53810 Definitions

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

(a)

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

(b)

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

(c)

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

(d)

American Indian means any person who is eligible under federal law to receive

health services provided directly by the United States Department of Health and Human Services, Indian Health Service (IHS) or by a tribal or urban Indian health program funded by IHS to provide health services to eligible individuals either directly or by contract. The definition includes members of an American Indian's household.

(e)

Assignment means the actions taken by the Health Care Options Program to enroll an eligible beneficiary into a plan, in the absence of a selection made by the beneficiary. Assignment also means action by a plan to assign a member to a primary care physician in the absence of a selection made by the member.

(f)

Capitated service means a medical service for which a plan is compensated in its fixed monthly per member rate.

(g)

Caseload means the number of Medi-Cal beneficiaries in mandatory aid categories in a given month.

(h)

Case Management means services provided by a primary care provider/physician to ensure the coordination of medically necessary health care services, assuring the provision of preventive services in accordance with established standards and periodicity schedules and ensuring continuity of care for Medi-Cal members. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.

(i)

Commercial plan means the prepaid health plan in a designated region awarded a

contract by the department pursuant to section 53800(b)(1).

(j)

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

(k)

Contract means the written agreement entered into between a prepaid health plan and the department to provide health care services to plan members in a designated region.

(l)

Contracted capacity means the number of Medi-Cal beneficiaries in the mandatory aid categories a prepaid health plan has either contracted with the department to enroll and serve in a region, or has committed to enter a prepaid health plan contract with the department to enroll and serve in a region.

(m)

Department means the Department of Health Care Services.

(n)

Designated region means that geographic area designated by the director within which a plan is approved by the department to provide services to Medi-Cal beneficiaries pursuant to a contract authorized by Welfare and Institutions Code Section 14087.3. The designated regions shall be within, between, or among the counties of Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare, and any other county, with the approval of the Director, which may elect to participate in accordance with the provisions of this regulation.

(o)

Disproportionate share hospital (DSH) means any hospital receiving payments as

provided in Welfare and Institutions Code Section 14105.98.

(p)

Eligible beneficiary means a person who resides in an area covered by the Two-Plan Model Managed Care Program, who has been determined eligible to receive Medi-Cal services, whose scope of Medi-Cal benefits is not limited, and meets the enrollment criteria as specified in section 53845.

(q)

Enrollment level means the number of Medi-Cal beneficiaries enrolled in a plan.

(r)

Fair hearing means an administrative hearing conducted by the State relating to Medi-Cal eligibility or benefits, pursuant to sections 50951 through 50955, 51014.1, 51014.2, and 53894.

(s)

Federally qualified health centers means an entity which:(1) Is receiving a grant under section 330 of the Public Health Service Act; or (2) Is receiving funding from such a grant under a contract with the recipient of such a grant, and meets the requirements to receive a grant under section 330 of such Act; or (3) Based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary of Health and Human Services to meet the requirements for receiving such a grant; or (4) Was treated by the Secretary, for purposes of Part B of title XVIII, as a comprehensive federally funded health center as of January 1, 1990; and (5) May be an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638) or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary health services.

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

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

(t)

Health Care Options Program means the entity providing Medi-Cal managed care and fee-for-service options presentations, managed care plan enrollment and disenrollment activities, and managed care related problem resolution functions in designated regions.

(u)

Indian Health Service facility means a tribal or urban Indian organization operating health care programs or facilities with funds from the Department of Health and Human Services, IHS, appropriated pursuant to the Indian Health Care

Improvement Act (25 U.S.C. section 1601) or the Snyder Act (25 U.S.C. section 13).

(v)

Initial health assessment means an assessment conducted by the plan of a member's medical health status.

(w)

Local initiative means the prepaid health plan which is organized by a county government or by county governments of a region designated by the director, or organized by stakeholders of the designated region, and awarded a contract by the department pursuant to section 53800(b)(2).

(x)

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

(y)

Mandatory aid categories means the Medi-Cal aid categories of Public Assistance-Aid to Families with Dependent Children, as described in section 1931 of the Social Security Act (42 United States Code, section 1396) as added by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Medically Needy-Family (Aid to Families with Dependent Children) with No Share of Cost, as described in section 1931 of the Social Security Act (42 United States Code, section 1396) as added by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, and Medically Indigent Children with No Share of Cost, which will be required to enroll in a prepaid health plan under the two-plan model.

(z)

Maximum enrollment means the maximum commercial plan enrollment level at

which the commercial plan ceases to receive default assignment enrollments as provided under this Chapter.

(aa)

Member means an eligible beneficiary who is enrolled in a plan.

(bb)

Nondesignated region means any geographic region of California other than a designated region or the counties of Orange, Sacramento, San Mateo, Santa Barbara, Santa Cruz, or Solano. Unless other geographic boundaries are established by the department, region shall mean a single county.

(cc)

Ombudsman means the individual within the department who investigates and resolves complaints about managed care made by, or on behalf of, Medi-Cal beneficiaries.

(dd)

Plan means a prepaid health plan that has entered into a contract with the department.

(ee)

Prepaid Health Plan (PHP) means a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975, which has entered into a contract with the department on a capitated rate basis to arranger for the provision of health services to eligible beneficiaries in a designated region.

(ff)

Primary Care Case Management (PCCM) plan means a primary care provider or other entity who has entered into a contract to provide health care services under the provisions of article 2.9 commencing with section 14088, Welfare and Institutions Code.

(gg)

Primary care physician means a physician who has the responsibility for providing, or for supervising nonphysician medical practitioners providing integrated services addressing a large majority of personal health care needs sustained over time; for maintaining and coordinating the continuity of member care, and for initiating referrals for specialist care. A primary care physician is a physician in general practice or is a board certified or board eligible internist, pediatrician, obstetrician/gynecologist, or family practitioner.

(hh)

Primary care provider means a person responsible for coordinating and providing primary care to members, within the scope of their license to practice, for initiating referrals and for maintaining continuity of care. A primary care provider may be a primary care physician or nonphysician medical practitioner including a nurse practitioner, certified nurse midwife or physician assistant.

(ii)

Safety net provider means any provider of comprehensive primary care or acute hospital inpatient services that provides these services to a significant total number of Medi-Cal and charity and/or medically indigent patients in relation to the total number of patients served by the provider.

(jj)

Service site means the location designated by a plan at which a member receives primary care physician services.

(kk)

Traditional provider means any physician who has delivered services to Medi-Cal beneficiaries within the last six months; this notwithstanding, local initiatives or commercial plans may establish their own policies and participation standards for

the inclusion of traditional providers in their provider networks. Policies and participation standards established pursuant to this subsection shall be consistent with those required under section 1915(b)(4) of the Social Security Act.

(II)

Two-plan model means the health care delivery system described in section 53800.