vision care services shall be provided so that an enrollee may be seen initially by either a physician or an optometrist.

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

14452.4. Where the prepaid health plan agrees to provide dental services such services shall be provided in a manner that does not require the enrollees to receive prior screening or authorization by nondental personnel.

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

14452.5. Each prepaid health plan shall provide the services of a psychologist and psychiatrist when the prepaid health plan contract requires the provision of mental health services. Mental health services shall be provided so that an enrollee may be seen initially by either a physician or a psychologist, or by psychiatric social workers under qualified supervision as otherwise allowed by law.

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

14452.6. Prepaid health plans, or their subcontractors, shall not bill any enrollee for covered benefits provided under this chapter and for which capitation has been paid, except as provided in Article 7 (commencing with Section 14490) of this chapter. Health care providers shall not seek reimbursement from enrollees for any services provided under this chapter.

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

14453. In compensating directors and officers, the prepaid health plan shall not compensate at a rate substantially greater than the prevailing charge for similar services in the community. For purposes of this chapter, salaries or other compensation from the prepaid health plan and its subcontractors, excluding reasonable expenses, shall be considered as one.

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

14454. (a) The prepaid health plan shall be liable for all in-area and out-of-area emergency services which are required by the contract and rendered by a nonprepaid health plan provider. Payment for such services shall include treatment of emergency conditions and shall continue until such time as the enrollee may be transferred to any provider of the prepaid health plan.

(b) Where a dispute arises between the prepaid health plan and the nonprepaid health plan provider as to the liability of the prepaid health plan for such services, the nonprepaid health plan provider may submit the matter to the director for determination in the form of a claim documenting as fully as reasonably possible the nature of the emergency, the necessity for the treatment rendered, the appropriateness of the length of stay for inpatient care, the reason the patient could not have been transferred to a provider of the prepaid health plan, and including any response by the prepaid health plan to the claim which resulted in the dispute. The director shall, by regulation, provide for resolution of the dispute in a timely fashion and in a manner guaranteeing the procedural due process requirements of the provisions of Chapter 5 (commencing with Section 11500), Part 1, Division 3, Title 2 of the Government Code, except that the department shall use its own hearing officers. The hearing officer may be assisted by a physician. To the extent feasible, the director shall consolidate the claims of the nonprepaid health plan provider against the prepaid health plan.

In no event, shall the prepaid health plan or the nonprepaid health plan provider bill the enrollee for services which are or have been the subject of review by the director pursuant to this section.

(c) If the director determines that the prepaid health plan is liable for the emergency service, the plan shall reimburse the nonprepaid health plan provider within 30 days. If the prepaid health plan fails to reimburse the nonprepaid health plan provider within 30 days, the director shall arrange to set off the amount of the unpaid claim or claims from no fewer than two future capitation payments owed to the prepaid health plan by the department and the department shall forward such setoff or setoffs to the nonprepaid health plan provider. In making such arrangements to set off, the director shall consult with the affected prepaid health plan in an attempt to minimize the impact of such setoff or setoffs on cash flow. When the claim of the nonprepaid health plan provider is satisfied by setoff or setoffs, the director shall satisfy the claim only with the funds of the prepaid health plan and shall in no event use state funds to satisfy such a claim.

(d) Nothing in this section shall preclude prepaid health plans and nonprepaid health plan providers from entering into voluntary agreements to settle disputed claims for services by means of binding arbitration or by other means acceptable to both parties.

(Amended by Stats. 1977, Ch. 1121.)

14455. The prepaid health plan shall maintain a complete unit medical record for each enrollee. Enrollee medical records shall also include records of all treatment received from subcontractors. Such records shall be maintained and preserved in a manner prescribed by the director and shall be available for review by the department and the United States Department of Health, Education, and Welfare.

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

14456. The department shall conduct annual medical audits of each prepaid health plan unless the director determines there is good cause for additional reviews.

The reviews shall use the standards and criteria established pursuant to the Knox-Keene Health Care Service Plan Act of 1975, as appropriate. Except in those instances where major unanticipated administrative obstacles prevent, or after a determination by the director of good cause, the reviews shall be scheduled and carried out jointly with reviews carried out pursuant to the Knox-Keene Health Care Service Plan Act of 1975, if reviews will be carried out within time periods which satisfy the requirements of federal law.

The department shall be authorized to contract with professional organizations or the Department of Managed Health Care, as appropriate, to perform the periodic review required by this section. The department, or its designee, shall make a finding of fact with respect to the ability of the prepaid health plan to provide quality health care services, effectiveness of peer review, and utilization control mechanisms, and the overall performance of the prepaid health plan in providing health care benefits to its enrollees.

The director shall publicly report the findings of finalized annual medical audits conducted pursuant to this section as soon as possible, but no later than 90 days following completion of any corrective action plan initiated pursuant to the audit, if any, unless the director determines, in his or her discretion, that additional time is reasonably necessary to fully and fairly report the results of the audit.

(Amended by Stats. 2014, Ch. 573, Sec. 5. (SB 964) Effective January 1, 2015.)

14456.3. (a) The department shall share with the Department of Managed Health Care its findings from medical audits and monthly provider files of a Medi-Cal managed care plan that provides services to Medi-Cal beneficiaries pursuant to Chapter 7 (commencing with Section 14000) or this chapter and is subject to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(b) To the extent that the department communicates its preliminary investigative audit findings to the Department of Managed Health Care under subdivision (a), those communications shall be exempt from disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code).

(Amended by Stats. 2021, Ch. 615, Sec. 457. (AB 474) Effective January 1, 2022. Operative January 1, 2023, pursuant to Sec. 463 of Stats. 2021, Ch. 615.)

14456.5. (a) For purposes of this section, Medi-Cal managed care plan means any prepaid health plan or Medi-Cal managed care plan contracting with the department to provide services to enrolled Medi-Cal beneficiaries under Chapter 7 (commencing with Section 14000) or this chapter, or Part 4 (commencing with Section 101525) of Division 101 of the Health and Safety Code.

(b) The department shall ensure that coverage is provided for medically necessary prescription medications and related medically necessary medical services that are prescribed by a local mental health plan provider, and are within the Medi-Cal scope of benefits, but are excluded from coverage under Chapter 8.9 (commencing with Section 14700), by doing, at least, all of the following:

(1) Requiring Medi-Cal managed care plans to comply with the following standards:

(A) The decision regarding responsibility and coverage for a prescription drug shall be made by the Medi-Cal managed care plan within 24 hours, or one business day, from the date the request for a decision is received by telephone or other telecommunication device.

(B) The decision regarding responsibility and coverage for services, such as laboratory tests, that are medically necessary because of medications prescribed by a mental health provider, shall be made by the Medi-Cal managed care plan within seven days following the date the request for a decision is received by telephone or other telecommunication device.

(C) If the decision of the Medi-Cal managed care plan on the request is a deferral because of a determination that the Medi-Cal managed care plan needs more information, the Medi-Cal managed care plan shall transmit notice of the deferral, by facsimile or by other telecommunication system, to the pharmacist or other service provider, to the prescribing mental health provider, and to a designated mental health plan representative. The notice shall set out with specificity what additional information is needed to make a medical necessity determination.

(D) Any denial of authorization or payment for a prescription medication or for any services such as laboratory tests that may be medically necessary because of medications ordered by a mental health plan provider shall set forth the reasons for the denial with specificity. The denial notice shall be transmitted by facsimile or other telecommunication system to the pharmacist or other service provider, to the prescribing mental health provider, to a designated mental health plan representative, and by mail to the Medi-Cal beneficiary.

(E) For purposes of subsequent requests for a medication, the local mental health plan provider prescribing the prescription medication shall be treated as a plan provider under subdivision (a) of Section 1367.22 of the Health and Safety Code.

(F) If the decision cannot be made within five working days because of a request for additional information, any Medi-Cal managed care plan licensed pursuant to Division 2 (commencing with Section 1340) of the Health and Safety Code shall inform the enrollee as required by paragraph (5) of subdivision (h) of Section 1367.01 of the Health and Safety Code. In regard to any Medi-Cal managed care plan contract as described pursuant to subdivision (a) that is issued, amended, or renewed on or after January 1, 2001, with a plan not licensed pursuant to Division 2 (commencing with Section 1340) of the Health and Safety Code, if the decision cannot be made within five working days because of a request for additional information as specified in subparagraph (C), the plan shall notify the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization. All managed care plans shall, upon receipt of all information reasonably necessary for making the decision and that was requested by the plan, approve, modify, or deny the request for authorization within the timeframes specified in subparagraph (A) or (B), whichever applies.

(2) In consultation with the Medi-Cal managed care plans and local mental health plans, establishing a process to recognize credentialing of local mental health plan providers, for the purpose of expediting approval of medications prescribed by a local mental health plan provider who is not contracting with the Medi-Cal managed care plan. In implementing this requirement, the Medi-Cal managed care plan shall not be required to violate licensure, accreditation, or certification requirements of other entities.

(3) Requiring any Medi-Cal managed care plan to enter into a memorandum of understanding with the local mental health plan. The memorandum of understanding shall comply with applicable regulations.

(c) The department may sanction a Medi-Cal managed care plan for violations of this section pursuant to Section 14088.23 or 14197.7.

(d) Every Medi-Cal managed care plan that provides prescription drug benefits and that maintains one or more drug formularies shall provide to members of the public, upon request, a copy of the most current list of prescription drugs on the formulary of the Medi-Cal managed care plan, by therapeutic category, with an indication of whether any drugs on the list are preferred over other listed drugs. If the Medi-Cal managed care plan maintains more than one formulary, the plan shall notify the requester that a choice of formulary lists is available.

(e) This section shall apply to any contracts entered into, amended, modified, or extended on or after January 1, 2001.

(Amended by Stats. 2019, Ch. 465, Sec. 10. (AB 1642) Effective January 1, 2020.)

14457. (a) In addition to the reviews required or authorized by Section 14456, the department shall conduct periodic onsite visits or additional visits after a determination by the director of good cause by departmental representatives to include observation of the general operation of the prepaid health plan, the condition of the facilities for delivering health care, the availability of emergency services, the degree of satisfaction of the enrollees, the operation of the plan's grievance system, and the administrative and financial aspects of the operation of the prepaid health plan.

(b) Except when reviewing a plan's grievance system or marketing activities, this evaluation shall use standards and criteria established pursuant to the Knox-Keene Health Care Service Plan Act of 1975. Except in those instances where major, unanticipated administrative obstacles prevent, or after a determination by the director of good cause, the visits shall be scheduled and carried out jointly with reviews carried out pursuant to the Knox-Keene Health Care Service Plan Act of 1975, if reviews under that act will be carried out within time periods that satisfy the requirements of federal law.

(c) The State Department of Health Services may contract with the Department of Managed Health Care to perform the periodic visits required by this section.

(Amended by Stats. 2023, Ch. 266, Sec. 6. (AB 614) Effective January 1, 2024.)

14458. The prepaid health plan shall establish procedures for continuously reviewing the quality of care, performance of medical personnel, the utilization of services and facilities, and costs. Information derived from such review shall be made available to the department.

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

14459. (a) The prepaid health plan shall maintain financial records and shall have an annual audit or additional audits after a determination by the director of good cause, performed by an independent certified public accountant. A prepaid health plan operated by a public entity shall have an annual audit performed in a manner approved by the department. All certified financial statements shall be filed with the department as soon as practical after the end of the prepaid health plan's fiscal year and in any event, within a period not to exceed 90 days thereafter. These financial statements shall be filed with the department and shall be public records. The department shall perform routine auditing of prepaid health plan contractors and their affiliated subcontractors. Except in those instances where major unanticipated obstacles prevent, or after a determination by the director of good cause, the

audits shall be scheduled and carried out jointly with audits carried out pursuant to the Knox-Keene Health Care Service Plan Act of 1975, if audits under that act are carried out within time periods that satisfy the requirements of federal law. The department is authorized to contract with the Department of Managed Health Care to carry out the audits required by this section. The prepaid health plan shall make all of its books and records available for inspection, examination, or copying by the department during normal working hours at the prepaid health plan's principal place of business or at such other place in California as the department shall designate. For good cause, the department may grant an exception to the time when annual financial statements are to be submitted to the department. The annual report required in Section 14313 shall include an itemization of expenditures made by each prepaid health plan for the following categories of expenditures: physician services, inpatient and outpatient hospital services, pharmaceutical services and prescription drugs, dental services, medical transportation services, vision care services, mental health services, laboratory services, X-ray services, enrollee education programs, marketing and enrollment costs, data-processing costs, other administrative costs and health service expenditures and any payments made to subcontractors, and the purposes of the payments, including, but not limited to, contributions to election campaigns.

(b) The requirements of a financial and administrative review by the department of any health care service plan licensed by the Director of the Department of Managed Health Care pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code may be waived upon submission of the financial audit for the same period conducted by the Department of Managed Health Care pursuant to Section 1382 of the Health and Safety Code.

(Amended by Stats. 2023, Ch. 266, Sec. 7. (AB 614) Effective January 1, 2024.)

14459.5. (a) As delegated by the federal government, the department has responsibility for monitoring the quality of all Medicaid services provided in the state. A key component of this monitoring function is the performance of annual, independent, external reviews of the quality of services furnished under each state contract with a health maintenance organization, as specified by the federal Centers for Medicare and Medicaid Services.

(b) In accordance with Section 438.332 of Title 42 of the Code of Federal Regulations, the department shall require, through its contracts, that each managed care plan inform the department whether it has been accredited by a private independent accrediting entity.

(c) In accordance with Section 438.332 of Title 42 of the Code of Federal Regulations, the department shall require, through its contracts, that each managed care plan that has received accreditation by a private independent accrediting entity shall authorize the private independent accrediting entity to provide the department a copy of its most recent accreditation review, including all of the following:

(1) Accreditation status, survey type, and level, as applicable.

(2) Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings.

(3) Expiration date of the accreditation.

(d) The Legislature finds and declares that the final report obtained from the external reviews will provide valid and reliable information regarding health care outcomes and the overall quality of care delivered by the managed care plans.

(e) The department shall make the final report of each external review available, within 30 calendar days of completion, to the fiscal and health policy committees of the Legislature.

(f) In accordance with Section 438.332 of Title 42 of the Code of Federal Regulations, the department shall make the accreditation status for each contracted entity available on its Internet Web site, including whether each entity has been accredited, and if applicable, the name of the accrediting entity, accreditation program, and accreditation level. The department shall update this information at least annually.

(g) Subdivisions (b), (c), and (f) shall be effective for the rating period for managed care plan contracts beginning on or after July 1, 2017.

(Amended by Stats. 2017, Ch. 511, Sec. 30. (AB 1688) Effective January 1, 2018.)

14459.6. (a) The department shall establish a list of performance measures to ensure dental health plans meet quality criteria required by the department. The list shall specify the benchmarks used by the department to determine whether and the extent to which a dental health plan meets each performance measure. Commencing January 1, 2013, and quarterly thereafter, the list of performance measures established by the department along with each plan's performance shall be posted on the department's Internet Web site. The Department of Managed Health Care and the advisory committee established pursuant to Section 14089.08 shall have access to all performance measures and benchmarks used by the department as described in this section.

(1) Commencing April 30, 2017, the quarterly reporting required by this subdivision shall be posted in the following manner:

(A) On or before April 30, 2017, the reporting shall be posted for the July 2016 to September 2016, inclusive, fiscal quarter.

(B) After April 30, 2017, the reporting shall be posted on a quarterly basis on or before April 30, July 31, October 31, and January 31 for the fiscal quarter ending seven months prior.

(2) The performance measures established by the department shall include, but not be limited to, all of the following: provider network adequacy, overall utilization of dental services, annual dental visits, the total number of patients seen on a per-provider basis and the total number of dental services rendered by each provider during each calendar year, use of preventive dental services, use of dental treatment services, use of examinations and oral health evaluations, sealant to restoration ratio, filling to preventive services ratio, treatment to caries prevention ratio, use of dental sealants, use of diagnostic services, and survey of member satisfaction with plans and providers.

(3) The survey of member satisfaction with plans and providers shall be the same dental version of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey as used by the Healthy Families Program.

(4) The department shall notify dental health plans at least 30 days prior to the implementation date of these performance measures.

(5) The department shall include the initial list of performance measures and benchmarks in any dental health contracts entered into between the department and a dental health plan pursuant to Section 14204.

(6) The department shall update performance measures and benchmarks and establish additional performance measures and benchmarks in accordance with all of the following:

(A) The department shall consider performance measures and benchmarks established by other states, the federal government, and national organizations developing dental program performance and quality measures.

(B) The department shall notify dental health plans at least 30 days prior to the implementation date of updates or changes to performance measures and benchmarks. The department shall also post these updates or changes on its Internet Web site at least 30 days prior to implementation in order to provide transparency to the public.

(C) To ensure that the dental health needs of Medi-Cal beneficiaries are met, the department shall, when evaluating performance measures and benchmarks for retention on, addition to, or deletion from the list, consider all of the following criteria:

(i) Monthly, quarterly, annual, and multiyear Medi-Cal dental managed care trended data.

(ii) County and statewide Medi-Cal dental fee-for-service performance and quality ratings.

(iii) Other state and national dental program performance and quality measures.

(iv) Other state and national performance ratings.

(b) In establishing and updating the performance measures and benchmarks, the department shall consult the advisory committee established pursuant to Section 14089.08, as well as dental health plan representatives and other stakeholders, including representatives from counties, local dental societies, nonprofit entities, legal aid entities, and other interested parties.

(c) In evaluating a dental health plan’s ability to meet the criteria established through the performance measures and benchmarks, the department shall select specific performance measures from those established by the department in subdivision (a) as the basis for establishing financial or other incentives or disincentives, including, but not limited to, bonuses, payment withholds, and adjustments to beneficiary assignment to plan algorithms. These incentives and disincentives shall be included in the dental health plan contracts.

(d) (1) The department shall designate a qualified external quality review organization (EQRO) that shall conduct external quality reviews for any dental health plan contracting with the department pursuant to Section 14204.

(2) As determined by the department, but at least annually, dental health plans shall arrange for an external quality of care review with the EQRO designated by the department that evaluates the dental health plan’s performance in meeting the performance measures established in this section. Dental health plans shall cooperate with and assist the EQRO in this review. The Department of Managed Health Care shall have direct access to all external quality of care review information upon request to the department.

(3) (A) No later than July 1, 2018, the department shall require that the dental EQRO shall have sufficient information to use in performing the review, and the department shall require the external quality review (EQR) to comply with the following requirements:

(i) The information used to carry out the review shall be obtained from the EQR-related activities in accordance with federal Medicaid regulations, including Section 438.358 of Title 42 of the Code of Federal Regulations, or, if applicable, from a

Medicare or private accreditation review as authorized under Section 438.360 of Title 42 of the Code of Federal Regulations.

(ii) For each EQR-related activity, the information gathered for use in the EQR shall include the elements described in federal Medicaid regulations, including the elements described in Section 438.364(a)(2)(i) to (iv), inclusive, of Title 42 of the Code of Federal Regulations.

(iii) The information provided to the EQRO in accordance with this paragraph is obtained through methods consistent with the protocols established by the federal Secretary of Health and Human Services in accordance with federal Medicaid regulations, including Section 438.352 of Title 42 of the Code of Federal Regulations.

(iv) The results of the reviews are made available as specified in federal Medicaid regulations, including Section 438.364 of Title 42 of the Code of Federal Regulations.

(B) The qualified EQRO shall produce and submit to the department an annual EQR technical report in accordance with Section 438.364(a) of Title 42 of the Code of Federal Regulations. The department shall finalize the annual technical report by April 30 of each year.

(C) Once the annual technical report is finalized, the department shall post by April 30 of each year the most recent copy of the annual EQR technical report on the Internet Web site required under Section 438.10(c)(3) of Title 42 of the Code of Federal Regulations.

(D) An external quality of care review shall include, but not be limited to, all of the following: performance on the selected performance measures and benchmarks established and updated by the department, the CAHPS member or consumer satisfaction survey referenced in paragraph (2) of subdivision (a), reporting systems, and methodologies for calculating performance measures. An external quality of care review that includes all of the above components shall be paid for by the dental health plan and posted online annually, or at any other frequency specified by the department, on the department's Internet Web site. The department shall provide printed or electronic copies of the information specified under Section 438.364(a) of Title 42 of the Code of Federal Regulations, upon request, to interested parties, such as participating health care providers, enrollees and potential enrollees of the managed care plan entity, beneficiary advocacy groups, and members of the general public.

(E) The department shall make the information specified in Section 438.364(a) of Title 42 of the Code of Federal Regulations available in alternative formats for persons with disabilities, when requested.

(e) All marketing methods and activities to be used by dental plans shall comply with subdivision (b) of Section 10850, Sections 14407.1, 14408, 14409, 14410, and 14411, and Title 22 of the California Code of Regulations, including Sections 53880 and 53881 of Title 22 of the California Code of Regulations. Each dental plan shall submit its marketing plan to the department for review and approval.

(f) Each dental plan shall submit its member services procedures, beneficiary informational materials, and any updates to those procedures or materials to the department for review and approval. The department shall ensure that member services procedures and beneficiary informational materials are clear and provide timely and fair processes for accepting and acting upon complaints, grievances, and disenrollment requests, including procedures for appealing decisions regarding coverage or benefits.

(g) Each dental plan shall submit its provider compensation agreements to the department for review and approval.

(h) The department shall post on its Internet Web site a copy of all final reports completed by the Department of Managed Health Care regarding dental managed care plans.

(i) The department shall ensure, to the greatest degree possible, that the categories of data and performance measures selected under this section are consistent with the categories of data and performance measures selected under Section 14132.915.

(Amended by Stats. 2017, Ch. 511, Sec. 31. (AB 1688) Effective January 1, 2018.)

14459.7. (a) The department shall implement a Management Information System/Decision Support System (MIS/DSS) for the Medi-Cal Program, that shall integrate data from managed care plans to monitor and evaluate the quality of care provided to beneficiaries, including access to services, establish provider rates, and analyze ways to improve both the managed care and fee-for-service systems.

(b) The department shall provide the fiscal and health policy committees of the Legislature with an annual progress and status report on the implementation of the MIS/DSS. The annual progress and status report shall include a description of the current status of the project, including a list of the specific project objectives that have and have not been met at the time of the report and a comparison of the actual progress of the project with the most recent project schedule approved by the Legislature. The report also shall include estimated expenditures and staffing for the current fiscal year and proposed expenditures and staffing for the next fiscal year as well

as a summary of cumulative total project expenditures to date and a projection of future expenditures necessary to complete the project.

(c) The department shall provide system or information access to the fiscal and health policy committees of the Legislature, with the most cost-effective technology available, by the conclusion of the third phase of this multiphase project. Access shall include both the management information system and ad hoc report systems, or their equivalent, with safeguards to block access to individual patient identities. Public access shall be provided to at least the management information system summary presentation, or an equivalent, by the time of project completion.

(Added by Stats. 1997, Ch. 294, Sec. 78. Effective August 18, 1997.)

14459.8. (a) By no later than March 15, 2013, with annual updates thereafter, the department shall provide the fiscal and appropriate policy committees of the Legislature with either a comprehensive report or separate reports on dental managed care in the Counties of Sacramento and Los Angeles. This report shall articulate specific changes and improvements implemented to increase Medi-Cal beneficiary access to preventive services and dental treatment, the utilization of services, and beneficiary satisfaction. Key measures, outcomes, and department findings pertaining to participating dental managed care plans and provider networks shall also be included.

(b) Any report provided pursuant to subdivision (a) on the County of Sacramento shall also provide data regarding the outcomes and findings from the beneficiary dental exception (BDE) process implemented by the department pursuant to Section 14089.09, including the consideration of voluntary enrollment in the County of Sacramento as compared to the existing mandatory enrollment.

(c) The department may seek foundation funding or federal grant funding to facilitate data analysis and reporting as applicable for this purpose.

(Added by Stats. 2012, Ch. 23, Sec. 115. (AB 1467) Effective June 27, 2012.)

14460. A schedule of reviews, visits, and audits shall be jointly established by the Department of Managed Health Care or the Department of Insurance, as the case may be, and the State Department of Health Services. Nothing in Section 14456, 14457, or 14459 shall be construed to prohibit the State Department of Health Services from conducting reviews, visits, or audits either jointly or individually, for the purpose of following up on findings resulting from reviews, visits, or audits carried out in accordance with this chapter.

(Amended by Stats. 2000, Ch. 857, Sec. 96. Effective January 1, 2001.)

14461. Upon request by the department, each prepaid health plan shall submit to the department a copy of any financial report submitted to any other public or private organization, if such report differs in content or format from any financial report already submitted to the department.

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

14462. In accordance with Section 14081.5, the provisions of Section 15459 of the Government Code shall not be applicable to a hospital, whether or not it negotiates to obtain a contract pursuant to Article 2.6 (commencing with Section 14081), if the hospital predominantly serves or will predominantly serve members of a health maintenance organization that has negotiated in good faith to obtain a prepaid contract pursuant to this part or pursuant to Article 2.91 (commencing with Section 14089).

(Added by Stats. 1983, Ch. 1018, Sec. 3. Effective September 22, 1983.)

14463. (a) Except as otherwise provided in this chapter, each prepaid health plan shall be responsible for all of the costs of services rendered under the provisions of this chapter to any Medi-Cal beneficiary enrolled in the plan.

(b) The department shall bear the costs of providing to each Medi-Cal beneficiary enrolled in a prepaid health plan the services covered under the plan, to the extent that the aggregate of these costs, based on Medi-Cal reimbursement levels, and exclusive of third-party recoveries, exceeds the 12-month risk limit. The risk limit shall not exceed twenty-five thousand dollars ($25,000) based on Medi-Cal reimbursement levels, shall be specified in the contract between the department and the plan, and shall be determined concurrently with the annual determination of rates of payment.

The department shall have the authority to adopt regulations to increase the risk limit, to an amount not to exceed thirty-five thousand dollars ($35,000). Regulations to increase the risk limit shall be based upon and supported by changes in prepaid health plan rates paid by the department and changes in the medical component of the Consumer Price Index (CPI) as actuarially determined by the department. It is the intent of the Legislature that these risk limit adjustments are not to exceed thirty-five thousand dollars ($35,000) until the 1986–87 fiscal year or beyond. For plans having contracts in existence on the effective date of this section, the risk limit shall be announced on or before the first day of each state fiscal year, to become effective concurrently with the effective date for the new rates of payment for the next succeeding state fiscal year.

The department may negotiate with a prepaid health plan a mutually agreed-to risk limit in an amount in excess of thirty-five thousand dollars ($35,000).

Within 90 days of the receipt of the documentation required under paragraph (2), the department shall pay the reimbursement provided for by this section to the extent that it determines that the services rendered were medically necessary, and that the amount of the payments sought for those services is reasonable. The department may, if a dispute exists as to whether the services rendered were medically necessary or if the amount of the payments for those services was reasonable, delay paying the reimbursement for such services until a final determination of the dispute is made.

(1) Each prepaid health plan shall arrange and provide initial payment, at Medi-Cal reimbursement levels, for medically necessary care for any Medi-Cal beneficiary enrolled in the plan when the cost for this care exceeds the 12-month risk limit. No person shall be disenrolled by any prepaid health plan for the sole reason that the cost of his or her care under the plan has exceeded the risk limit.

(2) As a condition of reimbursement for costs of care in excess of the risk limit as to a Medi-Cal beneficiary enrolled in a prepaid health plan, the plan must submit to the department, in a format to be designated by the department, documentation of all costs incurred for services to the beneficiary during the 12-month period.

(c) No prepaid health plan may enter into any subcontract that would in any way limit its obligation assumed under this chapter to retain the significant risk of the cost of services rendered under this chapter to any Medi-Cal beneficiary enrolled in the plan.

(d) As a condition of the department's approval of any subcontract entered into by a prepaid health plan under this chapter, the plan shall specify its retention of significant risk by designating one of the options under subdivision (e) as its operating definition of significant risk, or by any other method approved by the department that would meet the requirement set forth in subdivision (c).

(e) "Significant risk" means financial responsibility for either of the following:

(1) All expenditures in excess of 115 percent of the specified total expenditures estimated under each subcontract.

(2) All inpatient hospitalization expenditures as determined by the department, including expenditures for services connected with hospitalization.

(Added by renumbering Section 14462 (as amended by Stats. 1985, Ch. 1579) by Stats. 1986, Ch. 248, Sec. 272.)

14464. (a) The department may negotiate and establish an individual administrative cost limit in its contracts with each prepaid health plan or Medi-Cal managed care plan contracting under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) providing services to Medi-Cal beneficiary enrollees.

(b) As used in this section, prepaid health plan or Medi-Cal managed care plan "administrative costs" includes net profit or revenue in excess of expenditures, in addition to those items set forth in Section 1300.78 of Title 10 of the California Code of Regulations and those items set forth by the director.

(Added by Stats. 1995, Ch. 859, Sec. 10. Effective January 1, 1996.)