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 3. Administration [14300 - 14316] *(Article 3 repealed and added by Stats. 1974, Ch. 983.)*

14300. The department shall publish a notice of intent to contract at least 60 days prior to the effective date of any initial or renewed contract. The notice shall appear in local newspapers circulated in the service areas of the prepaid health plan. The notice shall announce the department's intent to contract and any person affected by the contract shall have the opportunity to request that a public hearing be held. The request for public hearing shall be accompanied by an explanation of the reason for the request and a description of problems or questions regarding the plan's ability to meet its contractual obligations. A hearing shall be held by the department if the director determines that the request is reasonable and warrants a full public hearing. A request shall be considered reasonable if there is a question regarding the plan's ability to meet its contractual obligations.

No contract shall be signed by the department until the department determines that the plan has the ability to fully comply with its contractual obligations.

(Amended by Stats. 1984, Ch. 1338, Sec. 4.)

14301. (a) The department shall determine, by actuarial methods, prospective per capita rates of payment for services provided under this chapter for Medi-Cal beneficiaries enrolled in a prepaid health plan. The rates of payment shall be determined annually, shall be effective no later than either the first day of July each year, or another date chosen by the department, and shall not exceed the total per capita amount (including cost of administration) which the department estimates (with appropriate adjustments to provide actuarial equivalence) would be payable for all services and requirements covered under the prepaid health plan contract if all such services and requirements were to be furnished to Medi-Cal beneficiaries under the fee-for-service Medi-Cal program provided for by Chapter 7 (commencing with Section 14000).

In the event that there is any delay in the payment of the new annual rates determined pursuant to this subdivision, continued payment to the prepaid health plan of the rate in effect at the time the delay occurred shall be interim payment only, and shall be subject to increase or decrease, as the case may be, to the level of the new annual rates effective as of either the first day of July or the date chosen by the department.

Notwithstanding the foregoing provision, in the event that a contract amendment providing for the new annual rates has been executed by the department and a prepaid health plan, but has not yet received the approval of all required control agencies and departments by the end of the first month following the effective date of the new rate, payment of the new annual rates shall commence no later than the first day of the second month following the effective date of the new rate. Contract amendments providing for the new annual rates shall provide that the prepaid health plan contractor agrees that by accepting payment of the new annual rates prior to final approval, such contractor stipulates to a confession of judgment for any amounts received in excess of the final approved rate. If the final approved rates differ from the rates set forth in such amendments, any underpayment by the state shall be paid by the department to the prepaid health plan within 30 days after final approval of such rates. Any overpayment by the state shall be recaptured by the state withholding the amount due from the prepaid health plan's next capitation check. If the amount to be withheld from subsequent capitation checks exceeds 25 percent of the appropriate capitation payment for that month, amounts up to 25 percent shall be withheld from each successive monthly capitation payment until such deficiencies are recovered by the state.

The contract shall provide the specific per capita rates, to be determined by sound actuarial methods on the basis of age, sex, and aid categories, which the state shall pay the prepaid health plan each month for each beneficiary enrolled in the prepaid health plan, a detailed description of the specific actuarial method or methods and assumptions used in determining per capita rates, and a summary of the data base, including costs and inflation assumptions and utilization rates, which was used to determine per capita

rates. In addition, the director shall engage and rely upon the services of an actuary or consulting actuary in determining prospective per capita rates.

(b) Any prepaid health plan with an operating experience and scale of operation deemed by the department to be insufficient to justify the application of an actuarially determined per capita rate, shall be reimbursed on a cost basis up to the fee-for-service maximum for services provided until such time as the director determines that a per capita method is reasonable, but not to exceed a period of one year. For purposes of this section, costs shall be net of intercompany profits in those circumstances where any of the following persons have a substantial financial interest, as defined by Section 14478, in any vendor to the prepaid health plan or any vendor to a subcontractor of the plan:

(1) Any person also having a substantial financial interest in the plan.

(2) Any director, officer, partner, trustee or employee of the plan.

(3) Any member of the immediate family of any person designated in paragraph (1) or (2).

(c) The obligations of a prepaid health plan shall be changed only by contract or contract amendment. Any such change may be made during a contract term or at the time of contract renewal, where there is a change in obligations required by federal or state law or regulation, or required by a change in the interpretation or implementation of any such law or regulation. If any such change in obligations occurs which affects the cost to a prepaid health plan of performing under the terms of its contract, then the per capita rates under the contract may be redetermined in the manner provided by subdivision (a) to reflect such change. During such period of time as is required to redetermine the per capita rates, payment to a prepaid health plan of the per capita rates in effect at the time such change occurred shall be considered interim payments and shall be subject to increase or decrease, as the case may be, effective as of the date on which such change is effective.

(d) The obligations of a prepaid health plan shall be changed only by contract or contract amendment wherein payment for the changes, whether payment results in an increase or decrease in the prior per capita rates paid to a prepaid health plan, shall be determined in accordance with this section and paid to affected prepaid health plans.

(e) Nothing contained in this section shall be construed as removing from a prepaid health plan the risk of beneficial or adverse effects, including inflation, which normally result from contracting to furnish health services.

(f) Per capita rates of payment for services provided to Medi-Cal beneficiaries enrolled in prepaid health plans or Medi-Cal managed care plans contracting in areas specified by the director for expansion of the Medi-Cal managed care program under Section 14087.3 or contracting under Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, 14087.96, 14089, and 14089.05 shall be paid by the state effective the date a beneficiary's enrollment takes effect. A primary care provider or clinic contracting with a prepaid health plan or a Medi-Cal managed care plan on a capitation basis and whose assignment to or selection by a beneficiary has been confirmed by the plan shall be paid capitation payments effective the date of the beneficiary's enrollment. However, a primary care provider whose assignment to or selection by a beneficiary was not confirmed by the plan on the date of the beneficiary's enrollment, but is later confirmed by the plan, shall be paid capitation payments effective no later than 30 days after the beneficiary's enrollment. The prepaid health plan or Medi-Cal managed care plan shall be financially responsible for all Medi-Cal services covered under the contract with the department for any newly enrolled beneficiary until that beneficiary has a confirmed assignment to a primary care provider or clinic. This subdivision shall not apply when a beneficiary requests a change in primary care provider after initial selection or assignment.

(Amended by Stats. 1995, Ch. 859, Sec. 7. Effective January 1, 1996.)

14301.1. (a) For rates established on or after August 1, 2007, the department shall pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods and may establish health-plan- and county-specific rates. Notwithstanding any other law, this section shall apply to any 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 contracted with the department as a primary care case management plan pursuant to Article 2.9 (commencing with Section 14088) of Chapter 7 to provide services to beneficiaries who are HIV positive or who have been diagnosed with AIDS for rates established on or after July 1, 2012. The department shall utilize a county- and model-specific rate methodology to develop Medi-Cal managed care capitation rates for contracts entered into between the department and any entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7 that includes, but is not limited to, all of the following:

(1) Health-plan-specific encounter and claims data.

(2) Supplemental utilization and cost data submitted by the health plans.

(3) Fee-for-service data for the underlying county of operation or other appropriate counties as deemed necessary by the department.

(4) Department of Managed Health Care financial statement data specific to Medi-Cal operations.

(5) Other demographic factors, such as age, gender, or diagnostic-based risk adjustments, as the department deems appropriate.

(b) To the extent that the department is unable to obtain sufficient actual plan data, it may substitute plan model, similar plan, or county-specific fee-for-service data.

(c) The department shall develop rates that include administrative costs, and may apply different administrative costs with respect to separate aid code groups.

(d) The department shall develop rates that shall include, but are not limited to, assumptions for underwriting, return on investment, risk, contingencies, changes in policy, and a detailed review of health plan financial statements to validate and reconcile costs for use in developing rates.

(e) The department may develop rates that pay plans based on performance incentives, including quality indicators, access to care, and data submission.

(f) The department may develop and adopt condition-specific payment rates for health conditions, including, but not limited to, childbirth delivery.

(g) (1) Before finalizing Medi-Cal managed care capitation rates, the department shall provide health plans with information on how the rates were developed, including rate sheets for that specific health plan, and provide the plans with the opportunity to provide additional supplemental information.

(2) For contracts entered into between the department and any entity pursuant to Article 2.8 (commencing with Section 14087.5) of Chapter 7, the department, by June 30 of each year, or, if the budget has not passed by that date, no later than five working days after the budget is signed, shall provide preliminary rates for the upcoming fiscal year.

(h) For the purposes of developing capitation rates through implementation of this ratesetting methodology, Medi-Cal managed care health plans shall provide the department with financial and utilization data in a form and substance as deemed necessary by the department to establish rates. These data shall be considered proprietary and shall be exempt from disclosure as official information pursuant to Section 7927.705 of the Government Code as contained in the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code).

(i) Notwithstanding any other law, on and after the effective date of the act adding this subdivision, the department may apply this section to the capitation rates it pays under any managed care health plan contract.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may set and implement managed care capitation rates, and interpret or make specific this section and any applicable federal waivers and state plan amendments by means of plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action.

(k) (1) The department shall report, upon request, to the fiscal and policy committees of the respective houses of the Legislature regarding implementation of this section.

(2) The department shall publish on its public internet website a description of the rate methodology, data used for rate development, and core actuarial assumptions and adjustments in each year that the department develops rates pursuant to this section.

(l) Before October 1, 2011, the risk-adjusted countywide capitation rate shall comprise no more than 20 percent of the total capitation rate paid to each Medi-Cal managed care plan.

(m) (1) It is the intent of the Legislature to preserve the policy goal to support and strengthen traditional safety net providers who treat high volumes of uninsured and Medi-Cal patients when Medi-Cal enrollees are defaulted into Medi-Cal managed care plans.

(2) As the department adds additional factors, such as managed care plan costs, to the Medi-Cal managed care plan default assignment algorithm, it shall consult with the Auto Assignment Performance Incentive Program stakeholder workgroup to develop cost factor disregards related to intergovernmental transfers and required wraparound payments that support safety net providers.

(n) (1) The department shall develop and pay capitation rates to entities contracted pursuant to Chapter 8.75 (commencing with Section 14591), using actuarial methods and in a manner consistent with this section, except as provided in this subdivision.

(2) (A) The department may develop capitation rates using a standardized rate methodology across managed care plan models for comparable populations. The specific rate methodology applied to PACE organizations shall address features of PACE that distinguishes it from other managed care plan models.

(B) The rate methodology shall be consistent with actuarial rate development principles and shall provide for all reasonable, appropriate, and attainable costs for each PACE organization within a region.

(3) The department may develop statewide rates and apply geographic adjustments, using available data sources deemed appropriate by the department. Consistent with actuarial methods, the primary source of data used to develop rates for each PACE organization shall be its Medi-Cal cost and utilization data or other data sources as deemed necessary by the department.

(4) Rates developed pursuant to this subdivision shall reflect the level of care associated with the specific populations served under the contract.

(5) The rate methodology developed pursuant to this subdivision shall contain a mechanism to account for the costs of high-cost drugs and treatments.

(6) Rates developed pursuant to this subdivision shall be actuarially certified before implementation.

(7) The department shall consult with those entities contracted pursuant to Chapter 8.75 (commencing with Section 14591) in developing a rate methodology according to this subdivision.

(8) Consistent with the requirements of federal law, the department shall calculate an upper payment limit for payments to PACE organizations. In calculating the upper payment limit, the department shall correct the applicable data as necessary and shall consider the risk of nursing home placement for the comparable population when estimating the level of care and risk of PACE participants.

(9) The department shall pay the entity at a rate within the certified actuarially sound rate range developed with respect to that entity, to the extent consistent with federal requirements and subject to paragraph (11), as necessary to mitigate the impact to the entity of the methodology developed pursuant to this subdivision.

(10) During the first two years in which a new PACE organization or existing PACE organization enters a previously unserved area, the department shall pay at a rate within the certified actuarially sound rate range developed with respect to that entity, to the extent consistent with federal requirements and subject to paragraph (11), to reflect the lower enrollment and higher operating costs associated with a new PACE organization relative to a PACE organization with higher enrollment and more experience providing managed care interventions to its beneficiaries.

(11) This subdivision shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available.

(12) This subdivision shall apply for rates implemented no earlier than January 1, 2017.

(o) (1) Notwithstanding any other law, as a component of the CalAIM Initiative authorized pursuant to Article 5.51 (commencing with Section 14184.100) of Chapter 7, and any successor waiver, demonstration, or state plan amendment authorizing the Medi-Cal managed care program, the department may establish capitation rates to contracted health plans on a regional basis in lieu of health plan and county-specific rates.

(2) Before initially implementing regional-based capitation rates under this subdivision, the department shall report to the Legislature on the process for developing those regional rates and determining the regional groups.

(3) The department shall provide a briefing to providers and stakeholders, including, but not limited to, physicians, hospitals, and consumer advocates, that describes the actuarial assumptions and rate methodologies used by the department following submission of rates to the federal government for approval that initially implement regional-based capitation rates under this subdivision. This publicly noticed meeting to providers and other stakeholders shall occur no more than 60 days after submission of the capitation rates to the federal government for approval. The meeting shall be for explanatory purposes and shall not otherwise impact the methodology and data provided to the federal government for approval.

(4) The department shall consult with affected contracted health plans in developing the regional groups and rate methodologies, consistent with applicable federal requirements, actuarial methods, and the CalAIM Terms and Conditions as defined in subdivision (c) of Section 14184.101 prior to implementing this subdivision. In developing and implementing any methodology pursuant to this subdivision, the department shall seek to incentivize improved quality and outcomes for Medi-Cal managed care enrollees.

(5) This subdivision shall be implemented only to the extent that the department obtains any necessary federal approvals, and that federal financial participation is available and not otherwise jeopardized.

(p) (1) It is the intent of the Legislature that both affected contracted health plans and the state have appropriate actuarial protections against the risk of either significant overpayments or significant underpayments in capitation rates developed and paid pursuant to this section that are associated with the changes to the Medi-Cal managed care program described in Article 5.51 (commencing with Section 14184.100) of Chapter 7, as identified by the department.

(2) (A) Notwithstanding any other law, as a component of the CalAIM initiative authorized pursuant to Article 5.51 (commencing with Section 14184.100) of Chapter 7, and any successor waiver, demonstration, or state plan amendment authorizing the Medi-Cal managed care program, the department may develop and implement appropriate actuarial methods to prevent significant overpayments or significant underpayments as described in paragraph (1), subject to paragraph (4). This may include, but need not be limited to, one or more of the following:

(i) A medical or profit and loss risk corridor.

(ii) Blended capitation rates based on projected member risk.

(iii) Other prospective or retrospective shared savings or risk models.

(B) The methods or models described in subparagraph (A) shall seek to encourage quality improvement and promote appropriate utilization incentives, including, but not limited to, reduced rehospitalization and shorter lengths of institutional stay.

(3) The department shall consult with affected contracted health plans in implementing this subdivision.

(4) This subdivision shall be implemented only to the extent that the department obtains any necessary federal approvals, and that federal financial participation is available and not otherwise jeopardized.

(Amended by Stats. 2022, Ch. 28, Sec. 163. (SB 1380) Effective January 1, 2023.)

14301.11. (a) Notwithstanding any law, and subject to subdivisions (e) and (f), in order to account for the impacts of the COVID-19 public health emergency on Medi-Cal managed care capitation rates, the department shall develop and pay capitation rates and capitation increments under any Medi-Cal managed care plan contract pursuant to this section.

(b) In consultation with affected Medi-Cal managed care plans, the department shall develop and implement a risk corridor that is symmetrical to risk and profit to limit the financial risk of either significant capitation rate overpayments or underpayments, pursuant to both of the following:

(1) The risk corridor shall apply to those capitation increments, services and populations, as determined by the department.

(2) The risk corridor shall apply from July 1, 2019, to December 31, 2020, inclusive. The department may continue to apply the risk corridor for rating periods starting on or after January 1, 2021, if the department determines that the continuation of the risk corridor is actuarially appropriate and necessary to account for the impacts of the COVID-19 public health emergency.

(c) To the extent the department determines appropriate, the department shall reduce applicable capitation rate increments by up to 1.5 percent pursuant to subsection (c)(3) of Section 438.7 of Title 42 of the Code of Federal Regulations for capitation rates associated with the July 1, 2019, to December 31, 2020 rating period. The department may apply this reduction to rating periods starting on or after January 1, 2021, if the department determines that the continued reduction is actuarially appropriate and necessary to account for the impacts of the COVID-19 public health emergency.

(d) The department shall evaluate the impact of the COVID-19 public health emergency on capitation rates it develops and pays under Medi-Cal managed care plan contracts, and shall make any adjustments it determines are necessary to ensure capitation rates are actuarially appropriate.

(e) (1) This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(2) The department shall seek any federal approvals it deems necessary to implement the adjustments described in this section, subject to subdivision (f). If federal approval is unavailable with respect to one or more of the adjustments described in this section, or if one or more of the adjustments is held to be invalid or unconstitutional by a decision of a court of competent jurisdiction, the department shall implement the remaining adjustments for which any necessary federal approvals are obtained.

(f) The department, in consultation with the Department of Finance, may modify the requirements of this section, or modify any application of this section with respect to certain capitation rate increments, certain Medi-Cal managed care enrollee categories and subcategories of aid, or certain categories or subcategories of medical assistance provided under a Medi-Cal managed care plan contract, if the department determines necessary to meet federal requirements, to obtain or maintain federal approval, or to maximize federal financial participation.

(g) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-county letters, plan letters, provider bulletins, or other similar instructions, without taking any further regulatory action.

(h) For purposes of this section, the following definitions apply:

(1) “COVID-19 public health emergency” means the Public Health Emergency declared by the federal Secretary of Health and Human Services on January 31, 2020 pursuant to Section 247d of Title 42 of the United States Code (entitled “Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus”), and any subsequent renewal of such declaration.

(2) “Medi-Cal managed care plan” means any individual, organization, or entity that enters into a comprehensive risk contract with the department to provide covered full-scope health care services to enrolled Medi-Cal beneficiaries pursuant to Chapter 7 (commencing with Section 14000) or this chapter.

(Added by Stats. 2020, Ch. 12, Sec. 68. (AB 80) Effective June 29, 2020.)

14301.2. (a) The director may defer fee-for-service payments or payments to Medi-Cal managed care health plans contracting with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), Article 2.9 (commencing with Section 14088), or Article 2.91 (commencing with Section 14089) of this chapter, or Chapter 8 (commencing with Section 14200) or Chapter 8.75 (commencing with Section 14591), the Senior Care Action Network Health Plan, and Medi-Cal managed care health plan providers, as applicable, which are payable during the final month of the state fiscal year. This section may be implemented only to the extent consistent with federal law.

(b) Notwithstanding subdivisions (c) and (d) of Section 34 of Chapter 37 of the Statutes of 2013, this section shall not be made inoperative as a result of any determination made by the Director of Finance pursuant to Section 34 of Chapter 37 of the Statutes of 2013.

(Amended by Stats. 2017, Ch. 52, Sec. 76. (SB 97) Effective July 10, 2017.)

14301.3. The department shall ensure that Medi-Cal managed care plans demonstrate ongoing ability and readiness to perform the obligations set forth in Section 14132.195. The department shall, as may be appropriate and in its discretion, adjust the capitation rate of a Medi-Cal managed care plan to promote improved outcomes through value-based purchasing payment protocols to create improved incentives for outcomes.

(Added by Stats. 2019, Ch. 387, Sec. 4. (AB 1004) Effective January 1, 2020.)

14301.4. (a) It is the intent of the Legislature, to the extent federal financial participation is not jeopardized and consistent with federal law, that the intergovernmental transfers described in this section provide support for the nonfederal share of risk-based payments to managed care health plans to enable those plans to compensate providers designated by the transferring entity for Medi-Cal health care services and for support of the Medi-Cal program.

(b) For the purposes of this section, the following definitions apply:

(1) “Intergovernmental transfer” or “IGT” means the transfer of public funds by the transferring entity to the state in accordance with the requirements of this section.

(2) “Managed care health plan” means a Medi-Cal managed care plan contracting with the department under this chapter or Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), or Article 2.91 (commencing with Section 14089) of Chapter 7.

(3) “Public provider” means any provider that is able to certify public expenditures under state and federal Medicaid law.

(4) “Rate range increases” means increases to risk-based payments to managed care health plans to increase the payments from the lower bound of the range determined to be actuarially sound to the upper bound of that range, as determined by the department’s actuaries to take into account the variations in underwriting, risk, return on investment, and contingencies.

(5) “Transferring entity” means a public entity, which may be a city, county, special purpose district, or other governmental unit in the state, regardless of whether the unit of government is also a health care provider, except as prohibited by federal law.

(c) To the extent permitted by federal law, a transferring entity may elect to make an intergovernmental transfer to the state, and the department may accept all intergovernmental transfers from a transferring entity, for the purposes of providing support for the nonfederal share of risk-based payments to managed care health plans to enable those plans to compensate providers designated by the transferring entity for Medi-Cal health care services and for the support of the Medi-Cal program. The transferring entity shall certify to the department that the funds it proposes to transfer satisfy the requirements of this section and are in compliance with all federal rules and regulations.

(d) (1) Pursuant to paragraphs (2), (3), and (4), the state shall, upon acceptance of the IGT described in subdivision (c), assess a fee of 20 percent on each IGT subject to this section to reimburse the department for the administrative costs of operating the IGT program pursuant to this section and for the support of the Medi-Cal program.

(2) The IGTs subject to the fee shall be limited to those made by a transferring entity to provide the nonfederal share of rate range increases.

(3) The 20-percent assessment shall not apply to IGTs designated for increases to risk-based payments to managed care health plans intended to increase reimbursement for designated public providers for purposes of equaling the amount of reimbursement the public provider would have received through certified public expenditures under the fee-for-service payment methodology.

(4) The 20-percent assessment shall not apply to IGTs authorized pursuant to Sections 14168.7 and 14182.15.

(e) Participation in the intergovernmental transfers pursuant to this section is voluntary on the part of the transferring entities for the purposes of all applicable federal laws.

(f) The director shall seek any necessary federal approvals for the implementation of this section.

(g) To the extent that the director determines that the payments made pursuant to this section do not comply with the federal Medicaid requirements, the director retains the discretion to return the IGTs or not accept the IGTs.

(h) This section shall be implemented only to the extent that federal financial participation is not jeopardized.

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of policy letters or similar instructions, without taking further regulatory action.

(j) This section shall be implemented on July 1, 2011, or the date on which all necessary federal approvals have been received, whichever is later.

(Added by Stats. 2011, Ch. 29, Sec. 19. (AB 102) Effective June 29, 2011.)

14301.5. (a) (1) To the extent federal financial participation is not jeopardized and consistent with federal law, and subject to the conditions set forth in subdivision (b), the department shall pay Medi-Cal managed care plans rate range increases, as defined by paragraph (4) of subdivision (b) of Section 14301.4, at a minimum level of 75 percent of the rate range available with respect to all enrollees who are newly eligible beneficiaries for purposes of this section. If a nonfederal share is necessary to fund the rate range increases, a county public hospital health system as defined in subdivision (f) of Section 17612.2 or affiliated governmental entity may voluntarily provide intergovernmental transfers for the nonfederal share.

(2) The increased payments to Medi-Cal managed care plans that would be paid consistent with actuarial certification and enrollment in the absence of this section, including, but not limited to, payments described in Section 14182.15, shall not be reduced as a consequence of payment under this section.

(b) Payments to Medi-Cal managed care plans pursuant to subdivision (a) are conditioned on all of the following:

(1) The Medi-Cal managed care plan shall pay all of the rate range increases provided under this section as additional payments to county public hospital health systems for providing and making available services to Medi-Cal enrollees of the plan.

(2) The Medi-Cal managed care plan shall demonstrate that it has a contract or other arrangement in place with county public hospital health systems to provide additional payments to county public hospital health systems for services rendered to Medi-Cal beneficiaries that meet the requirements of paragraph (1). The existence of those agreements or arrangements shall be reported to the department by the county public hospital health system.

(3) Additional payments described in paragraph (1) shall not supplant amounts that would otherwise be payable by Medi-Cal managed care plans to county public hospital health systems. A Medi-Cal managed care plan shall not impose a fee or retention amount, or reduce other payments to a county public hospital health system, that would result in a direct or indirect reduction to these payments.

(4) The county public hospital health system or affiliated governmental entity voluntarily provides an intergovernmental transfer of public funds to the state for use as the nonfederal share, if any, of the increased capitation rates. Notwithstanding any other provision of law, the department shall not assess the fee described in subdivision (d) of Section 14301.4, or any other similar fee.

(c) To the extent a Medi-Cal managed care plan is not compliant with any of the requirements imposed upon it pursuant to this section, the department shall reduce by 25 percent the default assignment into the Medi-Cal managed care plan with respect to all Medi-Cal beneficiaries, as long as the other Medi-Cal managed care plan or plans in that county have the capacity to receive the additional default membership.

(Added by Stats. 2013, Ch. 24, Sec. 3. (AB 85) Effective June 27, 2013.)

14302. Except as provided in Section 14490, the duration of initial contracts entered into pursuant to this chapter shall be for a maximum of one year and of renewed contracts for a maximum of five years.

(Amended by Stats. 1979, Ch. 1061.)

14302.1. (a) (1) Once it is determined that a contract shall be renewed pursuant to this chapter with a prepaid health plan, by the state agency responsible for negotiating these contracts, the agency shall, no later than 25 working days prior to the expiration date of the existing contract or immediately, if that date has passed, draft an extension of the existing contract for a period not to exceed two calendar months. A contract extension shall contain the same terms as the prior existing contract except for the contract's expiration date. The contract extension shall be for a period of time not to exceed two months from the termination date of the original contract.

(2) The state agency responsible for negotiating the contract shall simultaneously submit to each federal and state agency required to approve a contract extension, a draft of the contract for extension no later than 20 working days prior to the expiration date of the prior existing contract.

(3) Each state agency to which an extension for contract has been submitted shall approve or disapprove the extension no later than 10 working days after receipt of the contract.

(4) In the course of any contract negotiations, the responsible state agency shall encourage the participation of other involved state and federal agencies in the negotiation process and shall cooperate with those agencies and with the contractor, or proposed contractor, to seek the resolution of any obstacles to contractual agreement.

(5) No extension shall become effective until and unless federal approval is received indicating that federal funds will be available for services provided under the Medi-Cal program during the period of the contract extension.

(6) These contract extensions shall remain in force and effect until such time as:

(A) The contract expires because the extension date has been reached.

(B) The contract for renewal is entered into and is in force and effect.

(C) The state agency responsible for negotiating the contract determines not to contract or renew a contract with the provider and notifies the provider in writing to that effect.

(D) The state agency responsible for negotiating the contract terminates the contract in accordance with Section 14197.7.

(b) When contract renewals are entered into, the effective date of the contract shall be the termination date of the prior contract, not the ending date of any contract extension. The state agency responsible for negotiating the contract, once a new contract is finalized, shall retroactively make adjustments in any amounts paid under the contract extension to reflect the new terms and rates of reimbursements as provided in the new contract.

(c) It is the intent of the Legislature to provide for the payment of services provided for under this chapter in a timely and efficient manner. Nothing in this chapter shall be construed as to hinder, prohibit, or interfere with the negotiating and contract process of the responsible state agency and provider.

(d) This section shall apply only to those instances in which both parties have reason to believe that their contract renewal process will not be completed by the termination date of the contract.

(Amended by Stats. 2019, Ch. 465, Sec. 7. (AB 1642) Effective January 1, 2020.)

14303. No contract between the department and the prepaid health plan shall be amended without the public notice and if necessary the holding of a public hearing as required in Section 14300 if such amendments make any of the following changes in the contract:

(a) Reduction in the scope or availability of services.

(b) Enlargement of the service area.

(c) Increase in the maximum enrollment permitted under the contract.

(d) Any other change in the plan's organization, operation, or delivery of services which the director determines will have a substantial impact on the ability of enrollees to obtain health care services.

(Amended by Stats. 1980, Ch. 1073, Sec. 3.)

14303.1. The department shall have authority to amend a prepaid health plan contract in accordance with the terms of a merger of a prepaid health plan with another organization or organizations other than the plan's subsidiary corporation, its parent corporation, or

another subsidiary of its parent corporation, provided the surviving organization meets the following conditions:

(a) The surviving organization assures the continued and accessible delivery of health care services to enrollees.

(b) The plans concerned have satisfactorily demonstrated the fiscal and administrative soundness of the newly proposed organization.

(c) The enrollees of the plans concerned are informed of the impending merger, any resulting changes in the service area or delivery of health care services, and such other information required by subdivision (a) of Section 14406 at least 30 days in advance of the merger.

(d) The enrollees of the plans concerned are given the option of disenrolling for any cause within 60 days following the effective date of the merger.

(e) Public notice is given and if necessary a public hearing is held as required by Section 14300.

(f) The organization meets such other requirements as deemed necessary by the department in order to carry out the purpose of this chapter.

(Amended by Stats. 1980, Ch. 1073, Sec. 4.)

14303.2. The department shall have authority to amend a prepaid health plan contract in accordance with the terms of the reorganization of a prepaid health plan or a merger of the plan with its subsidiary corporation, its parent corporation, or another subsidiary of its parent corporation, provided the following conditions are met:

(a) The resulting or surviving organization assures the continued and accessible delivery of health care services to enrollees.

(b) The plan has satisfactorily demonstrated the fiscal and administrative soundness of the newly proposed organization.

(c) If the proposed reorganization or merger results in any change of the plan's service area or delivery of health care services, or if the director otherwise deems it to be appropriate, the following additional conditions shall be met:

(1) Public notice is given and if necessary a public hearing is held as required by Section 14300.

(2) The enrollees of the plan are informed of the impending reorganization or merger, any resulting changes in the service area or delivery of health care services, and such other information required by subdivision (a) of Section 14406 at least 30 days in advance of the reorganization or merger.

(3) The enrollees of the plan are given the option of disenrolling for any cause within 60 days following the effective date of the reorganization or merger.

(d) The plan meets such other requirements as deemed necessary by the department in order to carry out the purpose of this chapter.

(Amended by Stats. 1980, Ch. 1073, Sec. 5.)

14303.3. The department shall renew a contract unless good cause is shown for nonrenewal.

(Added by Stats. 1980, Ch. 1073, Sec. 6.)

14304.5. Each prepaid health plan shall provide directly or through subcontractors, not less than the basic scope of health care benefits as defined in Section 14256. The director shall establish the scope and duration of such services and may require other services listed in Section 14053 be provided on a risk or nonrisk basis. The director shall encourage the prepaid health plan to provide all of the services enumerated in Section 14053 on a prepaid basis. When mutually agreeable to the prepaid health plan, the department, and the hospital involved, and provided that the confidentiality of the selected hospital contracting rates negotiated pursuant to Chapter 7 (commencing with Section 14081) is maintained by all parties, contracts entered into by the department pursuant to this chapter may provide for alternative arrangements in any or all of a prepaid health plan's Medi-Cal service area for the payment of inpatient hospital services using Medi-Cal hospital inpatient rates.

Subject to prior approval by the director, any additional services other than those listed in Section 14053 may be provided at reasonable cost to Medi-Cal enrollees, provided the enrollees are notified of services for which they will be charged and the amount of the charge prior to rendering such services.

(Amended by Stats. 1988, Ch. 1348, Sec. 14.)

14305. The department may limit the scope of health care benefits provided by a prepaid health plan under this chapter to exclude the care of illness or injury which results from or is greatly aggravated by, a catastrophic occurrence, including, but not limited to, an act of war, declared or undeclared, and which occurs subsequent to enrollment in the prepaid health plan.

(Repealed and added by Stats. 1974, Ch. 983.)

14308. (a) Each prepaid health plan shall furnish to the director such information and reports as required by Title XIX of the federal Social Security Act.

(b) The director may require a prepaid health plan to provide the director with information and reports that are furnished by the prepaid health plan to the Director of the Department of Managed Health Care pursuant to the provisions of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, the Knox-Keene Health Care Service Plan Act of 1975.

(c) The director may, by regulation, require plans to furnish statistical information to the extent the information is necessary for the department to establish rates of payment pursuant to Section 14301.1 and to provide reports pursuant to Section 14313. The department shall, to the extent feasible, accept this information in a form which is consistent with reports required to be provided pursuant to the Knox-Keene Health Care Service Plan Act of 1975. In the case of a hospital based plan that is a health maintenance organization qualified pursuant to Title XIII of the federal Public Health Service Act, and that has more than one million enrollees, of whom less than 10 percent are Medi-Cal enrollees, information required pursuant to this subdivision shall consist of reports required to be made to the United States Department of Health and Human Services pursuant to Title XIII of the federal Public Health Service Act.

(Amended by Stats. 2023, Ch. 266, Sec. 3. (AB 614) Effective January 1, 2024.)

14309. The department shall provide for a continuing study of the quality of care and services resulting from the operation of this chapter and for surveys and reports on prepaid health plans. With respect to such plans contracted for under this chapter, the department may contract with professional organizations for studies and reports of the experience of such plans as to the standards of care available to eligible persons, gross and net costs, administrative costs, benefits, utilization of benefits, the portion of actual personal expenditures of eligible persons for health care which are being met by prepaid benefits, and the methods of evaluating and improving the quality of, and controlling the costs of, health care provided under such contracts. However, this section shall not be construed to require any prepaid health plan to provide accounting data or statistical data not required by regulations adopted by the director.

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

14311. Prepaid health plans, the services they provide, and the persons receiving these services shall not be subject to the limitations on services set forth in Section 14133, 14133.1, 14133.25, or 14133.3 or subdivisions (c), (d), and (e) of Section 14120, or subdivision (c) of Section 14105. Notwithstanding this section, the requirements set forth in Section 14301 for the determination of prospective per capita rates of payment for services provided under this chapter to Medi-Cal beneficiaries enrolled in a prepaid health plan shall remain unchanged.

Nothing in this section or in Article 7 (commencing with Section 14490) shall relieve the director of his responsibility to provide the benefits provided for in Section 14132. Where a contract between the department and a prepaid health plan does not require the prepaid health plan to provide a benefit to which a Medi-Cal recipient is otherwise entitled, the recipient shall be entitled to receive such benefit pursuant to Chapter 7 (commencing with Section 14000) of this part.

(Amended by Stats. 1984, Ch. 780, Sec. 1.)

14312. The director shall adopt all necessary rules and regulations to carry out the provisions of this chapter. In adopting such rules and regulations, the director shall be guided by the needs of eligible persons as well as prevailing practices in the delivery of health care on a prepaid basis. Except where otherwise required by federal law or by this part, the rules and regulations shall be consistent with the requirements of the Knox-Keene Health Care Service Plan Act of 1975.

(Amended by Stats. 2014, Ch. 442, Sec. 38. (SB 1465) Effective September 18, 2014.)

14314. The director may recover a due and payable overpayment made to a prepaid health plan by means of a repayment agreement executed between such prepaid health plan and the director, and by any other means available at law.

(Amended by Stats. 1979, Ch. 373.)

14315. When it has been determined that a prepaid health plan has received an overpayment which is due and payable, the director may recover such overpayment by offset against any amount currently due to the prepaid health plan under the provisions of this chapter or Chapter 7 (commencing with Section 14000) of this part.

(Added by Stats. 1977, Ch. 1046.)

14316. Notwithstanding any other provisions of law, contracts with plans which are entered into, renewed, or amended pursuant to this article may include one or more of the following:

(1) A provision to the effect that if the rate for a plan is less than 90 percent of the estimated Medi-Cal fee-for-service cost, the plan's rate shall be increased by one-half the difference between the rate fixed and 90 percent of the estimated fee-for-service cost. The rate shall not, however, be less than 85 percent of the estimated fee-for-service costs.

(2) Guaranteed capitation payments for Medi-Cal beneficiaries, who are entitled to benefits under Title IV of the Social Security Act, for a period of six months or less, even if the eligibility for benefits of such beneficiaries terminates prior to the end of the guaranteed payment period. Each guaranteed payment period shall be calculated beginning on the date a beneficiary's enrollment takes effect.

(3) Benefits in addition to those listed under Section 14132, as long as the provision of such additional services permits plans to remain more cost effective than fee-for-service reimbursement.

(Added by Stats. 1982, Ch. 328, Sec. 45. Effective June 30, 1982.)