INTRODUCTORY REMARKS

The public notice for this regulatory proposal was published on April 26th, 2013, in the California Regulatory Notice Register 2013 Number 17-Z, and was also released to interested groups and individuals. No public hearing was originally scheduled, but a written request to hold a public hearing was received by the Department of Health Care Services ("the Department" or "DHCS") Office of Regulations on May 21, 2013. The Department held a public hearing on Tuesday, June 11, 2013, at 11:00 a.m. The Department received 19 written comment letters. In addition, six oral statements and two written exhibits were received at the public hearing. This addendum presents the comments identified from these sources and responds to them.

Three themes appeared frequently in the comments received. The first involves claims that the Department lacks legal authority to make the proposed changes by way of a regulatory amendment. The second concerns the necessity for the proposed changes. The third asserts that the proposed amendment to allow the Department to contract with an Alternative Health Care Service Plan (AHCSP) will detrimentally impact safety net providers. The Department responds to these common themes in this Introductory Remarks section, and incorporates those responses where appropriate in the table below. The second and third themes are addressed together because they relate to each other.

I. Authority

The Department has the authority to modify the Two-Plan Model of managed care it established through regulation in Title 22 California Code of Regulations (CCR), Section 53800, allowing the Department to contract with an AHCSP for purposes of continuity of care.

In Welfare and Institutions Code (W&I Code) Section 14087.3, the Legislature granted the director of the Department the authority to contract for the delivery of Medi-Cal services in any geographic region, on either an exclusive or non-exclusive basis, as follows, in relevant part (emphasis added):

> 14087.3. (a) The director may contract, on a bid or nonbid basis, with any qualified individual, organization, or entity to provide services to, arrange for or case manage the care of Medi-Cal beneficiaries. At the director's discretion, the contract may be exclusive or nonexclusive, statewide or on a more limited geographic basis, and include provisions to do the following:
>
> (1) Perform targeted case management . . .

(2) Provide for delivery of services in a manner consistent with managed care principles. ...

(3) Provide for alternate methods of payment, including, but not limited to, a prospectively negotiated reimbursement rate, fee-for-service, retainer, capitation, shared savings, volume discounts, lowest bid price, negotiated price, rebates, or other basis.

(4) Secure services directed at any or all of the following:

(A) Recruiting and organizing providers to care for Medi-Cal beneficiaries.

(B) Designing and implementing fiscal or other incentives for providers to participate in the Medi-Cal program in cost-effective ways.

(C) Linking beneficiaries with cost-effective providers.

Contrary to the received comments, the Legislature did not enact statutes creating the Two-Plan Model structure. Further, neither the "statutory scheme" nor Article 2.7(Sections 14087.3-14087.48) "committed to the Two-Plan Model." Instead, the Two-Plan Model was created by the Department through regulation, as authorized by W&I Code Section 14203, which designated the Department "as the single or appropriate state agency with full power to administer and adopt regulations in order to secure full compliance with applicable provisions of state and federal laws." The Legislature enacted statutes that enabled, but did not mandate, counties to create and operate the local initiatives or commissions to administer Medi-Cal benefits in Two-Plan Model counties. There is no statutory mandate that any county operate under a Two-Plan Model.

For example, with respect to Los Angeles County, W&I Code Section 14087.967 states, in relevant part, "To the full extent permitted by federal law, the department and the commission may enter into contracts to provide or arrange for health care services for any or all persons who are eligible to receive benefits under the Medi-Cal program. The contracts may be on an exclusive or nonexclusive basis . . . " W&I Code Section 14087.9725(b) then states, [Begin Bold & Underline for Emphases]"**Nothing in this article shall be construed to preclude the department from expanding Medi-Cal managed care in ways other than those expressly provided in this article.**"[End Bold & Underline for Emphases]

Similarly, W&I Code Section 14087.31 authorizes the establishment of a special commission in Tulare and San Joaquin Counties, but does not mandate that these counties operate only under a Two-Plan Model of managed care.

The same structure is found in W&I Code Section 14087.35, authorizing (not mandating) Alameda County to create a health authority as a local initiative "as a means of establishing the local initiative component of the state-mandated two-plan managed care model for the delivery of medical care and services to the Medi-Cal populations." This statement does not refer to a statutory mandate as there is no such statutory mandate. Instead, it necessarily refers to the regulatory provision, Title 22 CCR Section 53800 (discussed below), which implements W&I Code Section 14087.3, authorizing the Department to designate regions where Medi-Cal services shall be provided through "no more than two plans."

Neither the identified statutes nor the statutory scheme in any way limit the ability of the director to contract with other health plans in the counties designated by the Department as Two-Plan Model counties pursuant to Title 22 CCR Section 53800. Only the regulation contains this limit. The Department is not usurping the role of the Legislature, rather it is taking the steps specifically required to amend a regulation through the formal regulatory amendment process, within the scope of the implemented statute. When the Legislature sought to limit the number of managed care health plans in a county, it clearly did so, as shown in W&I Code Section 14087.5, authorizing "exclusive" contracts in County Operated Health Systems. Clearly, in W&I Code Section 14087.3, the Legislature granted the Department the flexibility to contract as needed to provide Medi-Cal services subject to any other statutory requirements.

It is true that the Department recently expanded the use of the managed care delivery system to rural counties by way of statute. However, that does not require or indicate that any change to the Two-Plan Model must also proceed through legislation. The rural expansion was accomplished through statutory addition in order for the Department to obtain the additional flexibility in statutory authority needed to address the unique concerns of those rural counties, and because federal law treats rural counties differently than other counties (see Title 42 Code of Federal Regulations [CFR] Section 438.52). In contrast, this regulatory amendment does not seek to alter the Department's statutory authority in contracting with managed care health plans in designated Two-Plan Model counties.

In W&I Code Section 14089, the Legislature granted the Department the authority to contract for the provision of Medi-Cal services with "two or more" managed care health plans in "clearly defined geographical areas." W&I Code Section 14089.05 authorizes the Department to implement a multi-plan project in San Diego County, with a very specific structure as specified in the statute. Similarly, W&I Code Section 14089.07 authorizes Sacramento County to establish a stakeholder advisory committee to provide input on the delivery of health care services in the county. However, those

statutes in no way limit the statutory authority of the Department to contract under W&I Code Section 14087.3 in other counties.

In 1993, in its publication "Expanding Medi-Cal Managed Care: Reforming the Health System; Protecting Vulnerable Populations," the Department presented its conclusions regarding the need for a Two-Plan Model of managed care based on the Medi-Cal population and provider dynamics then in existence. In Title 22 CCR Section 53800(a), the Department implemented the director's statutory authority to contract for the provision of Medi-Cal services by adopting the Two-Plan Model, stating: "In regions designated by the department, health care services to eligible Medi-Cal beneficiaries shall be provided through no more than two prepaid health plans." At that time, given the limited populations being served by Medi-Cal managed care in the designated counties, two plans were sufficient to meet the needs of beneficiaries and to protect the local initiatives and safety net providers.

II. Necessity and Impact

Now in 2013, two decades after the 1993 publication regarding the creation of the Two-Plan Model, the Department seeks to modify the Two-Plan Model to meet the needs of the current Medi-Cal population and the realities of the publicly funded health care landscape. Contrary to the comments, the proposed regulatory amendment, allowing the Department to directly contract with an AHCSP for purposes of continuity of care, is necessary and will not fatally impact safety net providers.

The nation's economic downturn, starting in 2008, has forced more people than ever before to rely on Medi-Cal for their health care. Further, the Affordable Care Act (ACA) has significantly expanded the reach of the Medicaid program and switched the focus of the delivery system in both Medicare and Medicaid from a fee-for-service (FFS) model to a managed care model.

As described in "Medi-Cal Facts and Figures: A Program Transforms" by the California Healthcare Foundation (May 2013)(emphasis added): "The [Medi-Cal] program is in the midst of a major transformation, as it shifts most enrollees to managed care and prepares for a major expansion due to the Patient Protection and Affordable Care Act (ACA). [Begin Bold for Emphases]**Enrollment in the program will surge in 2013 as more than 850,000 children transition to Medi-Cal from the Healthy Families Program. Medi-Cal will see an estimated total increase of one million or more enrollees due to the ACA, including 680,000 people in 2014,** [End Bold for Emphases] the first year of Medi-Cal expansion under health reform."

California chose to accept the opportunities available through the ACA, but to do so the Department must adjust the Medi-Cal landscape and procedures to address the volume and diversity challenges that accompany those opportunities. Medi-Cal is the single state agency responsible for providing quality health care to the vastly increasing Medi-Cal population while satisfying applicable Medicaid requirements, one of which is consideration of continuity of care for multiple populations.[1] This is true whether the person is a new Medi-Cal enrollee, a Senior or Person with Disabilities, a Healthy Families Program enrollee, or a Community-Based Adult Services (CBAS) recipient. The proposed regulatory amendment, which allows the Department to directly contract with an AHCSP if needed for continuity of care purposes, is necessary for the Department to meet the challenges posed by the increasingly large and diverse Medi-Cal population.

The proposed regulatory amendment would allow the Department to directly contract with any plan meeting the specified requirements for an AHCSP. An AHCSP is a unique model of managed care that is not available through traditional managed care organizations, and has been the model of choice for a significant number of people throughout California. AHCSP providers cannot contract with other plans outside of the AHCSP; therefore, it is not possible for beneficiaries transitioning from an AHCSP to Medi-Cal to retain continuity of care except through an AHCSP. That is not the case with other types of plans, where providers can participate in more than one health plan. Thus, the Department seeks to modify the Two-Plan Model to allow it to contract directly with an AHCSP to meet continuity of care needs where necessary--meaning when the local plan fails to subcontract with an AHCSP.

Several comments assert that the care continuity agreements regarding subcontracts between AHCSPs and Two-Plan Model counties make the proposed regulatory amendment unnecessary; however, that assertion fails for several reasons:

- First, a contract between parties does not provide a governmental entity with the legal authority to enter into a contract or to modify formally adopted regulations. The authority to contract must be legislatively granted, and regulations must be formally amended unless the Legislature has granted a specific exception for the regulation at issue. Thus, the continuity of care agreements do not enable the Department to take any contracting action.
- Second, the referenced agreements are just statements of agreement and are not enforceable "contracts." There is no required consideration and no mechanism to provide the needed continuity of care if any party were to breach the agreement.

[1] See W&I Code Section 14181(a)(1)(G); and California's section 1115(a) Demonstration (11-W-00193/9), entitled the California Bridge to Reform Demonstration, last approved on August 29, 2013, paragraphs: 83.c., 84.f(iii) (Seniors and Persons with Disabilities Transition); 94.c(iii), 94.h(vi) (CBAS Transition); 104.a, 107.c; 111, 111.a(ii)(3), 111.a(iii), 111.b, 111.c(i), 116.a, 116.d(3), 117.a, 117.c, Attachment F (Healthy Families Transition); Attachment Q.

- Third, not all Two-Plan Model plans have made such agreements, and some that have signed such agreements are not following the terms of those agreements.
- Fourth, even if a plan has a subcontract with an AHCSP, contractual arrangements can be terminated at any time; therefore, there is no certainty that the local plans will continue to subcontract with an AHCSP.

Unfortunately, not all Two-Plan Model health plans are considering the continuity of care needs of the expanding Medi-Cal population. Some have been paying subcontracted AHCSPs pursuant to a rate structure that reflects retention of an "administration fee" which in some cases exceeds one-third of the rate. In such situations, the subcontracts with AHCSPs are a significant profit center for those plans. AHCSPs have asserted that they will no longer subcontract at such a discounted rate, and at least one Two-Plan Model county health plan is refusing to agree to subcontract with an AHCSP unless they are able to continue to keep the administrative fee. This means that beneficiaries in that Two-Plan Model county who are transitioning to Medi-Cal from an AHCSP will not be able to obtain continuity of care with their AHCSP providers and clinics. Without the proposed regulatory amendment, the existing plans in a Two-Plan Model county can, based on their own financial interests, unilaterally prevent beneficiaries transitioning to Medi-Cal from an AHCSP from receiving continuity of care with an AHCSP by refusing to subcontract with an AHCSP for a reasonable amount of the capitated rate.

In proposing the regulatory amendment, the Department is taking the minimal action necessary to address the continuity of care issues now arising in connection with the transition of beneficiaries from AHCSPs to Medi-Cal managed care plans. There is no reasonable alternative capable of providing the Department with the ability to promote continuity of care for Medi-Cal beneficiaries transitioning from an AHCSP. The proposed regulatory amendment does **not** require that the Department directly contract an AHCSP in each Two-Plan Model county. Rather, it merely provides the Department with the limited authority to directly contract with an AHCSP when necessary to promote continuity of care for a narrowly defined group of beneficiaries. If the local plan does subcontract with an AHCSP, there will be no need for the Department to directly contract with an AHCSP.

Notably, there is no evidence that there will be any impact on safety net providers even if the Department were to directly contract with an AHCSP in a county. As the comments point out, most counties are already subcontracting with AHCSPs and the beneficiaries already have the choice to join an AHCSP. The proposed regulatory amendment will merely allow the Department to continue the availability of an AHCSP plan choice should the local plan at some point in time choose not to subcontract with an AHCSP. Thus, there will be no change in the interplay between AHCSPs and safety net providers. Further, it currently is, and under the proposed regulatory amendment, the <u>choice</u> of an eligible beneficiary whether he or she chooses to enroll in an AHCSP or one of the other two available plans. No beneficiary will be forced to

choose an AHCSP, and the beneficiary's choice will likely depend on the quality of care and access provided by the different plan options. Further, it is likely that some eligible beneficiaries will choose to join one of the other two available plans. The proposed regulatory amendment ensures that there will be no default assignment of beneficiaries to an AHCSP; therefore, if a beneficiary fails to make a plan choice, they will not be assigned to an AHCSP, but will be assigned to either the local initiative or the commercial plan according to the current default algorithm. If an eligible beneficiary is already enrolled in a Two-Plan Model health plan, and wishes to remain in said plan, the beneficiary is not obligated or forced to disenroll from their current plan and enroll in an AHCSP. Lastly, an AHCSP which directly contracts with the Department will be required to pay for out-of-network care (including care provided by safety net providers and FQHCs) under the same rules as other contracting Medi-Cal plans. The safety net currently exists with local plans subcontracting with AHCSPs, and it will continue to exist if the Department contracts directly with an AHCSP.

Thus, the Department now seeks to amend Title 22 CCR Section 53800(a) to allow the Department to contract with an AHCSP when necessary for purposes of continuity of care for a specifically defined population. This proposed amendment to Title 22 CCR Section 53800(a) falls well within the scope of the statutory authority, and there is no legal authority, statutory or otherwise, precluding the amendment.

The following table includes comments identified, grouped by submission (Comment Letter) which includes comments received in an email, as an attachment to an email, by fax, as an oral statement, in a written exhibit, or by using a combination of these methods.

COMMENT LETTER 1 (SynerMed 4/25/13 - EMAIL)

Comment Number: 1

SUBJECT: Methodology

COMMENT: My concern with the proposal is that it seeks to add a new health plan (the AHCSP) to the existing 2-Plan model, thereby essentially creating a 3-plan model program. I don't have a problem with adding a new health plan per se and understand the reasoning behind it; rather, I have a problem with the method by which the new health plan can be added.

RESPONSE: The comment is vague; however, see Introductory Remarks regarding Authority.

Comment Number: 2

SUBJECT: AHCSP Definition

COMMENT: As defined, the Alternate Health Care Service Plan (AHCSP) must be a non-profit with 3.5 million members. Ostensibly, this appears to be written specifically for Kaiser. However, there are other non-profits that may qualify, including Blue Shield and even Blue Cross (although the latter is owned by for-profit WellPoint).

RESPONSE: Any plan meeting the proposed definition would qualify to be an AHCSP.

Comment Number: 3

SUBJECT: Expanding Access

COMMENT: My question is "why stop there?" Why non-profit? Why a 3.5 million member minimum? Why not just open it to any licensed entity? The way the draft is written is NOT to enable adding additional health care service plans to the mix, but to EXCLUDE OTHERS from being able to participate. Thus it becomes a 'restraint of trade' issue rather than an 'expanding access' one in order to maintain physician-patient relationships as proposed in Section 53800 subsection (c).

I would also suggest that in light of California's soon-to-be live health insurance exchange (Covered California) and the

potential movement of future beneficiaries between Medi-Cal and private health coverage, opening the field to all licensed entities will ensure the maintenance of these physician-patient relationships.

RESPONSE: Please see Introductory Remarks regarding Necessity and Impact.

There is no demonstrated need for the Department to have the ability to directly contract with additional plans in the designated Two-Plan counties. Because AHCSP providers cannot contract with plans outside of the AHCSP, it is not possible for beneficiaries transitioning from an AHCSP to Medi-Cal to obtain continuity of care except through their AHCSP. That is not the case with other types of plans, where providers can participate in more than one plan. The proposed regulatory amendment has been drafted as narrowly as possible to address the specific beneficiary need for continuity of care in a specific type of plan for a defined population. The Department is not proposing to eliminate the Two-Plan Model. This is not a "restraint of trade" issue because the Department already has the statutory authority to determine how many plans, and which plans, it will contract with to provide Medi-Cal services.

COMMENT LETTER 2 (BD of Supervisors, County of Santa Clara 6/4/13 – Email Attached Letter)

Comment Number: 1

SUBJECT: Keeping Status Quo

COMMENT: The Two-Plan Model was established in 1993 to provide Medi-Cal recipients with greater choice in their health care provider, while at the same time protecting the safety net. Currently, 3.8 million beneficiaries in 14 California counties are provided access to quality, cost-efficient medical care through the Two-Plan Model. The existing Two-Plan Model structure is working extremely well for ours and other counties- we simply do not believe that changes to the Model are warranted at this time.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

Although the comment states that the existing Two-Plan Model "is working extremely well for ours and other counties," that is a subjective opinion. Furthermore, it is not true for all counties, and not true with respect to the continuity of care needs of beneficiaries transitioning to and from AHCSPs in counties where there is no, or in the future will be no, subcontracted AHCSP.

Comment Number: 2

SUBJECT: Safety Net

COMMENT: Additionally, the implementation of the Affordable Care Act (ACA) will bring great opportunities, but also great uncertainties, to California's health care safety net. This includes an increase of approximately 50,000 new Medi-Cal recipients in our County; a large but unknown number of individuals who will additionally enroll in the program but may seek care from any provider; and the potential loss of federal (DSH) and state (realignment) dollars that currently support public hospitals, clinics and care.

This proposed regulation presents additional threats to the health care safety net. By allowing additional plans to participate in Medi-Cal managed care, already meager resources will become even more scarce.

RESPONSE: See Introductory remarks regarding Necessity and Impact.

The proposed regulations were drafted as narrowly as possible to define the Medi-Cal beneficiaries who will be eligible to voluntarily enroll in an AHCSP. The expansion of the Medi-Cal managed care population to include populations transitioning from an AHCSP, and the fundamental capacity limitation of the current health care structure, require that the Department to take action to meet the needs of the growing Medi-Cal population. Due to the significant influx of new Medi-Cal managed care beneficiaries, there will not be a shortage of beneficiaries utilizing the local initiative and commercial plans in any counties where the Department contracts directly with an AHCSP.

Comment Number: 3

SUBJECT: Coordination of Care

COMMENT: While continuity of care is important, the providers currently working with our Santa Clara Family Health Plan have vast experience in working with a patient population that often requires a host of treatments and services, due to multiple chronic and complex conditions. For example, Santa Clara Valley Medical Center currently works with the Family Health Plan to ensure that patients are enrolled, understand their benefits, are provided with a medical home, and receive high quality and coordinated services.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

COMMENT LETTER 3 (Community Clinic Association of Los Angeles County 6/4/13 – Email Attached Letter)

Comment Number: 1

SUBJECT: Lack of Clarity

COMMENT: Standard of Review.

Under Section 11349.1(a) of the Cal. Government Code the Office of Administrative Law reviews all regulations adopted, amended, or repealed pursuant to the California Administrative Procedures Act using all of the following standards: 1) necessity; 2) authority; 3) clarity; 4) consistency; 5) reference; and 6) nonduplication.

These standards are specifically defined in Section 11349 of the Cal. Government Code.

The proposed regulation are deficient for lack of clarity. "Clarity" means "written or displayed so that the meaning of regulations will be easily understood by those persons directly affected by them." Cal. Gov. Code § 11349(c).

Lack of Clarity
1. The proposed regulations are unclear for the following reasons: Proposed Section 53800 (c)(1) sets forth the eligibility criteria for enrollment in the AHCSP. It would appear that not all Medi-Cal beneficiaries in Two-Plan model counties would be eligible to enroll in an AHCSP. Based on the proposed language, beneficiaries who would be eligible to enroll are: 1) existing AHCSP members, 2) who had been AHCSP members at any time during the 12 month period prior to their Medi-Cal eligibility, or 3) whose parents, guardians, minor children, or minor siblings are AHCSP members or had been enrolled in AHCSP at any time during the 12 months prior to the beneficiaries' Medi-Cal eligibility. However, the proposed regulation does not contain explicit limiting language and is therefore vague.

CCALAC suggests the following limiting language be added to proposed Section 53800 (c)(1) as follows:
"Only the following beneficiaries enrolling in Medi-Cal managed care..."

2. Proposed Section 53800(c)(2) would require that if a Medi-Cal beneficiary is eligible to enroll in AHCSP but chooses not to, the beneficiary would be assigned to a plan consistent with the current enrollment and assignment

provisions set forth in existing regulation. However, the language of this section of the proposed regulation is vague and inconsistent with freedom of choice that exists in current Medi-Cal statute and regulations.

CCALAC suggests the following clarifying language be added to proposed Section 53800 (c)(2) as follows:
"A beneficiary who is eligible to enroll in the AHCSP but chooses not to enroll in the AHCSP, shall choose or be assigned to a plan through the enrollment processes..."

3. Proposed Section 53800(c)(3) would exempt AHCSP from the assignment system described in Section 53884 of the existing Two-Plan model regulation. Section 53884 sets forth the criteria for default assignment of beneficiaries. It is not clear whether the language of proposed Section 53800(c)(3) means that AHCSP would not be considered for beneficiary assignment in Two-Plan model counties at all if the beneficiary does not meet the AHCSP enrollment eligibility or whether this means that AHCSP is simply not subject to the assignment provisions for default assignment.

CCALAC recommends revision of proposed Section 53800(c)(3) to clarify this point.

RESPONSE: The proposed regulatory amendment is clear as written. The suggested language would not add clarity.

Comment Number: 2

SUBJECT: Impact of Changes

COMMENT: Impact of Proposed Changes.

CCALAC estimates that several provisions of the proposed rule could negatively affect FQHC's and community clinics that currently provide services to Medi-Cal beneficiaries in Two-Plan model counties if these beneficiaries are eligible for, and would choose to enroll with, the proposed AHCSP. To the extent that CHCs are not AHCSP contractors, this would mean that FQHC's and clinics may lose significant (indeterminate) revenues for the provision of Medi-Cal benefits.

Under California law,(b) (1) All state agencies proposing to adopt, amend, or repeal a regulation that is not a major regulation or that is a major regulation proposed prior to November 1, 2013, are required to prepare an economic impact assessment that assesses whether and to what extent it will affect the following:
(A) The creation or elimination of jobs within the state.
(B) The creation of new businesses or the elimination of existing businesses within the state.

(C) The expansion of businesses currently doing business within the state.
(D) The benefits of the regulation to the health and welfare of California residents, worker safety, and the state's environment.
See Cal. Gov. Code §11346.3 (b)(1).

DHCS states that it has determined that the proposed regulations would not significantly affect the creation or elimination of jobs within the State of California; the creation of new businesses or the elimination of existing businesses within the State of California; or the expansion of businesses currently doing business within the State of California. However, DHCS offers no analysis to support these statements.

In its Notice of Proposed Rulemaking Fiscal Impact Estimate, DHCS has determined that the regulations would potentially affect small businesses that voluntarily choose to be Medi-Cal providers in the situation when a beneficiary may choose to enroll and receive services through an AHCSP contracting directly with the Department. DHCS does not make a specific determination as to the extent of this impact.

The proposed regulations will have a real negative impact on California's FQHC's and community clinics for the following reasons:

1. FQHC's are required under Section 330 of the Public Health Services Act to enroll in and be reimbursed for providing services to Medi-Cal beneficiaries as a condition of receiving a federal grant. A significant portion of FQHC revenue is Medi-Cal. Loss in Medi-Cal revenues means reduced access to services for all FQHC patients.

2. FQHC's rarely subcontract to provide health services to AHCSP patients. The proposed regulation include as eligible to enroll in an AHCSP a beneficiary who has been enrolled in the AHCSP at any time during the 12 months immediately prior to the beneficiaries' Medi-Cal eligibility. Therefore, a Medi-Cal beneficiary who was assigned to an FQHC for primary care services but had been enrolled as an AHCSP patient in any of the 12 months prior to becoming a Medi-Cal beneficiary would be eligible to re-enroll in an AHCSP. Based on the language of the proposed regulation, the patient would either have to be enrolled in An AHCSP or be assigned to another plan.

In addition, the proposed regulation include as eligible to enroll in an AHCSP a beneficiary with an AHCSP family member linkage. This means according to the language of the proposed regulation that where a Medi-Cal beneficiary's parent, guardian, minor child or minor sibling has been enrolled in an AHCSP at any time during the 12 months immediately prior to the beneficiary's Medi-Cal eligibility, the beneficiary must either enroll in an AHCSP or be assigned to another plan.

Under both scenarios, there is potential for FQHCs operating in Two-Plan model counties to lose a significant number of Medi-Cal patients to an AHCSP, disrupting continuity of care. Because most FQHCs do not currently contract with an AHCSP to provide primary care services, the FQHCs will have no opportunity to recapture these patients.

3. FQHCs are well-positioned to meet the needs of the expanding Medi-Cal population. In anticipation of Medicaid expansion and the need for adequate numbers of primary care providers, the federal Affordable Care Act included funds for new FQHC sites. Many FQHC's in California received federal funding for expansion to serve growing numbers of newly insured.

The success of these expansion efforts depends on the ability to maximize Medi-Cal revenues.

If the AHCSP captures a disproportionate share of new Medi-Cal beneficiaries in the Two-Plan model counties and FQHCs are not offered contracts to provide primary care services to AHCSP enrollees, the FQHCs will not be able to sustain expansion efforts for lack of anticipated revenues.

RESPONSE: The Department encourages FQHCs to subcontract with all available health plans in a county; however, the Department cannot mandate such subcontracts. Further, it is the choice of an eligible beneficiary whether they choose to enroll in an AHCSP, another Two-Plan Model plan, or receive services from a Community Health Clinic (CHC) or FQHC. If a beneficiary enrolled in an AHCSP prefers to receive services from a CHC or FQHC, an AHCSP may authorize a beneficiary to receive services from those providers out-of-network, or a beneficiary may choose a Two-Plan Model plan that subcontracts with a specific CHC or FQHC in order to receive services from those providers. Nothing in this regulatory amendment precludes a beneficiary's right to receive services from an FQHC.

The Department did assess potential economic impact. Participation in the Medi-Cal program is voluntary. As such, California business enterprises and individuals that choose to participate are not considered to be economically impacted in a mandatory manner by the Department's regulations.

Comment Number: 3

SUBJECT: Repealing Maximum Enrollment

COMMENT: Repealing Maximum Enrollment Provisions Exacerbates Impact.

The proposed regulations also repeal the existing maximum enrollment provisions. This means that neither the AHCSP nor the commercial plans in the Two-Plan model would have a cap on Medi-Cal enrollment. This will negatively impact the local health plans and its service provider contractors.

DHCS states that the maximum enrollment section is being repealed because the Department's managed care model has evolved since the regulations were added and that the original intent of the regulation to "indirectly" protect safety net providers that contract with the local health plans- is no longer necessary because safety-net providers are now contracted through both the commercial plans and the local health plans. However, DHCS provides no analysis as to what extent safety net providers contract with commercial plans in the Two-Plan model counties. Further, in repealing the maximum enrollment provisions, DHCS does not anticipate how the addition of the AHCSP will negatively affect local health plan enrollment and impact local health plan contractors. As such, CCALAC urges DHCS to reconsider the repeal of Title 22
CCR Section 53800.

RESPONSE: In consideration of comments, and after further review, the Department withdraws the proposed repeal of Title 22, CCR Section 53820.

Comment Number: 4

SUBJECT: Continuity of Care

COMMENT: Beneficiary Continuity of Care is Not Protected.
The proposed regulation are slanted to protect continuity of care for existing an AHCSP patients but do not consider the impact on beneficiaries who currently receive health care services through commercial plans or local health plans and who, based on the AHCSP eligibility criteria, may be eligible to enroll in an AHCSP. The proposed regulations would require a person eligible to enroll in the AHCSP to enroll or be assigned to a plan through the existing enrollment and assignment process. There is no language in the proposed regulation to allow beneficiaries who would be AHCSP eligible to remain with their current health plans and assigned primary care providers.

RESPONSE: The language of the proposed regulatory amendment specifically says that the regular enrollment processes will apply if a beneficiary does not choose to enroll in an AHCSP contracted with the Department. Enrollment in an AHCSP is [Begin Underline for Emphases]voluntary[End Underline for Emphases] for eligible beneficiaries. No

beneficiaries will be defaulted into or forced to enroll in an AHCSP if the Department directly contracts with one. The proposed regulatory amendment only enables the Department to offer an additional enrollment choice to those who qualify. It does not in any way alter current Medi-Cal managed care enrollment processes. Those beneficiaries who are currently enrolled in another Medi-Cal managed care plan who are eligible for enrollment in an AHCSP, and do not choose to enroll in an AHCSP, will not be affected.

As always, beneficiaries have the right to choose and change plans at any time. It is up to beneficiaries where they choose to receive their health care. That choice will likely depend on their satisfaction with the health care services they receive.

COMMENT LETTER 4 (California Primary Care Association 6/10/13 – Email Attached Letter)

Comment Number: 1

SUBJECT: Lack of Authority

COMMENT: Lack of Authority.

With the implementation of Medi-Cal managed care, the administration contemplated and the Legislature created a body of law to support a Two-Plan model. Specifically, the Legislature created the Local Initiative to serve a specific purpose within the Two-Plan model structure. Recently, the Legislature granted authority to DHCS to expand Medi-Cal managed care into rural counties. By inference, these actions demonstrate that the Legislature, and not DHCS, has the primary authority to determine changes in the Medi-Cal managed care program, including administration of the Two- Plan Model. This exercise of authority is usually accomplished through specific legislation. By promulgating these regulations without statutory authority, DHCS is bypassing the Legislature's leadership role that support the Two- Plan Model and the Local Initiative and, instead, proposes by regulation to devastate the existing Two- Plan model structure. DHCS' actions are without statutory authority. Therefore, the proposed regulations are deficient for lack of authority.

RESPONSE: See Introductory Remarks regarding Authority.

Comment Number: 2

SUBJECT: Lack of Clarity

COMMENT: Lack of Clarity. The proposed regulations are unclear for the following reasons:

1. Proposed Section 53800 (c)(1) sets forth the eligibility criteria for enrollment in the AHCSP. It would appear that not all Medi-Cal beneficiaries in Two-Plan model counties would be eligible to enroll in the AHCSP. Based on the proposed language, beneficiaries who would be eligible to enroll are: 1) existing AHCSP members, 2) those who had been a AHCSP members at any time during the 12 month period prior to their Medi-Cal eligibility, or 3) those whose parents, guardians, minor children, or minor siblings are AHCSP members or had been enrolled in the AHCSP at any time during the 12 months prior to the beneficiaries' Medi-Cal eligibility. However, the proposed regulation does not contain explicit limiting language and is, therefore, vague.

CPCA suggests the following limiting language be added to proposed Section 53800 (c)(1) as follows:

" Only the following beneficiaries enrolling in Medi-Cal managed care…"

2. Proposed Section 53800(c) (2) would require that if a Medi-Cal beneficiary is eligible to enroll in the AHCSP but chooses not to, the beneficiary would be assigned to a plan consistent with the current enrollment and assignment provisions set forth in existing regulation. However, the language of this section of the proposed regulation is vague and inconsistent with freedom of choice that exists in current Medi-Cal statute and regulations.

CPCA suggests the following clarifying language be added to proposed Section 53800 (c)(2) as follows:

"A beneficiary who is eligible to enroll in the AHCSP but chooses not to enroll in the AHCSP, shall [Begin Bold & Underline for Emphases]**choose or**[End Bold & Underline for Emphases] be assigned to a plan through the enrollment processes…"

3. Proposed Section 53800(c)(3) would exempt the AHCSP from the assignment system described in Section 53884 of the existing Two-Plan model regulation. Section 53884 sets forth the criteria for default assignment of beneficiaries. It is not clear whether the language of proposed Section 53800(c)(3) means that the AHCSP would not be considered at all for beneficiary assignment in Two-Plan model counties if the beneficiary does not meet the AHCSP enrollment eligibility, or whether this means that the AHCSP is simply not subject to the assignment provisions for default assignment.

CPCA recommends complete revision of proposed Section 53800(c)(3) to clarify this point.

Because significant sections of the regulations are unclear, CPCA urges rejection of the proposed regulations as a whole and remit to DHCS for reconsideration.

RESPONSE: The proposed regulatory amendment is clear as written. The suggested language would not add clarity.

Comment Number: 3

SUBJECT: Lack of Necessity

COMMENT: Lack of Necessity. DHCS has provided no evidence to support the need for this regulation. While CPCA understands the need to preserve continuity of care in health care delivery, there is no evidence to suggest that current Kaiser patients who move to Medi-Cal eligibility will be precluded from continuing to seek services at Kaiser through contacts with plans currently operating in Two-Plan model counties.

RESPONSE: Please see Introductory Remarks regarding Necessity and Impact.

Comment Number: 4

SUBJECT: Analysis of Impact on Safety Net Provider

COMMENT: No Analysis of Impact on Safety Net Providers.

The proposed regulations also repeals the existing maximum enrollment provisions. This means that neither the AHCSP nor the commercial plans in the Two-Plan model would have a cap on Medi-Cal enrollment. This has great potential to negatively impact the local health plans and its service provider contractors.

DHCS states that the maximum enrollment section is being repealed because the Department's managed care model has evolved since the regulations were added, and that the original intent of the regulation- to "indirectly" protect safety net providers that contract with the local health plans- is no longer necessary because safety-net providers are now contracted through both the commercial plans and the local health plans. However, DHCS provides no analysis as to what extent safety net providers contract with commercial plans in the Two-Plan model counties. Further, in repealing the maximum enrollment provisions, DHCS does not anticipate how the addition of the AHCSP will negatively affect local health plan enrollment and impact local health plan contractors.

If implemented, the proposed regulation will destabilize local health plans. In Two-Plan model counties, local health plans include more safety-net providers, primarily community health centers and clinics (CHCs), in their provider networks than commercial plans. If the addition of an AHCSP resulted in beneficiaries being siphon off healthy beneficiaries that otherwise may enroll in, or be assigned to, local health plans, this would destabilize local health plans by decreasing overall enrollment, and driving up costs. As a direct result, the number of Medi-Cal beneficiaries who seek care in CHCs will decline, destabilizing these providers whose existence depends on the ability to generate revenues by providing services to beneficiaries of government health care programs such as Medi-Cal.

DHCS provides no data to assure that there will be no negative impact on safety- net providers. As such, CPCA urges DHCS to reconsider the repeal of Title 22 CCR Section 53800.

RESPONSE: In consideration of comments, and after further review, the Department withdraws the proposed repeal of Title 22, CCR Section 53820.

Comment Number: 5

SUBJECT: Analysis of Impact on Providers

COMMENT: No Analysis of Impact on Direct Care Providers.

Under California law, all state agencies proposing to adopt, amend, or repeal a regulation that is not a major regulation, or that is a major regulation proposed prior to November 1, 2013, are required to prepare an economic impact assessment that assesses whether, and to what extent, it will affect the following:
(A) The creation or elimination of jobs within the state.
(B) The creation of new businesses or the elimination of existing businesses within the state.
(C) The expansion of businesses currently doing business within the state.
(D) The benefits of the regulation to the health and welfare of California residents, worker safety, and the state's environment.
See Cal. Gov. Code §11346.3 (b)(1).

DHCS states that it has determined that the proposed regulations would not significantly affect the creation or elimination of jobs within the State of California; the creation of new businesses or the elimination of existing businesses within the

State of California; or the expansion of businesses currently doing business within the State of California. However, DHCS offers no analysis to support these statements.

Further, DHCS has determined that the proposed regulations would potentially affect small businesses that voluntarily choose to be Medi-Cal providers, in the situation when a beneficiary may choose to enroll and receive services through an AHCSP contracting directly with the Medi-Cal program.
The proposed regulations will have a real negative impact on California's community health centers and clinics for the following reasons:

1. Federally qualified health centers (FQHCs) are required under Section 330 of the Public Health Services Act to enroll in, and be reimbursed for, providing services to Medi-Cal beneficiaries as a condition of receiving a federal grant. In this sense, FQHC do not voluntarily choose to be Medi-Cal providers. A significant portion of FQHC revenue is Medi-Cal. Loss in Medi-Cal revenues means reduced access to services for all FQHC patients.

2. The Kaiser provider network is traditionally a closed network generally limited to Kaiser Permanente medical group providers. FQHC do not have the opportunity to subcontract to provide primary care health services or FQHC services to Kaiser patients. The proposed regulations include as eligible to enroll in an AHCSP, a beneficiary who has been enrolled in the AHCSP at any time during the 12 months immediately prior to the beneficiaries' Medi-Cal eligibility. Therefore, a Medi-Cal beneficiary who enrolled with, or was assigned to, an FQHC for primary care services but had been enrolled as a Kaiser patient in any of the 12 months prior to becoming a Medi-Cal beneficiary would be eligible to re-enroll in Kaiser. Based on the language of the proposed regulations, the patient would be required to either enroll in Kaiser or be assigned to another plan.

In addition, the proposed regulations include as eligible to enroll in an AHCSP, a beneficiary with an AHCSP family member linkage. This means according to the language of the proposed regulations where a Medi-Cal beneficiary's parent, guardian, minor child or minor sibling has been enrolled in Kaiser at any time during the 12 months immediately prior to the beneficiary's Medi-Cal eligibility, the beneficiary must either enroll in Kaiser or be assigned to another plan.

Under both scenarios, there is potential for FQHCs operating in Two-Plan model counties to lose a significant number of Medi-Cal patients to Kaiser, disrupting continuity of care. To the extent that patients who do not choose Kaiser would be assigned to a plan that does not contract with the FQHC, this would also cause a significant disruption in continuity of care and loss of Medi-Cal enrollment for the FQHCs. Because FQHCs do not currently contract with Kaiser to provide primary care services, the FQHCs will have no opportunity to recapture these patients.

3. FQHCs are well-positioned to meet the needs of the expanding Medi-Cal population. In anticipation of Medicaid expansion and the need for adequate numbers of primary care providers, the federal Affordable Care Act included funds for new FQHC sites. Many health centers in California received federal funding for expansion to serve the growing numbers of newly insured. The success of these expansion efforts depends on the ability to maximize Medi-Cal revenues. If the AHCSP captures a disproportionate share of new Medi-Cal beneficiaries in the Two-Plan model counties, and FQHCs are not offered contracts to provide primary care services to AHCSP enrollees, the FQHCs will not be able to sustain expansion efforts for lack of anticipated revenues.

RESPONSE: The Department did assess potential economic impact. Participation in the Medi-Cal program is voluntary. As such, California business enterprises and individuals that choose to participate are not considered to be economically impacted in a mandatory manner by the Department's regulations.

The Department encourages FQHCs to subcontract with all available health plans in a county; however, the Department cannot mandate such subcontracts. Further, it is the choice of an eligible beneficiary whether they choose to enroll in an AHCSP, another Two-Plan Model plan, or receive services from a CHC or FQHC. If a beneficiary enrolled in an AHCSP prefers to receive services from a CHC or FQHC, an AHCSP may authorize a beneficiary to receive services from those providers out-of-network, or a beneficiary may choose a Two-Plan Model plan that subcontracts with a specific CHC or FQHC in order to receive services from those providers. Nothing in this regulatory amendment precludes a beneficiary's right to receive services from an FQHC.

Enrollment in an AHCSP is voluntary for eligible beneficiaries. The proposed regulatory amendment clearly states that if an eligible beneficiary does not choose to enroll in an AHCSP the regular enrollment procedures apply. Further, beneficiaries in Two-Plan Model counties always have the option to choose a plan or change their plan. The proposed regulatory amendment only enables the Department to offer an additional enrollment choice to those who qualify. It does not in any way alter current Medi-Cal managed care enrollment processes. Those who are eligible for enrollment in an AHCSP who are currently enrolled in another Medi-Cal managed care plan and do not choose to enroll in an AHCSP, will not be affected.

If the Department directly contracts with an AHCSP, it is merely providing eligible beneficiaries the opportunity to enroll, and will not force any beneficiary to move to an AHCSP. It is the choice of the beneficiary whether they stay with their current provider. Beneficiaries always have the choice of where they receive their health care, which will likely depend on their satisfaction with the health care services they receive.

The projected influx of new Medi-Cal managed care beneficiaries over the next several years indicates that there will be sufficient beneficiary enrollment to support all available providers, including their expansion efforts. It will be up to the beneficiary to choose the plan that best serves their needs. The Department cannot, and should not, force beneficiaries to utilize FQHCs.

Comment Number: 6

SUBJECT: Continuity of Care Not Protected

COMMENT: Beneficiary Continuity of Care is Not Protected.

The proposed regulations are slanted to protect continuity of care for existing Kaiser patients but do not consider the impact on beneficiaries who currently receive health care services through commercial plans or local health plans and who, based on the AHCSP eligibility criteria, may be eligible to enroll in the AHCSP. The proposed regulations would require a person eligible to enroll in the AHCSP to enroll or be assigned to a plan through the existing enrollment and assignment process. There is no language in the proposed regulations to allow beneficiaries who would be AHCSP-eligible to remain with their current health plans and assigned primary care providers.

Further, there is nothing in the proposed regulations that would require the AHSCP to contract with FQHCs for the provision of FQHC services. Medi-Cal beneficiaries are entitled to FQHC services under both federal and state law. See 42 U.S.C. § 1396d(a)(2) and Cal. Welfare & Institutions Code § 14132.100.

Finally, with a closed provider network, there is no guarantee that the scope of services offered by the AHCSP would include the full range of benefits that Medi-Cal recipients currently may receive. Medi-Cal beneficiaries who now receive methadone treatments and other vital, evidence-based and effective medical services may lose ready access to these services when enrolled in the AHCSP. This will result in AHCSP enrollees needing to access Medi-Cal benefits outside the AHCSP network for care, causing unnecessarily fragmentation of care and greater chance that continuity of care would be compromised.

RESPONSE: Enrollment in an AHCSP is voluntary for eligible beneficiaries. Further, beneficiaries in Two-Plan Model counties always have the option to choose a different plan at any time. The proposed regulatory amendment only enables the Department to offer an additional enrollment choice to those who qualify. It does not in any way alter current

Medi-Cal managed care enrollment processes. Those who are eligible for enrollment in an AHCSP who are currently enrolled in another Medi-Cal managed care plan and do not choose to enroll in an AHCSP, will not be affected. That choice will likely depend on their satisfaction with the health care services they receive.

The Department encourages FQHCs to subcontract with all available health plans in a county; however, the Department cannot mandate such subcontracts. Further, it is the choice of an eligible beneficiary whether they choose to enroll in an AHCSP, another Two-Plan Model plan, or receive services from a CHC or FQHC. If a beneficiary enrolled in an AHCSP prefers to receive services from a CHC or FQHC, an AHCSP may authorize a beneficiary to receive services from those providers out-of-network, or a beneficiary may choose a Two-Plan Model plan that subcontracts with a specific CHC or FQHC in order to receive services from those providers. Nothing in this regulatory amendment precludes a beneficiary's right to receive services from an FQHC.

If the Department contracts with an AHCSP pursuant to this regulatory amendment, the contract will require an AHCSP to provide the same scope of benefits as any other Two-Plan Model health plan.

COMMENT LETTER 5 (Private Essential Access Community Hospitals, Inc. 6/10/13 – Email Attached Letter)

Comment Number: 1

SUBJECT: Protections for Safety Net Providers

COMMENT: 1. Retaining the Two-Plan Model and its Key Protections for Safety Net Providers is Critical

As defined by the proposed regulation, Kaiser Permanente is the only health plan that would meet the definition of an AHCSP. We are very concerned that the proposed regulation singles out Kaiser Permanente health plans for special treatment, which are closed systems of care without significant relationships with safety net providers.

This is diametrically opposed to a key tenet of the current Two-Plan Model, which the Legislature created with the specific intent to provide choice and access to care from a strong network of safety net providers. It is critical that the current protections for safety net providers in the Two-Plan Model continue in order to ensure network adequacy and optimize access and continuity of care for Medi-Cal beneficiaries

RESPONSE: Any plan meeting the proposed definition would qualify to be an AHCSP.

See Introductory Remarks regarding Necessity and Impact.

Comment Number: 2

SUBJECT: Lack of Necessity

COMMENT: 2. The Proposed Regulations are Unnecessary Since Continuity of Care is already being assured for Kaiser Permanente Plans through Three-Way Contracts

In its April 3, 2013 “Initial Statement of Reasons” for the proposed Two-Plan Model Modification, DHCS states that a primary reason for the regulatory change is to address continuity of care issues for specific categories of Medi-Cal beneficiaries and, in particular, the Healthy Families Program enrollees who were moved to Medi-Cal managed care.

However, in every Two-Plan Model county where children were previously in Kaiser Permanente as Healthy Families enrollees, those enrollees have been effectively transitioned to Medi-Cal and already assigned by the public plan back to Kaiser Permanente.

Further, the regulation remains unnecessary because the stated purpose of the proposed regulations has already been achieved through contracts that have been or shortly will be executed between Kaiser Permanente and the state’s public plans.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

This regulatory package is not exclusive to the Healthy Families Program transition. Further, the transition is not yet completed.

The regulatory amendment is necessary because the referenced agreements do not provide the Department with the necessary statutory authority to contract directly with an AHCSP.

Comment Number: 3

SUBJECT: Lack of Authority

COMMENT: 3. Changes to the Two-Plan Model Should Be Made through the Legislative Process

Additionally, we are very concerned about the consequences of DHCS's implementation of the proposed regulation, which could lead to a path to abandon the Two-Plan Model altogether. Once implemented, the regulation does not include language that would prevent DHCS from amending the regulation further to allow additional commercial plans into Two-Plan counties without limitation.

The Legislature created the Two-Plan Model legislation with the specific intent to create the Local Initiatives to support and strengthen the health care safety net. The Legislature recently granted authority to DHCS to take different approaches in certain rural counties to deliver Medi-Cal managed care services.

Both of these actions demonstrate that the Legislature has a leadership role in determining when to deviate from the Two-Plan Model – and, when it does so, it accomplishes this through specific legislation on a limited basis.

We are greatly concerned that DHCS appears to be bypassing the Legislature's leadership role, which created the Two-Plan Model and the Local Initiative, and proposes to significantly weaken the existing Two-Plan Model counties through the regulatory process without Legislative input.

For these reasons, we urge you to reconsider this proposal, which is unnecessary, and would undermine access to safety net providers at this critical time when the state and the provider community are rapidly preparing to expand Medi-Cal coverage to 1.4 million Californians on January 1, 2014 under the Affordable Care Act.

RESPONSE: See Introductory Remarks regarding Authority.

COMMENT LETTER 6 (California Children's Hospital Association 6/11/13 – Email Attached Letter)

Comment Number: 1

SUBJECT: Lack of Authority

COMMENT: Lack of Authority
CCHA believes that DHCS is acting outside the scope of its authority to implement the Two-Plan Model law and is bypassing the Legislature's leadership role that established the Two-Plan Model and the Local Initiative. While Wel. & Inst. Code, § 14087.3 does provide the DHCS Director with broad contracting authority for the delivery of services to Medi-Cal beneficiaries, Section 14087.3 is part of the very same article, Article 2.7 (§§ 14087.3-14087.48), which creates the Two-Plan Model system. (See, e.g., Wel. & Inst. Code, §§ 14087.31, 14087.35, 14087.36, 14087.38, creating the mechanisms for the Two-plan Model delivery system.)

DHCS has failed to explain how the Article creating the Two-Plan Model and providing authority to deliver services thereunder also authorizes it to fundamentally deviate and undermine the very same Two-Plan Model system. The Legislature specifically authorized DHCS to contract with multiple plans in two counties, Sacramento and San Diego. (Article 2.91 [§§ 14089-14089.4].) Both of these actions demonstrate that the Legislature preserves for itself the primary leadership role in determining when to deviate from the Two-Plan Model. When it does so, it accomplishes this through specific legislation and on a limited basis. But-for these explicit exceptions, the Legislature has appeared to remain committed to the Two-Plan Model in existing counties.

RESPONSE: See Introductory Remarks regarding Authority.

Comment Number: 2

SUBJECT: Lack of Necessity

COMMENT: Lack of Necessity

DHCS claims the change is necessary to address continuity issues for specific categories of Medi-Cal enrollees, most notably the Healthy Families Program enrollees who were moved to Medi-Cal managed care. The department also claims that the regulation would permit individuals who become eligible for Medi-Cal but were previously enrolled in Kaiser in the past 12 months to reenroll with Kaiser in order to maintain continuity of care.

However, in every Two-Plan Model county where children were previously enrolled in Kaiser through Healthy Families but have now been moved to Medi-Cal, those children have already been assigned by the public plan back to Kaiser. Further, for those disenrolled from Kaiser, continuity of care has already likely been lost at this point if the individual is no longer enrolled in Kaiser, most likely due to losing coverage through a loss of employment, etc.

Even if the regulation could be justified on the basis of continuity of care, CCHA's understanding is that the amendment would still be unnecessary because the stated purpose of the proposed regulation has already been achieved through contracts that have been or shortly will be executed between Kaiser and the public plans. These contracts are accompanied by a three-way agreement between Kaiser, DHCS, and the public plans that accomplish the stated purpose of the regulatory change. If Kaiser desired to enter the market in Two-Plan counties, they should compete to be the commercial plan.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

This regulatory package is not exclusive to the Healthy Families Program transition, but applies to all beneficiaries eligible for enrollment in an AHCSP, including but not limited to those transitioning from the Healthy Families Program. Further, the Healthy Families transition is not yet completed.

The 12 month eligibility period is consistent with the 12 month continuity of care period found in the 1115 Demonstration Waiver and California law. See Welfare & Institutions Code section 14181(a) and 14182(b)(14), incorporating Health & Safety Code section 1373.96.

Comment Number: 3

SUBJECT: Safety Net Viability

COMMENT: Safety Net Viability
Local community health plans have a stake in the stability and competitiveness of local safety-net providers, and their

investments in this system demonstrate that commitment. A closed-model delivery system has the opportunity to pick and choose the regions in which it does business and can ultimately undermine traditional community providers, including children's hospitals, putting the safety net at risk.

Local community health plans were challenged under Two-Plan legislation to operate as financially viable institutions, but also to protect the safety net and the access to care that they afford now and in the future. Commercial health plans, it was perceived, might selectively contract for the healthiest communities or enrollees and would not prioritize contracting with traditional community providers. Local health plans play a key role in protecting the safety net. Without the safety net, it would be impossible to have sufficient access in the Medi-Cal program. Medi-Cal revenue is crucial to the financial viability of safety net providers.

Finally, safety-net providers have numerous opportunities to influence the policies of the local community health plans. Safety-net providers are typically represented on the plans' governing boards, and also participate on provider advisory boards, quality improvement committees, and peer review and credentialing committees. As a result, safety-net needs and concerns have a voice in the operations of local community health plans. This voice would be vitiated under the proposed amendment to the Two-Plan regulation.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

The proposed regulatory amendment has been drafted to narrowly define the Medi-Cal beneficiaries who will be eligible to voluntarily enroll in an AHCSP. The expansion of the Medi-Cal managed care population, diversity of new beneficiaries, and the limitation of the current health care structure requires the Department to take action to meet the needs of this growing population.

There are no facts to support the statement that "This voice would be vitiated under the proposed amendment to the Two-Plan Regulation." The proposed regulatory amendment will in no way impact the ability of safety-net providers to influence the policies of the local community health plans. The local community health plans will continue to have the option to subcontract with an AHCSP. The safety-net providers will continue to carry the same influence with the plan governing boards, quality improvement committees, and peer review and credentialing committees.

COMMENT LETTER 7 (California Association of Public Hospitals and Health Systems 6/11/13 – by Fax and also Email Attached Letter)

Comment Number: 1

SUBJECT: Undermines the Implementation of Reform

COMMENT: Undermines the Implementation of Reform.
The proposed Two-Plan Model Modification could weaken a critical local health care delivery structure at the very time we are preparing for the largest coverage expansion in a generation. Two-Plan counties represent the majority of Medi-Cal enrollment statewide and will play an essential role in ensuring that those eligible for Medi-Cal next year do in fact enroll. Local health plans are already working closely with the State and other stakeholders on the transition of Low Income Health Program enrollees, and will be critical partners in the overall successful implementation of health reform in California.

The proposed regulation undermines the current Two-Plan Model structure, negatively impacting many of the local plans and replacing existing Kaiser subcontracts with direct contracts between Kaiser and the State. The modification is being offered even as many of these subcontracts are being re-negotiated, subverting that process with an across-the-board structure that renders those local negotiations moot. We believe that these negotiations should proceed and the State should allow local plans to retain subcontracts with Kaiser.

Furthermore, the proposed regulation deletes the min/max provision which was designed to send more default members to the plan that uses safety net providers. The rationale given by DHCS is that the protection is no longer necessary because safety-net providers are now contracted with both the commercial plans and the local health plans. While some public hospital systems do contract with commercial health plans, these relationships are not sufficient to justify the elimination of provisions that encourage plans to support this practice.

Public hospital systems, in addition to being major providers of care for the Medi-Cal program, will also serve many of the 3-4 million remaining uninsured who will continue to need access to health care services. Given the expected funding reductions for care to this population, it will be especially critical that public hospital systems maintain and expand our partnerships with both local and commercial plans. Eliminating existing incentives to promote such efforts could be harmful to safety net providers.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

In consideration of comments, and after further review, the Department withdraws the proposed repeal of Title 22, CCR

Section 53820.

Comment Number: 2

SUBJECT: Lack of Necessity

COMMENT: Unnecessary Change to Support Continuity of Care.

DHCS indicated that the Two-Plan Model Modification was put forward to address continuity of care concerns and preserve access to providers, expressing a particular concern about enrollees transitioning from Healthy Families to Medi-Cal. Although we support efforts to maintain continuity of care for enrollees, in Two-Plan counties, subcontracts with Kaiser already exist. Furthermore, our understanding from the Local Plans of California (LHPC) is that all Healthy Families children enrolled through Kaiser have been transitioned to Medi-Cal and assigned by the public plan back to Kaiser. Therefore the continuity of care concern appears to be addressed with the current Two-Plan Model structure. It is unclear why the proposed change is needed at this time. Any ongoing concerns regarding continuity of care could be addressed at the local level, without a structural statewide change.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

COMMENT LETTER 8 (CalViva Health 6/11/13 – Email Attached Letter)

Comment Number: 1

SUBJECT: Lack of Necessity

COMMENT: Lack of Necessity.

The proposed regulation is not necessary. It is limited to one health plan, Kaiser Permanente. This health plan already has contracts in place in every county in which it previously served Healthy Families children. As we have noted in reviewing the transition plans for Healthy Families, assuring that Healthy Families children can stay with the same plan and the same doctors and hospitals is an important objective. Achieving that objective does not require these regulations since that objective has already been met. Similarly, while local health plans that contracted with Kaiser had previously kept a higher percentage of the contract for redirection to the safety net, that percentage has now been limited by contract

thus obviating the need for the proposed regulation. In enacting the 2012-13 budget, the Legislature similarly determined that there was no need for a statutory change to correct what had already been corrected by contract.

RESPONSE: Any plan meeting the proposed definition would qualify to be an AHCSP.

See Introductory Remarks regarding Necessity and Impact.

Comment Number: 2

SUBJECT: Lack of Consistency with Statute

COMMENT: Lack of Consistency with the Statute

Numerous provisions of existing state law in the Welfare and Institutions Code create the two-plan model in various counties (Welfare and Institutions Code Sections xxx). Welfare and Institutions Code Section 14087.35 expressly refers to the "state-mandated two-plan managed care model". Yet in its citation of statutory authority, the Department of Health Care Services fails to reference these provisions of law. How does the Department reconcile the proposed regulations with the existing statute?

Geographic managed care for Sacramento and San Diego is expressly authorized in Welfare and Institutions Code Article 2.91, Section 14089-14089.4. This section does not apply to other counties. How does the Department reconcile the proposed regulations with these provisions of law?

Similarly, legislation enacted last year in the budget, Welfare and Institutions Code Article 2.82, Section 14087.98 expressly authorized the Department to take a different approach in expanding Medi-Cal managed care to rural counties but did not change the two-plan model where it exists.

If the Administration wishes to undo the two-plan model, it should seek statutory change to do so. We would oppose that statutory change but the Administration cannot do by regulation what is not consistent with the underlying statute.

RESPONSE: See Introductory Remarks regarding Authority.

Comment Number: 3

SUBJECT: Existing Alternative

COMMENT: Existing Reasonable Alternative.

As we have already noted, there is an existing reasonable alternative to these regulations: the contracts with the local health plans in the two-plan model counties have been amended to include contracts with Kaiser Permanente to continue to cover Healthy Families children and to cover other Medi-Cal beneficiaries at a reasonable administrative overhead.

RESPONSE: See Introductory Remarks regarding Necessity and Impact

COMMENT LETTER 9 (Santa Clara Family Health Plan 6/11/13 – Email Attached Letter)

Comment Number: 1

SUBJECT: Lack of Authority

COMMENT: Lack of Authority

Under the APA, "authority" to adopt a regulation is defined as "the provision of law which permits or obligates the agency to adopt, amend, or repeal a regulation." (Gov. Code,§ 11349, subd. (b).)

The April 15, 2013 Notice of Proposed Rulemaking relies heavily, if not exclusively, on Welfare and Institutions Code, Section 14087.3 as providing DHCS the authority to adopt the proposed regulation. (DHCS Notice of Proposed Rulemaking, Apr. 15, 2013, p. 2.) In particular, DHCS relies on a single phrase in Section 14087.3 which states that, "at the director's discretion," the contract may be on an exclusive or nonexclusive basis. (Ibid.) The assumption that this phrase in Section 14087.3 provides the director with carte blanche, unrestricted power to contract as the director sees fit is not a proper reading of that statutory section; and in contrast, the statutory scheme which surrounds Section 14087.3 unquestionably demonstrates the Legislature's commitment to the two-plan model. Since the statutory scheme is committed to the two-plan model and the regulation proposed here would seriously jeopardize that model, DHCS lacks the authority, as defined in the APA, to adopt the proposed regulation.

When engaging in statutory interpretation, "The words of the statute must be construed in context, keeping in mind the statutory purpose, and statutes or statutory sections relating to the same subject must be harmonized, both internally and

with each other, to the extent possible." (Dyna-Med, Inc. v. Fair Emp. & Housing Com. (1987) 43 Cal.3d 1379, 1387.)

Reading Section 14087.3 as authorizing DHCS to deviate from the two-plan model in two-plan model counties cannot be squared with the context in which Section 14087.3 exists or the surrounding statutory purpose; and it cannot be harmonized with statutory sections relating to the same subject. Section 14087.3 is part of the very same article, Article 2.7 (Wel. & Inst. Code, §§ 14087.3-14087.48), which creates the two-plan model system. (See, e.g., Wel. & Inst. Code,§§ 14087.31, 14087.35, 14087.36, 14087.38, creating the mechanisms for the two plan model delivery system.) Other similar portions of Chapter 7 (Wel. & Inst. Code, §§ 14000-14198.2) as Part 3 of Division 9 similarly affirm the Legislature's commitment to the two plan model. (See, e.g., Article 2.81, Wel. & Inst. Code,§§ 14087.96-14087.9725, creating a local initiative in Los Angeles County; and Wel. & Inst. Code, § 14018.7, creating a local initiative in Kern County.) Even beyond that, Welfare and Institutions Code, Section 14087.35 refers explicitly to the "state-mandated two-plan managed care model."

To date, DHCS has simply not explained how the Article within the Welfare and Institutions Code which creates the two-plan model also simultaneously authorizes DHCS to deviate from the very same system it creates.

In addition, when the Legislature wishes to authorize DHCS to contract with more than two plans in a single county, it has unmistakably shown that it knows how to do so expressly. For example, Article 2.91 (commencing with Section 14089, et seq.) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code authorizes multiplan projects in San Diego and Sacramento Counties by way of explicit reference. (See Wel. & Inst. Code,§§ 14089.05 and 14089.07.) The Legislature also recently granted explicit authority to DHCS to take different approaches in designated rural counties in order to bring managed care to Medi-Cal recipients in those counties. (Wel. & Inst. Code, Div. 9, Part 3, Ch. 7, Article 2.82 [commencing with Section 14087.98].)

"When the Legislature uses different words as part of the same statutory scheme, those words are presumed to have different meanings." (Romano v. Mercury Insurance Co. (2005) 128 Cal.App.4th 1333, 1343.) Furthermore, under the principle of expressio unius est exclusio alterius, "the expression of certain things in a statute necessarily involves the exclusion of other things not expressed." (Dyna-Med, Inc., supra, 34 Cal.3d at 1391 n. 13, citing Henderson v. Mann Theatres Corp. (1976) 65 Cal.App.3d 397, 403.)

Two conclusions flow from these rules of statutory interpretation. First, it cannot be presumed that Section I 4087.3 empowers DHCS to deviate from the two-plan model in two-plan model counties when the Legislature has demonstrated that when it wants to authorize alternative models it does so expressly, as was the case with San Diego and Sacramento

Counties, and a host of rural counties. The words used in Article 2.7 (i.e., Section 14087.3) cannot be read as authorizing essentially the same things as Articles 2.91 and 2.82, when the words used in those articles are markedly different. Second, the fact that the two-plan model counties were not identified in either Article 2.91 or Article 2.82- where multiplan models are established - necessarily means that the two-plan model counties are excluded from any authority DHCS may have with respect to other counties to use more than two plans.

Lastly, DHCS's assertion of authority to adopt the proposed regulation is contrary to its own longstanding view of its own authority to deviate from the two-plan model. In its 1993 document, Expanding Medi-Cal Managed Care: Reforming the Health System; Protecting Vulnerable Populations, DHCS stated that there were three "compelling" reasons for having just one non-governmentally owned mainstream plan enrolling Medi-Cal beneficiaries in each region: (1) it assures the mainstream plan will have a sufficient number of enrolled beneficiaries to maintain its financial viability; (2) it eliminates the potential for undesirable competition which can adversely affect the quality of care and create marketing abuses; and (3) it allows DHCS to focus its staff resources to maximize its ability to monitor for quality and access. (Dept. of Health Services, Expanding Medi-Cal Managed Care (1993), at pp. 15-16.)

For whatever reason, DHCS now seeks to completely disregard these "compelling" reasons and move in a direction that could undermine the two-plan model system and bring to life the three problems that DHCS identified in 1993 and sought to avoid. Continuous administrative interpretation is a persuasive force in a statute's construction. (Bates v. State Bd. of Equalization (1969) 275 Cal.App.2d 388, 391.) For at least two decades, DHCS took the position that deviating from the two plan model was inconsistent with the objectives the Legislature sought to achieve in terms of providing high quality care to Medi-Cal enrollees while conserving limited state resources. The history of that position is likewise persuasive in the interpretation of the scope of Section 14087.3, and it contradicts the claim of authority that DHCS currently asserts.

RESPONSE: See Introductory Remarks regarding Authority.

Comment Number: 2

SUBJECT: Lack of Necessity

COMMENT: Lack of Necessity

Under the APA, "necessity" to adopt a regulation is defined as "the record of the rulemaking proceeding demonstrates by substantial evidence the need for a regulation to effectuate the purpose of the statute, court decision, or other provision of

law that the regulation implements, interprets, or makes specific, taking into account the totality of the record." (Gov. Code, § 11349, subd. (a).)

DHCS claims the regulatory change is "necessary" to address continuity issues for specific categories of Medi-Cal enrollees, most notably the Healthy Families Program enrollees who were moved to Medi-Cal managed care. However, in every two-plan model county where children were previously enrolled in Kaiser Permanente through Healthy Families but have now been moved to Medi-Cal, those children have already been assigned by the public plan back to Kaiser Permanente. Thus, it is simply untrue that the regulatory change is "necessary" to deal with continuity issues for specific categories of Medi-Cal enrollees.

Moreover, DHCS claims that the regulation is needed to permit individuals who become eligible for Medi-Cal but were previously enrolled in Kaiser Permanente in the past 12 months to reenroll with Kaiser Permanente in order to maintain continuity of care. However, continuity of care has (sic) already likely been lost at this point if the individual is no longer enrolled in Kaiser Permanente, most likely due to losing coverage through a loss of employment, etc. "Necessity" simply cannot be justified on continuity of care grounds when the continuity of care has already been broken.

Even if the regulation could be justified on the basis of continuity of care, it would still be unnecessary because the stated purpose of the proposed regulation has already been achieved through contracts that have been or shortly will be executed between Kaiser Permanente and the public plans. These contracts are accompanied by a three way agreement between Kaiser Permanente, DHCS, and the public plans that accomplish the stated purpose of the proposed regulatory change.

DHCS's claims that protections for safety net providers are no longer necessary because safety net providers are now contracted through both commercial plans and local initiatives, even if true, ignores the fact that the commercial plan benefitting from the change in regulation, Kaiser Permanente, operates with a closed delivery system, and thus does not have significant relationships with traditional safety net providers.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

The 12 month eligibility period is consistent with the 12 month continuity of care period found in the 1115 Demonstration Waiver and California law. See Welfare & Institutions Code section 14181(a) and 14182(b)(14), incorporating Health & Safety Code section 1373.96.

Comment Number: 3

SUBJECT: Lack of Clarity and Consistency

COMMENT: Lack of Clarity and Consistency

Under the APA, "clarity" means "written or displayed so that the meaning of the regulations will be easily understood by those persons directly affected by them." (Gov. Code, § 11349, subd. (c).) Similarly, "consistency" means "being in harmony with, and not in conflict with or contradictory to, existing statutes, court decisions, or other provisions of law." (See, e.g., County of San Diego v. Bowen
(2008) 166 Cal.App.4'11 501, 516 [regulations must be reviewed for consistency with the law and clarity].)

As noted supra, there are already other provisions of law in place, in the form of legally binding contracts between DHCS, Kaiser Permanente, and the public plans, which address the specific circumstances set forth in the proposed regulation. DHCS was aggressive in encouraging the public plans to enter into these contracts, and stated that these contracts would obviate the need for DHCS to consider directly contracting with Kaiser Permanente to meet continuity goals - thus contradicting both the necessity and consistency aspects of the proposed regulation. Nonetheless, the proposed regulation makes no reference to these existing contracts and thus suggests that DHCS can contract directly with Kaiser Permanente despite the existence of these contracts.

Therefore, it is unclear whether the regulation would render the existing contracts null and void, or whether DHCS would acquire the authority to contract directly with Kaiser Permanente even though the issue has already been addressed in existing contracts; i.e., creating duplicative contracts. The status of the existing contracts, and the likely effect of the proposed regulation on those contracts, "cannot be easily understood by" Kaiser Permanente or the public plans even though both will be directly affected by the proposed regulation, in violation of Gov. Code, § 11349, subdivision (c).

RESPONSE: See Introductory Remarks regarding Authority.

The proposed regulatory amendment is clear as written and is consistent with exiting provisions of law.

See Introductory Remarks regarding Necessity and Impact.

Comment Number: 4

SUBJECT: More Reasonable Alternatives

COMMENT: More Reasonable Alternatives

Under the APA, DHCS must also determine that no reasonable alternative has been identified which would be as effective and less burdensome to affected parties than the proposed action. (Gov. Code, § 11346.5 subd. (a)(13).)

DHCS's stated justification for the proposed rulemaking has centered largely on continuity of care concerns. However, as noted supra, DHCS is already accomplishing today through contract what it seeks to accomplish later through regulation. The vast majority of public plans have already executed contracts with Kaiser Permanente that address the continuity of care issues identified by DHCS; and the small handful of remaining public plans who have yet to execute contracts with Kaiser Permanente are expected to do so in the very near future.

More importantly, in every two-plan model county where Medi-Cal children were previously enrolled in Kaiser Permanente through Healthy Families, those children have already been assigned by the public plan back to Kaiser Permanente.

Therefore, instead of burdening the public with potential reductions in the quality of care and marketing abuses - and mainstream plans in two-plan model counties with risks to their financial viability - by deviating from the two-plan model (see Dept. of Health Services, Expanding Medi-Cal Managed Care (1993), at pp. 15-16), DHCS can instead continue engaging in the public plan/Kaiser Permanente contracting process and achieve the same result in a far more reasonable and less burdensome manner.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

There is no evidence to indicate that the proposed regulatory amendment will reduce quality of care or create marketing abuses. All applicable Medi-Cal requirements will continue to be applied to all plans, as will all marketing requirements and restrictions. Rather, it will expand the health care options and access for Medi-Cal beneficiaries, promote continuity of care, and provide yet another resource to meet the health care needs of the quickly increasing Medi-Cal population.

COMMENT LETTER 10 (Luisa Blue, SEIU Locals 221, 521, 721, and 1021 6/11/13 – Email Attached Planned Hearing Testimony)

Comment Number: 1

SUBJECT: Need to Protect the Health and Viability of California's Healthcare Safety Net

COMMENT: The first point that I want to address is the claim on page 6 of the SOR that "this protection [of safety net providers] is no longer necessary because safety-net providers are now contracted through both the Commercial Plans and the Local Initiatives."

On its face, this statement does not prove its point, because there is no necessary correlation between a Commercial Plan contracting with safety net providers and actually directing a substantial proportion of covered lives to those providers. The Department has not presented evidence on the real world impact of these contracts that would justify this as a statement of fact. We therefore oppose the proposed repeal of Section 53820 and related sections.

But more importantly, this single, relatively minor, reference in the SOR to the state's interest in, and need to, continue protection for the health care safety net ignores the foundational role protecting the safety net played in the construction of the Two-Plan model from the beginning. The state's reasoning in 1993, presented in Expanding Medi-Cal Managed Care: Reforming the Health System; Protecting Vulnerable Populations, is just as true now as it was then.

Dr. Molly Coye, then Director of the Department of Health Services, emphasized the state's interest in viable local healthcare safety nets a number of times in her cover letter to the 1993 report. For example, Dr. Coye stated that a top state priority in developing the Two-Plan model was "to support the continued existence of a 'safety net' to care for the medically indigent, with protections for the continuing relationships between providers and the patients they care for...." [Ibid., p.2]

The regulations undermine this support. Today as in 1993, Medi-Cal funding is the bedrock on which local health care safety nets have built and support their care for vulnerable populations, including the medically indigent who are not eligible for Medi-Cal.

According to the California Health Care Foundation report Health Care Almanac for 2010 Medi-Cal accounts for almost two thirds of net patient revenue for public hospitals statewide. Medi-Cal and Health Families accounts for seventy one percent of net patient revenue for community clinics. Both providers also provide significant care for the indigent uninsured. [cited in California Health Care Almanac, California's Health Care Safety Net: A Complex Web, April 2013].

The current regulations recognize the integral connection between Medi-Cal and traditional providers; therefore we also oppose the proposal to strike “Medi-Cal in Section, 53800(b)(C)(2). [new numbering]

RESPONSE: In consideration of comments, and after further review, the Department withdraws the proposed repeal of Title 22, CCR Section 53820.

See Introductory Remarks regarding Necessity and Impact.

The term defined in existing Section 53810(jj) is “traditional provider” not “traditional Medi-Cal provider.” This change was simply made to have Section 53800(b)(C)(2) be consistent with the definition of “traditional provider.”

Comment Number: 2

SUBJECT: Continuity of Care

COMMENT: The principle of continuity of care was also an important factor in how the state structured the Two-Plan model. As Dr. Coye put it: “Because the eligibility status of Medi-Cal beneficiaries fluctuates frequently - and most often between Medi-Cal and medical indigency - a number of counties are exploring the potential for using the locally-developed Medi-Cal managed care plan to provide some or all services for indigent populations.”

The most important way the state can promote continuity of care is still through protecting the safety net, because this pattern of fluctuation is as true today as it was in 1993.

According to the Urban Institute’s analysis of the 2002 National Survey of America’s Families, 16% - 19% of individuals with incomes below 200% of the FPL were uninsured for some period of time during the calendar year. Those at lower incomes had longer periods of uninsurance than those at higher incomes. [cited in UC Berkeley Labor Center, After Millions of Californians Gain Coverage under the Affordable Care Act, Who Will Remain Uninsured? September 2012, p. 15].

California’s experience confirms the high degree of “churning” in the Medi-Cal population. According to data presented to the Legislative budget committees in February 2013, the state anticipated that 767,772 Medi-Cal beneficiaries would be expected to discontinue enrollment in the budget year without the ACA. [calculated from data in Senate Budget Subcommittee 3, March 14, 2013 analysis, p. 16]

While the administration contends that a very high percentage of these beneficiaries will no longer be dropped off Medi-Cal under the ACA, both the Legislative Analyst and UC's CalSIM projections strongly dispute those claims. Only the future will tell for sure who is right on that point, but we cannot predicate regulatory changes today on the department's best guess about the future. Instead, the Department's numbers demonstrate that what we do know is that there is a very high level - nearly 800,000 people a year - of historical volatility in Medi-Cal.

To provide these individuals and their families with continuity of care, it is critical that when low-income individuals fall off Medi-Cal, there is a strong local healthcare safety net for them to fall into. It is precisely these relationships, and this continuity of care for Medi-Cal disenrollees, that would be disrupted by inserting an Alternative Health Care Service Plan (AHCSP) into a Two-Plan model county.

There are also other categories of individuals who rely in other ways on a healthy safety net for continuity of care for themselves and their families. For example, many California families include members who are undocumented as well as members who are legal residents. For undocumented immigrants, county hospitals and clinics and community clinics and health centers are the main places they can go for care. Introducing an AHCSP that does not provide care to the undocumented members of a family would also undermine continuity of care for these families.

For the poor with a severe mental illness or substance abuse problem, county safety net providers are also the place they rely on for help. County safety net providers are currently engaged in a major effort to coordinate and integrate behavioral health with medical care for these individuals. Diverting more Medi-Cal beneficiaries to an AHCSP that does not have the obligation to care for the severely mentally ill/behavioral health population also undermines this important continuity of care that a healthy safety net provides.

Dr. Coye's 1993 letter further states another important rationale for the Two-Plan model: "In incorporating the safety net providers in each region into the local planning and delivery system for managed care, we also hope to stimulate planning for the eventual integration of all publicly-financed care."

Since 1993, the state, county, and federal governments, along with nonprofit community clinics and health centers, have made major investments toward that goal. Beginning with the 1995 Los Angeles 1115 waiver, and continuing through the 2010 waiver's DSRIP and other initiatives, California has made major investments in, and steady progress toward, this objective for the Two-Plan model, i.e., the "integration of all publicly-financed care."

Therefore on this ground as well, parachuting in an AHCSP through state or regional contracts - but divorced from the local planning process and from local safety net providers - undermines the substantial investments we have all made in local safety net systems.

Ironically, the proposed regulations would disrupt the way that the only plan qualifying for AHCSP status, Kaiser, has begun to play a role in the local healthcare safety net. In response to the transition of Healthy Families children to Medi-Cal, all Two-Plan counties have now assigned back to Kaiser the individuals who were formerly insured by Kaiser under Healthy Families (it is our understanding that in one county covered lives have been assigned to Kaiser, and a contract between the county and Kaiser will shortly be in place).

Thus as things stand - without these proposed regulations - Kaiser's important role for these children is being acknowledged by, and incorporated into, local safety net planning across Two-Plan model counties. The regulations would disrupt these local arrangements, and local solutions. In their place they would introduce an unknown factor - statewide or regional contracts, for populations potentially much larger than those directly referenced in the SOR - that would completely bypass and ignore local situations.

My testimony has focused on how the proposed regulations not only fail to further the Department's stated intention of promoting continuity of care for Medi-Cal beneficiaries and their families, but instead undermine it, while at the same time undermining the viability of the local healthcare safety net systems the Two-Plan model was designed to protect:

1. Instead of "support[ing] the continued existence of a 'safety net' to care for the medically indigent, with protections for the continuing relationships between providers and the patients they care for….", the proposal undermines the financial link between Medi-Cal and care for the indigent that is the foundation for the viability of California's safety net.

2. Instead of recognizing and supporting the fact that "Because the eligibility status of Medi-Cal beneficiaries fluctuates frequently - and most often between Medi-Cal and medical indigency - a number of counties are exploring the potential for using the locally-developed Medi-Cal managed care plan to provide some or all services for indigent populations", the proposal undermines the safety net's coverage for those who fluctuate between Medi-Cal and medical indigency, as well as undermining continuity of care for families that mix undocumented and legal residents, and those with severe behavioral health as well as medical needs.

3. Instead of recognizing the state's longstanding commitment to "incorporating the safety net providers in each region into the local planning and delivery system for managed care. to stimulate planning for the eventual integration of

all publicly-financed care," the proposal undermines decades of investment in and commitment to that goal by the state, counties, and the federal government.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

Further, the Department is proposing this regulatory amendment at a time when the implementation of the Affordable Care Act and the operation of Covered California, the new California Health Benefits exchange, are drastically changing the health care landscape from the way it existed in 2003.

The Covered California website explains:

- By 2017, an estimated 2.3 million Californians will be newly enrolled in a health plan through Covered California.

- Millions of Californians will be able to choose affordable, high-quality health insurance coverage offered through Covered California. Covered California is the marketplace that will connect Californians to accessible, high-quality health coverage that will take effect January 2014. Covered California is a new, easy-to-use marketplace where you and your family may get financial assistance to make coverage more affordable and where you will be able to compare and choose health coverage that best fits your needs and budget. By law, your coverage can't be dropped or denied if you get sick, or even if you have a pre-existing medical condition. A Pre-existing Medical Condition is any illness or condition a patient has prior to obtaining insurance.

- Covered California announced it is seeking federal approval for even more affordable health care for hundreds of thousands of low-income Californians. The so-called Bridge Plans will ease the transition for families who go in and out of eligibility for Medi-Cal, by enabling them to purchase standard benefit plans through Covered California at a substantially reduced cost.

- An estimated 670,000 Californians could benefit during 2014 from the Bridge Plan approved by Covered California's Board. Each year, approximately 15% of those enrolled in Medi-Cal experience a temporary increase in income that subsequently makes them ineligible for Medi-Cal. Parents of children enrolled in the Healthy Families Program will also be eligible, allowing family members access to a single health care provider. Starting in 2014, many of these individuals could qualify for federal subsidies to help them buy the plan of their choice through Covered California.

If an individual must exit Medi-Cal, the Bridge Plan would provide enhanced financial support to help that person maintain his or her Medi-Cal managed care plan, and keep the same provider network. This enhanced continuity would translate to

improved quality of care, more efficient delivery of care, and lower costs to the consumer.

(The Bridge Plan legislation is found in Senate Bill 3 {Hernandez, Chapter 5, Statutes of 2013-14 First Extraordinary Session} Approved and Filed July 11, 2013)

If the Department contracts with an AHCSP pursuant to this proposed regulatory amendment, the contract will require an AHCSP to provide the same scope of benefits as any other Two-Plan Model health plan.

Comment Number: 3

SUBJECT: Comments referencing Letter 15 (below, also from SEIU)

COMMENT: SEIU Locals 221, 521, 721 and 1021 have also submitted written comments. I want to close by briefly outlining their gist, which is that the proposed regulations

- are unnecessary, because the Healthy Families covered lives referenced in the SOR have already been assigned locally to Kaiser; contracts are in place in all but one county, and that will be concluded shortly;
- are overly broad, because under the guise of “continuity of care” they would sweep in beneficiaries who had a Kaiser connection up to 12 months previously, but have since lost it; and family members who have no Kaiser connection, but probably do have a local safety net link that would be broken;
- are discriminatory, because they make only Kaiser, and not other outside commercial plans, eligible for this special state contracting;
- are disruptive of the way that Kaiser has begun to be integrated into the safety net on a local level by replacing local arrangements with statewide or regional contracts.

RESPONSE: As these comments refer to another Comment Letter submission, please see Comment Letter 15 from SEIU below for responses.

Comment Number: 4

SUBJECT: Timing

COMMENT: The final point I want to address is timing. Millions of Californians, our healthcare providers, and our local

healthcare safety nets, are on the verge of the biggest healthcare change in our lifetimes - implementation of the ACA. As we speak, the Department is initiating a major study of the Two-Plan model.

Near the top of the many unknowns about the impact of the ACA is how it will affect the healthcare safety net. Also up in the air, particularly in view of 2013's budget changes to Health Realignment Funds, is what will happen to those excluded from the ACA - undocumented immigrants, those without an affordable offer of coverage, those who miss the open enrollment period and then get sick, and others we haven't yet thought about.

Given these enormous pending changes - and unknowns - it is simply premature for the Department to propose any piecemeal changes to the Two-Plan model, especially since the reasons given in the SOR do not justify the proposed changes.

For all of these reasons, we urge the Department to withdraw these regulations, or the Office of Administrative Law to deny them. Instead, the Department should work with the Legislature - which enacted the Two-Plan model, and up to now has also adopted any formal alterations to the structure of the state's Medi-Cal managed care programs - as well as with advocates, beneficiaries, and healthcare providers, including safety net hospitals and clinics, to meet the critical challenges and opportunities California's Medi-Cal system faces in the future.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

COMMENT LETTER 11 (Health Access California 6/11/13 – by Fax and also Email Attached Letter)

Comment Number: 1

SUBJECT: Lack of Necessity

COMMENT: Lack of Necessity

The proposed regulation is not necessary. It is limited to one health plan, Kaiser Permanente. This health plan already has contracts in place in every county in which it previously served Healthy Families children. As we have noted in reviewing the transition plans for Healthy Families, assuring that Healthy Families children can stay with the same plan and the same doctors and hospitals is an important objective. Achieving that objective does not require these regulations since that objective has already been met. Similarly, while local health plans that contracted with Kaiser had previously

kept a higher percentage of the contract for redirection to the safety net, that percentage has now been limited by contract thus obviating the need for the proposed regulation. In enacting the 2012-13 budget, the Legislature similarly determined that there was no need for a statutory change to correct what had already been corrected by contract.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

Any plan meeting the proposed definition would qualify to be an AHCSP.

Comment Number: 2

SUBJECT: Lack of Consistency

COMMENT: Lack of Consistency with the Statute

Numerous provisions of existing state law in the Welfare and Institutions Code create the two-plan model in various counties (Welfare and Institutions Code Sections xxx). Welfare and Institutions Code Section 14087.35 expressly refers to the "state-mandated two-plan managed care model". Yet in its citation of statutory authority, the Department of Health Care Services fails to reference these provisions of law. How does the Department reconcile the proposed regulations with the existing statute?

Geographic managed care for Sacramento and San Diego is expressly authorized in Welfare and Institutions Code Article 2.91, Section 14089-
14089.4. This section does not apply to other counties. How does the Department reconcile the proposed regulations with these provisions of law?

Similarly, legislation enacted last year in the budget, Welfare and Institutions Code Article 2.82, Section 14087.98 expressly authorized the Department to take a different approach in expanding Medi-Cal managed care to rural counties but did not change the two-plan model where it exists.

If the Administration wishes to undo the two-plan model, it should seek statutory change to do so. We would oppose that statutory change but the Administration cannot do by regulation what is not consistent with the underlying statute.

RESPONSE: See Introductory Remarks regarding Authority.

Comment Number: 3

SUBJECT: Existing Reasonable Alternative

COMMENT: Existing Reasonable Alternative

As we have already noted, there is an existing reasonable alternative to these regulations: the contracts with the local health plans in the two-plan model counties have been amended to include contracts with Kaiser Permanente to continue to cover Healthy Families children and to cover other Medi-Cal beneficiaries at a reasonable administrative overhead.
RESPONSE: See Introductory Remarks regarding Authority.

COMMENT LETTER 12 (California Association of Physician Groups 6/11/13 – Email Attached Letter)

Comment Number: 1

SUBJECT: Broaden the Regulation

COMMENT: As you know, several of our members have obtained Knox Keene licenses. These entities have the potential to seek to Medi-Cal Managed Care Plan status over time, as the needs of the coordinated care initiative (Cal Medi-Cal Connect) and other programs may require greater integration of the risk-bearing function with the delivery system. Generally speaking, CAPG advocates for the increased use of adequate actuarially adjusted prepayment to integrated risk-bearing entities that can provide health care services under a direct contract with the payer. Kaiser Permanente is one such system, but there are several others across California. **FN1** Such entities have demonstrated that the greater alignment of prepayment with a provider delivery system can increase the efficiency of health care service delivery in an accountable and transparent manner.

FN1 Berkeley Forum, A New Vision for California's Healthcare System; http://berkeleyhealthcareforum.berkeley.edu/

This policy leads us to conclude that this regulation should be broadened to allow and encourage the growth and proliferation of such entities that may serve as Alternative Health Care Service Plans (AHCSP) across California. We

believe that such a policy is consistent with the recommendations of the Berkeley Forum. By doing so, one existing system is not favored over others, which will tend to create a barrier to entry for new entities over time. We believe that such a broadened policy would increase competition, lower state costs and increase patient access and choice.

Accordingly, we suggest that §53810, Definitions, be amended as follows:

(b) [begin underline]Alternate Health Care Service Plan (AHCSP) means a prepaid health plan that is licensed as a health care service plan by the Department of Managed Health Care, and licensed by the Department of Health Care Services as a Medi-Cal Managed Care Plan, that includes an affiliated provider delivery system in specific geographic regions that is organized in an integrated system to produce accountable, coordinated patient care[end underline].

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

The proposed regulatory amendment has been drafted as narrowly as possible to address the current continuity of care issue arising in connection with AHCSPs. The suggested revision goes beyond that issue.

COMMENT LETTER 13 (San Francisco Community Clinic Consortium 6/11/13 – Email Attached Letter)

Comment Number: 1

SUBJECT: Minor Children Only – AHCSP Linkage (C)

COMMENT: Proposed Section 53800 (c) (1) sets forth the eligibility criteria for enrollment in the AHCSP. It would appear that following patients would be able to enroll in the AHCSP 1) existing Kaiser members, 2) patients who had been a Kaiser members at any time during the 12 month period prior to their Medi-Cal eligibility, or 3) patients whose parents, guardians, minor children, or minor siblings are Kaiser members or had been enrolled in Kaiser at any time during the 12 months prior to the beneficiaries' Medi-Cal eligibility.

We believe that Category 3 should only contain minor children. Most patients newly eligible under the Medi-Cal expansion will be over 18, and thus maintaining a "linkage" to Kaiser through parents, guardians, or minor siblings is not

necessary.

RESPONSE: The purpose of the proposed language is to allow a wide range of family members to obtain services within the same health plan. This definition promotes easy access to health care services for family members including those with limited access to transportation. This is consistent with Title 22, CCR Section 53884(b)(4).

Comment Number: 2

UBJECT: Proposed Repeal of Maximum Enrollment Provisions

COMMENT: The proposed regulations also repeal the existing maximum enrollment provisions. This means that neither the AHCSP nor the commercial plans in the Two-Plan model would have a cap on Medi-Cal enrollment. This has great potential to negatively impact the local health plans and its safety net contractors.

DHCS states that the maximum enrollment section is being repealed because the Department's managed care model has evolved since the regulations were added, and that the original intent of the regulation- to "indirectly" protect safety net providers that contract with the local health plans- is no longer necessary because safety-net providers are now contracted through both the commercial plans and the local health plans. However, DHCS provides no data to assure that there will be not be a negative impact on safety- net providers. Therefore, SFCCC urges DHCS to reconsider the repeal of Title 22 CCR Section 53800.

RESPONSE: In consideration of comments, and after further review, the Department withdraws the proposed repeal of Title 22, CCR Section 53820.

Comment Number: 3

SUBJECT: Safety Net

COMMENT: DHCS states that it has determined that the proposed regulations would not significantly affect the creation or elimination of jobs within the State of California; the creation of new businesses or the elimination of existing businesses within the State of California; or the expansion of businesses currently doing business within the State of California. However, DHCS offers no analysis to support these statements. We have two major concerns:

1. The proposed regulations allow the AHCSP to participate in Medi-Cal managed care, despite the fact that they do not contract with community based health care providers. Community Clinic providers anticipate that a significant portion of our patients who are currently uninsured will become insured through the expansion of Medi-Cal on 1/1/14. Under the current two plan model, most of these patients can then choose whether or not to remain with a community clinic as their medical home. It is a positive thing for patients to have a choice of health plans, providing these health plans contain traditional safety net providers. However, a closed system such as Kaiser shuts community providers out of a portion of the Medi-Cal managed care population, which may undermine the ability of community health clinics to continue to provide care for all patients, including the residually uninsured.

2. Clients who enroll in the AHCSP will lose access to culturally and linguistically relevant neighborhood based care. If clients are enrolled in chronic disease management systems in the clinics, they will lose the long term health benefits of continual tracking and monitoring by known doctors. If clients enroll in the AHSCP but do not find its services accessible due to transportation or other reasons, they may not receive care at all. Many of our patients live in or near the neighborhoods where the clinics are located. They have chosen the community health centers because community health centers are designed to accommodate the patients in their area. The AHSCP may not have sufficient providers with experience caring for this population.

RESPONSE: Please see Introductory Remarks regarding Necessity and Impact.

Participation in the Medi-Cal program is voluntary. As such, California business enterprises and individuals that choose to participate are not considered to be economically impacted in a mandatory manner by the Department's regulations.

The Department encourages FQHCs to subcontract with all available health plans in a county; however, the Department cannot mandate such subcontracts. Further, it is the choice of an eligible beneficiary whether they choose to enroll in an AHCSP, another Two-Plan Model plan, or receive services from a CHC or FQHC. If a beneficiary enrolled in an AHCSP prefers to receive services from a CHC or FQHC, an AHCSP may authorize a beneficiary to receive services from those providers out-of-network, or a beneficiary may choose a Two-Plan Model plan that subcontracts with a specific CHC or FQHC in order to receive services from those providers. Nothing in this regulatory amendment precludes a beneficiary's right to receive services from an FQHC.

Enrollment in an AHCSP is voluntary for eligible beneficiaries. Further, beneficiaries in Two-Plan Model counties always have the option to choose a plan. The proposed regulatory amendment only enables the Department to offer an additional enrollment choice to those who qualify. It does not in any way alter current Medi-Cal managed care enrollment

processes. Those who are eligible for enrollment in an AHCSP who are currently enrolled in another Medi-Cal managed care plan and do not choose to enroll in an AHCSP, will not be affected.

All Medi-Cal managed care plans, including an AHCSP, are required to comply with the applicable standards for Medi-Cal plans, including those discussed in this comment.

Comment Number: 4

SUBJECT: Contracting with FQHCs

COMMENT: In addition, there is nothing in the proposed regulations that would require the AHSCP to contract with FQHCs for the provision of FQHC services. Medi-Cal beneficiaries are entitled to FQHC services under both federal and state law. See 42 U.S.C. § 1396d (a) (2) and Cal. Welfare & Institutions Code § 14132.100.

RESPONSE: The Department encourages FQHCs to subcontract with all available health plans in a county; however, the Department cannot mandate such subcontracts. Further, it is the choice of an eligible beneficiary whether they choose to enroll in an AHCSP, another Two-Plan Model plan, or receive services from a CHC or FQHC. If a beneficiary enrolled in an AHCSP prefers to receive services from a CHC or FQHC, an AHCSP may authorize a beneficiary to receive services from those providers out-of-network, or a beneficiary may choose a Two-Plan Model plan that subcontracts with a specific CHC or FQHC in order to receive services from those providers. Nothing in this regulatory amendment precludes a beneficiary's right to receive services from an FQHC.

COMMENT LETTER 14 (Western Center on Law and Poverty 6/11/13 – Email Attached Letter and Proposed Edits)

Comment Number: 1

SUBJECT: Support for the Two-Plan Model framework

COMMENT: 1. While we support the ability of beneficiaries to receive services from an AHCSP, we also strongly support the Two-Plan Model framework and in particular the continuing availability of Local Initiative Plans.

Our work with low-income consumers in Two-Plan Model counties informs us that Local Initiative Plans provide valuable

services and a much-desired option to Medi- Cal beneficiaries. According to one study, on average almost 74 percent of Medi-Cal beneficiaries in Two-Plan counties select the Local Initiative Plan over the Commercial Plan.FN1

The community-based features and public input that are inherent in the policy development of Local Initiative Plans are important aspects of meeting the needs of low-income consumers in these counties. We therefore wholly support the continuance of the Two-Plan Model. If these proposed regulations are implemented, we urge DHCS to add a statement that the ability of the state to contract directly with Kaiser in Two-Plan counties does not diminish the state's continued commitment to the Two-Plan framework and the future viability of Local Initiative Plans.

FN1 California's Local Community Health Plans: A Story of Cost Savings, Quality Improvement, and Community Leadership, a report by Tim Reilly, Bobbie Wunsch, and Steven Krivit of the Pacific Health Consulting Group, Jan. 2010.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

The Two-Plan Model will continue to exist under the proposed regulatory amendment, as will the discussed community-based features and public input.

The California Code of Regulations is not a proper forum for policy statements.

Comment Number: 2

SUBJECT: AHCSPs to be Held to the Same Standard

COMMENT: 2. The Department should ensure that AHCSPs are held to the same standards as other plans.

Currently, the Department's regulations require plans in the Two-Plan Model to offer many important consumer protections and to meet quality standards. Plans must be Knox Keene licensed, and must meet specific standards of network adequacy, cultural and linguistic access, and financial stability. AHCSPs must be held to the same standards as other plans in the regions they serve. Holding all plans to the same standards will help to ensure that consumers receive high quality care no matter which plan they choose.

Below are our edits to the proposed regulation to implement this suggestion. Our additions are underlined and in [Begin Bold]**bold**[End Bold]:

Section 53800 (c): To promote continuity of care, preserve access to providers, and maintain physician-patient relationships, the department has the authority to contract with an Alternate Health Care Service Plan (AHCSP). To the extent allowable under the law, the department has the authority to enter into either one contract for all geographic areas where the AHCSP operates or enter into multiple contracts to serve the different geographic areas. [Begin Bold]***AHCSPs must comply with all laws and regulations applicable to plans in the Two-Plan model, including §§ 53840, 53851 – 53876 of this chapter.***[End Bold]

RESPONSE: The proposed regulatory amendment is clear as written. Specifically, Section 53800(c)(4) indicates "An AHCSP shall meet all the requirements of this chapter." The suggested language would not add clarity.

Comment Number: 3

SUBJECT: Extend Option to Enroll in the AHCSP to Those Whom Have Transitioned to Managed Care Since 2009

COMMENT: 3. We urge the Department to include all beneficiaries who have transitioned to managed care since 2009, to have the option of enrolling with an AHCSP if they have a previous relationship with the AHCSP.

As previously noted, the Department's Initial Statement of Reasons says that these proposed regulations will benefit many beneficiaries who have moved to Medi-Cal from the Healthy Families program.

We are heartened to hear that the Department is looking to ensure that Healthy Families enrollees have continuity of care when moving to Medi-Cal. But we note that in recent years there are other populations that have been mandatorily transitioned to Medi-Cal managed care and experienced lapses in continuity of care because their providers were not members of either the Local Initiative or Commercial Plans offered in their county. For example, as your staff is very much aware, it is well-documented that continuity of care issues were a serious issue in the transition of Seniors and Persons with Disabilities to Medi-Cal managed care. FN2

Because continuity of care and access to providers are issues that are not limited to the Healthy Families transition population, we firmly recommend that the proposed regulations allow persons who have been enrolled in Kaiser in the 12 months prior to their mandatory enrollment to Medi-Cal managed care back to June 1, 2009 be allowed to move back to Kaiser if they wish to do so.

FN2 See, e.g., A First Look: Mandatory Enrollment of Seniors and People with Disabilities Into Managed Care, by Bobbie Wunsch and Karen Linkins, August 2012 at p. 23 ("Issues pertaining to continuity of care ranged from basic concerns about the ability of enrollees to continue accessing their primary care physicians to very specific concerns regarding network adequacy (access to specialists) and access to durable medical equipment and prescription medications").

Below are our edits to the proposed regulation to implement this suggestion. Our additions are underlined and in [Begin Bold]**bold**[End Bold]:

Section 53800(c)(1)(B): A beneficiary who has been enrolled in the AHCSP at any time during the twelve (12) months prior to the beneficiary's Medi-Cal eligibility [Begin Bold]***or at any time during the twelve (12) months prior to a beneficiary's mandatory enrollment into Medi-Cal managed care dating back to June 1, 2009*** [End Bold]

To implement this proposal to include all persons who have been transitioned to managed care, we also add the above language to the definition of "AHCSP family linkage" at Section 53810(c). We describe this proposed change in more detail below.

RESPONSE: The 12 month eligibility period is consistent with the 12 month continuity of care period found in the 1115 Demonstration Waiver and California law. See Welfare & Institutions Code section 14181(a) and 14182(b)(14), incorporating Health & Safety Code section 1373.96.

Under the proposed regulatory amendment, all Medi-Cal beneficiaries meeting the specified criteria will be eligible to enroll in an AHCSP that contracts directly with the Department. Eligibility is in no way limited to beneficiaries transitioning from Healthy Families.

Comment Number: 4

SUBJECT: Expansion of AHCSP Definition of Family Member Linkage

COMMENT: 4. Finally, to better effectuate the Department's stated intent to promote easier access to care for family members by allowing them to receive care from the same health plan, we recommend that the definition of "AHCSP family member linkage" be expanded.

The current proposed regulation limits "AHCSP family member linkage" to parents, guardians, and minor children or

siblings.

If the Department truly wants to ensure that families are better able to coordinate care among themselves by being in one plan, then we urge the Department to expand the family member linkage definition to reflect the diversity of familial relationships and household compositions in which our clients live. A beneficiary's spouse or partner, foster care relationships, adult children with disabilities, and other relatives by blood or marriage in the household should be added.

Our proposed language is underlined and in [Begin Bold]**bold**[End Bold] below:

Section 53810(c): *AHCSP family member linkage* [begin strikeout]~~*means a situation where*~~[end strikeout] [Begin Bold]***includes a beneficiary's spouse or domestic partner, parent, guardian, foster parent or former foster parent if the age 18 or older beneficiary is living in the same household as the former foster parent, minor child or minor sibling under the age of 21 years, adult child with a disability, or other relative by blood or marriage living in the same household as the beneficiary provided the family member***[End Bold] *is enrolled in or has been enrolled in the AHCSP at any time during the twelve (12) months immediately prior to the beneficiary's Medi-Cal eligibility* [Begin Bold]***or at any time during the twelve (12) months prior to the beneficiary's mandatory enrollment into managed care dating back to June 1, 2009.***[End Bold]

The above suggested edits and our additional edits to the proposed regulations are in the attached document.

RESPONSE: This definition as proposed adequately addresses the common family make-up in California that will meet the immediate needs of the expanding Medi-Cal managed care population with the least disruption to the existing Two-Plan Model membership.

Comment Number: 5

SUBJECT: Attached Document of Proposed Text Edits

COMMENT: Proposed Edits re: DHCS 12-010 from DRC, DREDF, NHeLP and Project Inform

General Provisions: Section 53800

(c) To promote continuity of care, preserve access to providers, and maintain physician-patient relationships, the department has the authority to contract with an Alternate Health Care Service Plan (AHCSP). To the extent allowable under the law, the department has the authority to enter into either one contract for all geographic areas where the AHCSP operates or enter into multiple contracts to serve the different geographic areas. [begin underline]**AHCSPs must comply with all laws and regulations applicable to plans in the Two-Plan model, including §§ 53840, 53851 – 53876 of this chapter.**[end underline]

[begin underline]**(c)(1)**[end underline] (B) A beneficiary who has been enrolled in the AHCSP at any time during the twelve (12) months prior to the beneficiary's Medi-Cal eligibility [begin underline]**or at any time during the twelve (12) months prior to a beneficiary's mandatory enrollment into Medi-Cal managed care dating back to June 1, 2009:**[end underline] or

[begin underline]**(c)(1)**[end underline] (C) A beneficiary with an AHCSP family member linkage [begin underline]**as defined at Section 53810(c),**[end underline]

[begin underline]**(c)**[end underline] (2) [begin strikeout]**A beneficiary who is eligible to enroll in the AHCSP but chooses not to enroll in the AHCSP, shall be assigned to a plan through the enrollment processes set forth in Sections 53845, 53882, and 53883, except as otherwise provided by law:**[end strikeout] [begin underline]**Current beneficiaries already enrolled in Medi-Cal managed care shall be given an option to transfer enrollment to an AHCSP which contracts with the department.**[end underline]

[begin underline]**(c)**[end underline][begin strikeout] **(2)**[end strikeout] [begin underline]**(3)** [begin underline] **A**[end underline] beneficiary who is eligible to enroll in the AHCSP [begin underline]**per subsection (c)(1)(A) above may actively choose to enroll in another Medi-Cal managed care plan. Beneficiaries who are eligible to enroll in the AHCSP per subsection (c)(1)(B) or (C) may choose to enroll in the AHCSP or choose to remain with their existing Medi-Cal managed care plan, and if no choice is made,**[end underline] shall be assigned to a plan through the enrollment processes set forth in Sections 53845, 53882, and 53883, except as otherwise provided by law. [begin strikeout]**Beneficiaries eligible to enroll in an AHCSP under subsections (c)(1)(B) and (C) may choose not to do so and remain with their existing Medi-Cal managed care plan.**[end strikeout]

Definitions: Section 53810

(c) AHCSP family member linkage [begin strikeout]~~**means a situation where a**~~ [end strikeout] [begin underline]**includes a**[end underline] beneficiary's [begin underline]**spouse or domestic partner,**[end underline] parent, guardian, [begin underline]**foster parent or former foster parent if the age 18 or older beneficiary is living in the same household as the former foster parent,**[end underline] [begin strikeout]~~**minor**~~[end strikeout] child or [begin strikeout]~~**minor**~~[end strikeout] sibling [begin underline]**under the age of 21 years, adult child with a disability, or other relative by blood or marriage living in the same household as the beneficiary provided the family member**[end underline] is enrolled in or has been enrolled in the AHCSP at any time during the twelve (12) months immediately prior to the beneficiary's Medi-Cal eligibility [begin underline]**or at any time during the twelve (12) months prior to the beneficiary's mandatory enrollment into managed care dating back to June 1, 2009.**[end underline]

RESPONSE: See comments above for subjects 1 to 4 of Comment Letter 14.

COMMENT LETTER 15 (SEIU Locals 221, 521, 721, and 1021 6/11/13 – Email Attached Letter)

Comment Number: 1

SUBJECT: Existing Alternative

COMMENT: The proposed regulations would allow the Department of Health Care Services (DHCS) to undermine the intent of the Legislature in upholding the existing Two-Plan Model of Medi-Cal Managed Care (MCMC) delivery in California by granting the department authority to directly contract on a statewide or regional basis with an Alternate Health Care Service Plan (AHCSP) in Two-Plan Model counties. In this case, only Kaiser Foundation Health Plan, Inc. (Kaiser) meets the criteria of the AHCSP. This proposed rule would thereby effectively alter the fundamental nature of the Two-Plan Model by allowing the state to directly contract with a third plan.

The Statement of Reasons for the proposed regulation cites the need to ensure that current Kaiser beneficiaries have the option to maintain provider continuity in the context of MCMC transitions, including transition of the Healthy Families Program (HFP) beneficiaries to Medi-Cal already underway. Currently, however, all of Kaiser's HFP enrollees have been assigned to Kaiser in Two-Plan Model counties and plans have subcontracted with Kaiser in all but one of the affected counties. The one remaining plan has been in negotiations with Kaiser, which continue.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

Comment Number: 2

SUBJECT: Linkage to AHCSP

COMMENT: In addition, the regulation is narrowly drafted to limit its application to Kaiser, but it is overly in broad in several other ways. First, it would apply to any MCMC beneficiary who has been a Kaiser enrollee in the past year, or has a family member who has been with Kaiser in the past year. This definition goes far beyond the reach of the stated rationale for the regulation, and would allow for beneficiaries to choose Kaiser even if they are no longer enrolled with Kaiser, or never were in the first place, which runs counter to the provider continuity argument.

Second, the proposed regulation would apply to any beneficiary with a link to Kaiser, as defined in the proposed regulation, not just those children transitioning through Healthy Families. This means that the regulation could be used to justify direct contracting with Kaiser at any time, whether for the HFP transition, or other MCMC related events such as the implementation of CalMediConnect.

RESPONSE: Any plan meeting the proposed definition would qualify to be an AHCSP.

The purpose of the proposed language is to allow a wide range of family members to obtain services within the same health plan. This definition promotes easy access to health care services for family members including those with limited access to transportation. This is consistent with Title 22, CCR Section 53884(b)(4).

This comment is vague. The proposed regulatory amendment is not exclusive to the Healthy Families Program transition.

Comment Number: 3

SUBJECT: Repeal Maximum Enrollment Levels

COMMENT: Third, the proposed regulation would eliminate section 53820 establishing maximum enrollment levels.

RESPONSE: In consideration of comments, and after further review, the Department withdraws the proposed repeal of Title 22, CCR Section 53820.

Comment Number: 4

SUBJECT: Oppose Strike “Medi-Cal” Text

COMMENT: Fourth, the current regulations recognize the integral connection between Medi-Cal and traditional providers; therefore we oppose the proposal to strike “Medi-Cal” in Section 53800(b)(C)(2). [new numbering]

RESPONSE: The term defined in existing Section 53810(jj) is “traditional provider” not “traditional Medi-Cal provider.” This change was simply made to have Section 53800(b)(C)(2) be consistent with the definition of “traditional provider.”

Comment Number: 5

SUBJECT: Keeping Status Quo

COMMENT: Finally, the regulation would provide a special waiver of the Two-Plan Model criteria for one commercial plan, Kaiser, but deny this option for others. Other commercial plans in California have recently attempted to make changes in the Two-Plan Model structure to allow for market competition in Two-Plan counties and have been rebuffed in the legislative process. If the administration unilaterally grants an exemption to allow for Kaiser’s participation as a direct contractor in Two-Plan Model counties, it will upend the existing construct of one private, commercial plan and one public plan.

RESPONSE: See Introductory Remarks regarding Authority, and Necessity and Impact.

Any plan meeting the proposed definition would qualify to be an AHCSP.

Comment Number: 6

SUBJECT: Viability of Safety Net

COMMENT: The ability of enrollees to maintain continuity of care with their providers is of paramount importance. It is good policy and good practice. It is for those reasons that LI plans have made the commitment to enter into subcontracting arrangements with Kaiser for the HFP transition. One benefit of subcontracting arrangements with public safety net plans is that it integrates Kaiser into the larger safety net structure in a way that would be lost in direct contracts with the state. Better integrated continuums of care have been a hallmark of this administration’s health care policy. To

allow Kaiser to be further siloed in its provision of Medi-Cal managed care benefits would be detrimental to this progress.

The Two-Plan Model was conceived as a way to ensure the viability of the public safety net, and that need continues today. MCMC contracts are essential to the vitality and sustainability of the healthcare safety net, both for those lives covered through Medi-Cal, as well as private pay and uninsured patients. The inclusion of Kaiser as third plan option in Two-Plan model counties undermines the original intent of the Two-Plan model in that Kaiser does not have direct relationships with traditional safety net providers as it operates a closed delivery system.
Already, the commercial plans in Two-Plan counties do not exhibit the same strong relationships with safety net providers currently evidenced by the LIs.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

Comment Number: 7

SUBJECT: Necessity

COMMENT: Necessity: The proposed regulation argues that the authority to directly contract with Kaiser is needed to preserve continuity of care, but according to the Local Health Plans of California, all of Kaiser's HFP lives have been assigned to Kaiser, and subcontracts in all but one county have been finalized. The remaining county has been in ongoing negotiations with Kaiser.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

Comment Number: 8

SUBJECT: Consistency

COMMENT: Consistency: In the two decades since its creation, the Legislature has enacted statutes affirming the existence of the Two-Plan Model structure, in addition to affirming the intent of the Legislature in using it as a means to protect the public health care safety net. Even in those counties that never had a Two-Plan structure, the Legislature took pains to authorize a different model of MCMC.

RESPONSE: See Introductory Remarks regarding Authority.

Comment Number: 9

SUBJECT: Authority

COMMENT: Authority: Finally, the department attempted to make this change statutorily last year on the heels of the HFP transition and that attempt was rejected by the Legislature.

RESPONSE: See Introductory Remarks regarding Authority.

Comment Number: 10

SUBJECT: Lack of Clarity

COMMENT: DHCS articulated a rationale in its Statement of Reasons that continuity of care is the primary goal of this regulation, and specifically called out the HFP transition. It is also clear that the regulation does not pertain exclusively to the HFP transition, but the department has not been clear about what other circumstances it is attempting to address. The department has also said that this regulation would provide an important backstop should LI plans fail to subcontract with Kaiser on a prospective basis, and that it has no intention of actually using this regulation with subcontracts in place. That intention is not explicit in the proposed regulation, and no backstop is provided to protect a broader interpretation of this law by future administrations. The more reasonable, less burdensome alternative to these regulations would be for the department to continue to encourage subcontracting arrangements consistent with the existing Two-Plan Model construct.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

Comment Number: 11

SUBJECT: Open Forum of Models

COMMENT: SEIU is strongly supportive of the prominent and important role Kaiser plays in the delivery of health care in California. We are close partners, as our sister locals have organized workers at their facilities, and Kaiser provides care to SEIU employees and members. However, it is unclear why the proposed regulations are needed, and what harm will be

done to its beneficiaries in the absence of these regulations. Given that the Two-Plan model has served California well for twenty years, any decisions to fundamentally alter the underlying premise of the Two-Plan Model and its role in California's health care delivery systems should be made through an open and public policymaking process with input from the Legislature.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

COMMENT LETTER 16 (Molina Healthcare 6/11/13 – Email Attached Letter)

Comment Number: 1

SUBJECT: Medi-Cal Projected Growth

COMMENT: Molina is pleased to learn that the Department of Health Care Services is interested in discussing some of the challenges health plans, and more importantly, Medi-Cal beneficiaries are facing in counties operating under the Two-Plan model. Our comments focus specifically on Los Angeles County, considering Molina's long history serving the area, as well as the size, population and expected growth the county will see in the coming years. As you know, Los Angeles is not only the most populous county in the state, but in the country. Between 1.2 and 1.6 million more Californians will have coverage through Medi-Cal in 2019 due to the Affordable Care Act, and Los Angeles and the remaining Southern California counties are predicted to each account for more than thirty percent of this growth. **FN1**

FN1
http://laborcenter.berkeley.edu/healthcare/aca_fs_medi_cal.pdf

RESPONSE: The Department appreciates the information.

Comment Number: 2

SUBJECT: Expanded Direct Contracting Access

COMMENT: Millions of Californians count on the State to administer a Medicaid program that is accessible, user-friendly, quality driven, cost-effective and overtime, innovative and adaptive. Molina believes these qualities could be better achieved with more than two directly contracted health plans providing health care services to such a large and diverse population as exists in Los Angeles County. Having additional directly contracted health plans in Los Angeles County

would increase competition, increase cost effectiveness and administrative simplicity, and reduce member confusion. Medi-Cal managed care plans have already proven to be a cost-effective use of health care dollars that improve access and assure quality of care. Medi-Cal beneficiaries in Los Angeles should be able to choose from a variety of directly competing health plans and select the one that best meets their needs, and the needs of their family.

RESPONSE: Please see Introductory Remarks regarding Necessity and Impact.

There is no demonstrated need for the Department to have the ability to directly contract with additional plans in the designated Two-Plan Model counties. Because AHCSP providers cannot contract with plans outside of their AHCSP, it is not possible for beneficiaries transitioning from an AHCSP to Medi-Cal to retain continuity of care except through an AHCSP. That is not the case with other types of plans, where providers can participate in more than one plan.

The proposed regulatory amendment has been drafted as narrowly as possible to address the specific beneficiary need for continuity of care in a specific type of plan at this time. The Department is not proposing to eliminate the Two-Plan Model. This is not a “restraint of trade” issue because the Department already has the statutory authority to determine how many plans, and which plans, it will contract with to provide Medi-Cal services.

Comment Number: 3

SUBJECT: Open Forum of Models

COMMENT: This regulation attempts to address the continuity of coverage issue that exists in Two-Plan model counties, such as Los Angeles, for beneficiaries transitioning from Healthy Families into the Medi-Cal managed care program, and to allow for family linkages between commercial and Medi-Cal health coverage programs. Since the State chooses to contract with only two health plans in Los Angeles for Medi-Cal, situations arise where transitioning beneficiaries (or beneficiaries with family members enrolled in other health care programs) do not have the option to enroll with the health plan of their choice and benefit from continuous coverage. This issue is certainly worth discussing more fully, and should be done in a manner that contemplates the needs of all Medi-Cal beneficiaries. Instead of the limited solution proposed in this rule, Molina suggests that the larger issue – the inherent challenges of operating the Two-Plan model in the largest county in the nation – be reviewed by DHCS.

The Two-Plan model was started in the mid-1990’s, over a decade before the Affordable Care Act was even contemplated. There are significant differences between the Medi-Cal program of twenty years ago and the Medi-Cal

program today. We believe the influx of new eligible into the Medi-Cal program and the massive number of policy changes being implemented in the coming years necessitates a renewed discussion about the efficacy of existing Medi-Cal models, especially in LA County.

RESPONSE: The Department appreciates the information.

COMMENT LETTER 17 (Kaiser Permanente 6/11/13 – Email Attached Letter)

Comment Number: 1

SUBJECT: Support for Provisions

COMMENT: ***We support the establishment of a definition for "Alternate Health Care Service Plan" and related conditions of eligibility***.

We support the terms established in §53810 (b) and (c) on page 5 of 20 that read as follows:

(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, that owns or operates its own pharmacies and that provides medical services to enrollees in specific geographic regions through an exclusive contract with a single medical group in each specific geographic area 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 Medi-Cal eligibility.

We also support §53800 (c)(1)(A) through (C) on page 3 of 20 that establishes conditions of eligibility for enrollment in an AHCSP and reads as follows:
(1) The following beneficiaries enrolling in Medi-Cal managed care shall be eligible to enroll in an AHCSP which contracts with the department:

(A) An existing member of the AHCSP transitioning into Medi-Cal managed care;

(B) A beneficiary who has been enrolled in the AHCSP at any time during the twelve (12) months immediately prior tothe

beneficiary's Medi-Cal eligibility; or

(C) A beneficiary with an AHCSP family member linkage.

Together, these provisions, §53810 (b) and (c) on page 5 of 20 and §53800(c)(1)(A) through (C) on page 3 of 20, will provide a framework for establishing eligibility for specified individuals to enroll with or remain with Kaiser Permanente as Medi-Cal enrollees.

RESPONSE: The Department appreciates the information.

Comment Number: 2

SUBJECT: Proposed Clarifying AHCSP Text

COMMENT: We note that a clarification is needed related to a specific term included in each of these provisions. We suggest the term "Medi-Cal eligibility" needs to be replaced with "application to enroll in the AHCSP's Medi-Cal product" in §53800(c)(1)(B) and §53810(c). Two other language changes need to be made to reconcile the provisions. The proposed corrected terms and other changes would read as follows (changes shown in **bold**):

(B) A beneficiary who has been enrolled in [Begin Bold]**the**[End Bold] [Begin Bold & Underline]**any**[End Bold & Underline] AHCSP [Begin Bold]**product**[End Bold] at any time during the twelve (12) months immediately prior to the beneficiary's [Begin Bold]**Medi-Cal eligibility**[End Bold] [Begin Bold & Underline]**application to enroll in the AHCSP's Medi-Cal product**[End Bold & Underline]; or

(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 [Begin Bold]**the**[End Bold] [Begin Bold & Underline]**any**[End Bold & Underline] AHCSP [Begin Bold & Underline]**product**[End Bold & Underline] at any time during the twelve (12) months immediately prior to the beneficiary's [Begin Bold]**Medi-Cal eligibility**[End Bold] [Begin Bold & Underline]**application to enroll in the AHCSP's Medi-Cal product**[End Bold & Underline].

We are aware of concerns about the possibility of these proposed draft regulations diverging from the core foundation of the Two-Plan model in Medi-Cal. We want to acknowledge these concerns and simply emphasize our sincere interest in maintaining high quality, continuous care for our enrollees as they transition between health coverage programs.

RESPONSE: The proposed regulatory amendment is clear as written. The suggested language would not add clarity.

COMMENT LETTER 18 (Health Plan of San Joaquin 6/11/13 – Email Attached Letter)

Comment Number: 1

SUBJECT: Safety Net Support and Viability

COMMENT: Safety Net Support and Viability will be Compromised

The Two-Plan Model and Local Initiatives (LIs) were uniquely developed with the intent to support and sustain the safety net for Medi-Cal recipients and other underserved or vulnerable populations. The proposed language, written exclusively to apply to Kaiser, does nothing toward this objective. To the contrary, if enacted it would allow potentially thousands of Medi-Cal eligibles to be served by Kaiser's exclusive system, a system with no ties to the safety net infrastructure of our communities.
At the same time that Medi-Cal plans that already participate in Medi-Cal Managed Care are having discussions with their safety net partners regarding the Medi-Cal expansion, the Bridge Product, and safety net participation in programs such as the Exchange to enable them to remain viable and flourish post Reform, this proposed regulatory change would begin to move many of these safety net patients to Kaiser when it is not clear that Kaiser is their plan of choice, nor their established medical home.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

Any plan meeting the proposed definition would qualify to be an AHCSP.

Enrollment in an AHCSP would be voluntary for eligible beneficiaries. No default assignments will be made to an AHCSP. As always, beneficiaries have the right to choose and change plans at any time. It is up to beneficiaries where they choose to receive their health care. That choice will likely depend on their satisfaction with the health care services they receive.

Comment Number: 2

SUBJECT: Existing Alternative

COMMENT: Partnership Efforts With Kaiser Are Already Established

Local Initiatives have historically partnered with Kaiser to provide additional access and an option for care in Medi-Cal Managed Care counties throughout the State. More recently, with the transition of Healthy Families members to Medi-Cal, additional LIs have been working for many months (at the State's request) to establish similar partnerships to promote continuity of care for these young members. These agreements have been forged with several operational letters of agreement, and, finally, with the execution of delegated provider contracts between the Local Initiatives and Kaiser. The partners have agreed to formalize the relationship with limited or no administrative margin.

Therefore, the regulatory language proposed seeks to establish something that is already developed and in force, or will be in the coming months. There is no need for this regulatory change as these agreements between the partners achieve the same objective.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

Comment Number: 3

SUBJECT: Continuity of Care

COMMENT: Expanding Scope Beyond "Continuity of Care"
The recent interest of Kaiser in Medi-Cal Managed Care was predicated on the transition of children from Healthy Families to Medi-Cal, and the shared interest of all parties in maintaining continuity of care for that large group of children statewide.

The regulatory proposal would expand Kaiser's involvement to include family linked members, as well as new Medi-Cal eligibles with a prior history of Kaiser coverage. There is no requirement that the eligible had Kaiser coverage immediately preceding their new Medi-Cal eligibility. The argument that regulatory changes are necessary to promote continuity of care for these enrollees is specious for a number of reasons. The new Medi-Cal eligible may not have ever established a medical home with Kaiser during the time they had Kaiser coverage, and in fact may have chosen a different medical home since (as the eligibility period goes back 12 months). Further, though some members have been able to remain with Kaiser through partnerships with Local Initiatives for many years, that has not consistently been the case and, at least within San Joaquin and Stanislaus Counties, there have been no challenges raised regarding continuityof care concerns

for Kaiser members who move to Medi-Cal in the past 17 years since the inception of the two-plan model. Kaiser has never formally pursued a partnership with HPSJ in the past in San Joaquin County, nor previously demonstrated an interest in serving the population in Stanislaus County. As such, the proposed language seemingly seeks to remedy something that has not historically been a concern.

Health Plan of San Joaquin is genuinely committed to our partnership with Kaiser to promote continuity of care for the transitioning Healthy Families members and to promote additional access through the inclusion of Kaiser in our provider network. Our partnership agreement is intended to be executed during the current month in readiness for the August Healthy Families transition.

Therefore, we respectfully request that the Legislature preserve the Two Plan Model and decline to modify the regulatory language as proposed.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

Continuity of care requirements have recently become a high concern in conjunction with the issuance of the 1115 Demonstration Waiver, under which numerous populations, including, but not limited, to the Healthy Families population, are transitioning to Medi-Cal managed care.

The Department is proposing a regulatory amendment, not a legislative action.

COMMENT LETTER 19 (Private Essential Access Community Hospitals, Inc. 6/11/13 – Email Attached Planned Hearing Testimony)

Comment Number: 1

SUBJECT: Authority

COMMENT: We believe that the Two-Plan Model provides a currently well-functioning opportunity for two plans to contract directly with DHCS to provide services to Medi-Cal beneficiaries in each of the Two-Plan Model regions. This system also allows for additional health care plans to subcontract with each of the two plans to provide direct services in partnership with one of the two plans. We see no justifiable cause for the Department to modify the spirit and intent of the Two-Plan Model as adopted after significant policy debate by the Administration and the Legislature in 1991.

At that time, the Legislature set forth 12 counties (which has since been expanded by the Legislature) to operate under the Two-Plan Model which would ensure through the hallmarks of a Local Initiative Plan, maximum enrollment levels, and a default mechanism for beneficiaries who do not exercise their right to choose a plan, the protection and promotion of safety net providers. This was deemed necessary in certain areas of the state where safety net providers were particularly dependent on Medi-Cal as the chief source of payment for patient services and where reduction of either that core patient base and/or income would threaten the viability of those providers. Nothing has changed in our patient population since 1991. We are still heavily dependent on Medi-Cal as a predominant payer of services for the patient population in our communities. This fact will be underscored when the Dual Eligible population is enrolled in Medi-Cal managed care and at least 1.4 million additional Californians will be enrolled in Medi-Cal through implementation of the ACA.

Had the Legislature deemed it appropriate for the Two-Plan Model counties to be Two-Plans plus Kaiser, they would have done so through statute. They have exercised their ability to differentiate between the unique needs and make-up of regions throughout the state by creating various managed care models including the Two-Plan Model, designed to preserve and enhance the viability of the safety net, the County Organized Health System Model, which is limited to one plan in 5 counties, and the Geographic Managed Care system in two counties, which is based on fair market competition by health plans wanting to provide services to Medi-Cal patients through organized systems of care. Further, when the Legislature sought to expand Medi-Cal managed care to the remaining 28 rural counties, they set forth the operating guidelines for the state to use in plan selection. Had the Legislature wanted to evolve the Two-Plan Model into a Two-Plan Plus Kaiser model, they would have moved forward with this significant policy change in legislation. In fact, the Legislature in 2012 rejected the notion of amending the Two-Plan model to accommodate Kaiser and their Healthy Families Program patient population, instead informally instructing the Two-Plan Counties, Kaiser and the DHCS to develop an action plan to ensure continuity of care for HFP eligible children and family members as they transition into Medi-Cal.

In addition to all of the sound legal arguments as to why proposed regulation DHCS-12-010 exceeds the Department's regulatory authority, as expressed by our colleagues in opposition today, we contend that this proposal violates the spirit and intent of the existing statute and usurps the power of the Legislature which solely holds the authority to statutorily create a Three-Plan model which this proposed regulation does.

RESPONSE: See Introductory Remarks regarding Authority.

Comment Number: 2

SUBJECT: Necessity

COMMENT: The proposed DHCS-12-010 Two-Plan Model Modification seeks to provide choice, access and continuity of care to Healthy Families Program children enrolled in Kaiser, and their family members who may not have been enrolled in Kaiser by ensuring that Kaiser can continue to be their plan of choice. We support this policy through the three-way contracts (between the state, the Two Plans and Kaiser) that have either been signed (in all but two of the Two-Plan Model counties) or on the verge of signature in the remaining Two-Plan Model counties. Developing a contractual solution was the informal directive of the Legislature and it has indeed been accomplished, rendering the proposed regulation unnecessary and indeed harmful to the very safety net providers the Two Plan Model was designed to consider. In their Statement of Reasons, DHCS contends that the Department "has no reasonable alternative . . . that has otherwise been identified and brought to the attention of the Department [which] would be more effective…" We assert that the three-way contracts either signed or ready for signature are indeed the appropriate alternative and remedy to adoption of the proposed regulation.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

Comment Number: 3

SUBJECT: Safety Net

COMMENT: By allowing a third plan to directly contract with DHCS, this proposed regulation sets in motion a regulatory preference for a third plan that is a closed network which excludes safety net hospitals, physicians and clinics. Under the current framework of the Two-Plan Model, Local Initiative Plans are required to contract and the Commercial Plans are incented to contract with safety net providers through the default mechanism process administered by DHCS. By allowing a closed system that neither has nor intends to have a relationship with safety net providers, this proposed regulation violates the goal of the Two-Plan Model to ensure an adequate patient base and funding source for safety net hospitals and clinics. Further, it provides preference for the Kaiser plan at the expense of the various other Medi-Cal managed care plans that currently operate with Kaiser on a level-playing field as subcontractors to the Two-Plans and who do contract with safety net providers.

Finally, relative to the repeal of Article 3 and Section 53820 "Maximum Enrollment Levels," the DHCS Statement of Reasons contends that the repeal is justified stating that "While the original intent was to indirectly protect safety-net providers that contracted with the Local Initiatives, this protection is no longer necessary because safety-net providers are

now contracted though both the Commercial Plans and the Local Initiatives . . .” The default mechanism along with the enrollment caps are a key cornerstone of the Two-Plan Model and ensure that commercial plans continue to give strong consideration to contracting with as many safety net providers as possible to ensure continuity of care and a stable safety net in the regions they serve. Commercial plans are again not required, but incented, to offer contracts while Local Initiative Plans are indeed required to offer contracts to all safety net providers. This is not a small distinction, but provides necessary assurances that safety net providers will be able to continue serving their historic and traditional population of Medi-Cal patients and that they can maintain continuity of care, access and choice of providers in the community in which they reside. We strongly object to the repeal of this provision.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

In consideration of comments, and after further review, the Department withdraws the proposed repeal of Title 22, CCR Section 53820.

COMMENT LETTER 20 (California Primary Care Association - 6/11/13 – Public Hearing Oral Testimony)

Comment Number: 1

SUBJECT: Safety Net

COMMENT: CPCA feels that preserving the Two-Plan Model is essential for sustaining the health care safety net and also for the successful implementation of the Affordable
Care Act.

The Two-Plan Model was created for the purpose of ensuring that the transition of the Medi-Cal Program to managed care did not have a negative impact on safety net providers, including community health centers. The local initiatives provided further protections for safety net provider, specifically requiring that the local initiatives offer contracts to community health centers, that they include health community centers in their governance structure. Also provisions governing assignments of lives help further protections allowing the safety net to retain their market share. The relationship between community health centers and local initiatives has been essential for assuring a viable safety net in a managed care environment.

The promise of the Two-Plan Model in maintaining a vibrant safety net in the managed care in California has come to fruition for California's community health centers. Their Medi-Cal patients have grown significantly over the years and their overall capacity to serve the needs of California's low-income, uninsured population has grown.

And now in this environment of health care reform, many of uninsured population will become eligible for Medi-Cal. It will be critical for community health centers to retain and grow their Medi-Cal population. The best vehicle to accomplish this will be to retain the Two-Plan Model infrastructure and the continuation of the long-standing relationship between local initiatives and community health centers.

The proposed regulation promulgated by the Department of Health Care Services would amend or repeal specified provision of Title 22 of the California Code of Regulations to create an alternative health care services plan sets forth criteria for eligibility for enrollment in this plan. It exempts this plan from the current assignment system for the Two-Plan Model, except as otherwise provided by law. It repeals the maximum enrollment for pre-paid health plans and primary care case management plan contracts to allow plans to receive default assignment enrollment without limitations. It repeals the local initiative plan minimum enrollment requirement, and it repeals requirements for pre-paid health plan and PCCM plan enrollment during the Medi-Cal management transition period.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

In consideration of comments, and after further review, the Department withdraws the proposed repeal of Title 22, CCR Section 53820.

Comment Number: 2

SUBJECT: Lack of Necessity

COMMENT: This proposed regulation lacks necessity. The Department has provided no evidence to support the need for the regulation. While CPCA understands the need to preserve continuity in care and health care delivery, there is no evidence to suggest that the current Kaiser patients who move to Medi-Cal will be precluded from continuing to seek services at Kaiser through contracts with plans currently operating in Two Plan Model counties.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

Comment Number: 3

SUBJECT: Lack of Authority

COMMENT: The proposed regulations are deficient for lack of authority. With the implementation of Medi-Cal managed care, the administration contemplated and the Legislature created a body of law to support the Two-Plan Model. Specifically, they created the local initiative infrastructure to serve a specific purpose within the Two-Plan Model structure.

Recently, the Legislature granted the Department authority to expand Medi-Cal managed care into rural counties. And by inference, this action demonstrates that the Legislature, not the Department of Health Care Services, has the primary authority to determine changes in the Medi-Cal Managed Care Program, including administration of the Two-Plan Model. This exercise of authority is usually accomplished through specific legislation.

By promulgating these regulations without statutory authority, the Department is bypassing the Legislature's leadership role that supports the Two-Plan Model and the local initiative and instead proposes by regulation to devastate the existing Two-Plan structure. The Department's actions are without statutory authority, and therefore, these regulations are deficient for lack of authority.

RESPONSE: See Introductory Remarks regarding Authority.

Comment Number: 4

SUBJECT: Safety Net Impacts

COMMENT: We're also concerned that the proposed regulation repeals the existing maximum enrollment provisions. It means that neither the AHCSP, nor the commercial plans in the Two-Plan Model, will have a cap on Medi-Cal enrollment. And this has a great potential to negatively impact local health plans and the service provider contractors, including, but not limited to, community health centers.

Now, the Department states that the maximum enrollment is being repealed because the Medi-Cal managed care model has evolved since the regulations were added and the original intent of the regulations to indirectly protect safety net providers that contract with health plans as no longer necessary, stating that the safety net providers are now contracted through both commercial plans and local health plans.

However, the Department provides no analysis to show what extent safety net providers contract with commercial plans in Two-Plan Model counties. And in repealing the maximum enrollment provisions, the Department does not anticipate how the addition of the AHCSP will negatively effect local health plan enrollment and impact local health plan contractors.

The regulation, if implemented, will have a de-stabilizing effect on local health plans. In Two-Plan Model counties, the local health plans include more safety net providers, primarily community health centers, than other provider networks like commercial plans. We believe that the addition of this new plan will result in beneficiaries being siphoned off and thus stabilize local health plans by decreasing overall enrollment and driving up cost.

As a direct result, the number of Medi-Cal beneficiaries who seek care at community health centers could decline. Kaiser was a closed network, and we do not have access to those patients that cannot be contractors in that plan.

As such, CPCA urges the Department to reconsider the repeal of Title 22 CCR Section 53800.

Speaking to the analysis of impact on the providers, major regulations cannot be promulgated without an economic impact assessment. And DHS states it has determined that the proposed regulations would not significantly affect the creation or elimination of jobs in California, the creation of new businesses or elimination of existing businesses or expansion of businesses currently doing business in the state.

However, the Department offers no analysis to support these statements. Further, the Department has determined that the proposed regulations would potentially effect small businesses that voluntarily choose to be Medi-Cal providers in a situation when the beneficiary may chose to enroll and receive services through this AHCSP contracting directly with the Medi-Cal program. We believe the proposed regulation will have a real negative impact on community health centers for the following reasons.

First of all, a federally qualified health centers are required under Section 330 of the Public Health Services Act to enroll in and be reimbursed for providing services to Medi-Cal beneficiaries as a condition of receiving their federal grant. In this sense, FQHCs do not voluntarily choose to be Medi-Cal providers. It's a significant portion of FQHC revenue that comes from Medi-Cal and loss of Medi-Cal revenue means reduced access to services for all FQHC patients.

Secondly, the proposed regulations include as eligible to enroll in the AHCSP a beneficiary who has been enrolled in the plan at any time during the twelve months immediately prior to the beneficiary's Medi-Cal eligibility. Therefore, a Medi-Cal

beneficiary who enrolled with or was assigned to an FQHC for primary care services, but had been enrolled as a Kaiser patient in any of the twelve months prior to becoming a Medi-Cal beneficiary would be eligible to re-enroll in Kaiser.

In addition, the proposed regulations include as eligible to enroll in AHCSP a beneficiary with a family member linkage. This means according to the language of the proposed regulations when a Medi-Cal beneficiary's parent, guardian, or minor child or minor sibling has been enrolled in Kaiser at any time during twelve months immediately prior to the beneficiary's Medi-Cal eligibility, they must either enroll or be in Kaiser or be assigned to another plan.

Now, under both scenarios, there is potential for the FQHC's operating in the Two-Plan Model counties to lose patients. Kaiser is a closed network generally limited to Kaiser's medical group providers. FQHCs do not have the opportunity to subcontract to provide primary care services or FQHC services to Kaiser patients. This reality will mean there could be a significant disruption in continuity of care. To the extent the patients do not chose Kaiser, it could be assigned to a plan that does not contract with the FQHC potentially. This could also cause a disruption in the continuity of care and loss of Medi-Cal enrollment for the FQHC. So because they don't contract with Kaiser for primary care services, they will have no opportunity to recapture those patients.

Thirdly, FQHCs are well-positioned to meet the needs of the expanding Medi-Cal population in anticipation of the Medicaid expansion and the need for adequate numbers of primary care providers, the Affordable Care Act did provide funds for new FQHC sites. And many health centers have received federal funding to expand to serve the growing needs of the population. But the success of these expansion efforts depends on the ability to maximize Medi- Cal revenues. If this plan, this AHCSP plan, captures a disproportionate share of new Medi-Cal beneficiaries in any Two-Plan Model county and FQHCs are not offered contracts to provide primary care services to the AHCSP enrollees, as we are with the local initiatives, the FQHCs will not be able to sustain expansion efforts for lack of anticipated revenues.

And finally, the proposed regulations are slanted to protect continuity of care for existing Kaiser patients but do not consider the impacts on beneficiaries who currently receive health care services through commercial plans or local health plans and who, based on the AHCSP eligibility criteria, may be eligible to enroll in the AHCSP.

The proposed regulation would require a person eligible to enroll in the AHCSP to enroll or to be assigned to a plan through the existing enrollment and assignment process. There is no language in the proposed regulation to allow beneficiaries who would be AHCSP eligible to remain with their current health plan and assigned primary care providers.

Further, there is nothing in the proposed regulation that would require the new plan to contract with FQHCs for the

provision of FQHC services. And Medi-Cal beneficiaries are entitled to FQHC services under both federal and State law. So with these closed provider network, there is no guarantee that the scope of services offered would include the full range of benefits that Medi-Cal recipients currently may receive.

In summary, the proposed regulations would unfairly allow the AHCSP to capture a significant share of new Medi-Cal beneficiaries and as a result of Medi-Cal expansion to the detriment of safety net providers.

RESPONSE: The assumption has been made that this comment is in regard to Section 53820. In consideration of comments, and after further review, the Department withdraws the proposed repeal of Title 22, CCR Section 53820.

The projected influx of new Medi-Cal managed care beneficiaries over the next several years indicates that there will be sufficient beneficiary enrollment to support all available providers, including their expansion efforts. It will be up to the beneficiary to choose the plan that best serves their needs. The Department cannot, and should not, force beneficiaries to utilize FQHCs.

The Department did assess potential economic impact. Participation in the Medi-Cal program is voluntary. As such, California business enterprises and individuals that choose to participate are not considered to be economically impacted in a mandatory manner by the Department's regulations.

A provider that does choose to be a FQHC is held to the Public Health Services Act, which requires the provision of Medi-Cal services. Participation as a FQHC is not mandatory.

If the Department directly contracts with an AHCSP, it is merely providing eligible beneficiaries the opportunity to enroll, and will not force any beneficiary to move to an AHCSP. It is the choice of the beneficiary whether they stay with their current provider. Beneficiaries always have the choice of where they receive their health care, which will likely depend on their satisfaction with the health care services they receive.

Enrollment in an AHCSP is voluntary for eligible beneficiaries. Further, beneficiaries in Two-Plan Model counties always have the option to choose a plan. The proposed regulatory amendment only enables the Department to offer an additional enrollment choice to those who qualify, supporting continuity of care. It does not in any way alter current Medi-Cal managed care enrollment processes. Those who are eligible for enrollment in an AHCSP who are currently enrolled in another Medi-Cal managed care plan and do not choose to enroll in an AHCSP, will not be affected.

The Department encourages FQHCs to subcontract with all available health plans in a county; however, the Department cannot mandate such subcontracts. Further, it is the choice of an eligible beneficiary whether they choose to enroll in an AHCSP, another Two-Plan Model plan, or receive services from a CHC or FQHC. If a beneficiary enrolled in an AHCSP prefers to receive services from a CHC or FQHC, an AHCSP may authorize a beneficiary to receive services from those providers out-of-network, or a beneficiary may choose a Two-Plan Model plan that subcontracts with a specific CHC or FQHC in order to receive services from those providers. Nothing in this regulatory amendment precludes a beneficiary's right to receive services from an FQHC.

Any plan meeting the proposed definition would qualify to be an AHCSP. The regulations are intended to provide continuity of care to any beneficiary who is eligible to enroll in an AHCSP, as specified in Section 53800(c)(1)(A)-(C).

COMMENT LETTER 21 (SEIU Locals 221, 521, 721, and 1021 - 6/11/13 – Public Hearing Oral Testimony)

Comment Number: 1

SUBJECT: Safety Net

COMMENT: The first point I want to address is the claim on page 6 of the SOR that this protection "is no longer necessary because safety net providers are now contracted through both commercial plans and local initiatives." On its face, the statement does not prove its point, because there is no necessary correlation between a commercial plan contracting with the safety net provider and actually directing a substantial proportion of covered lives to those providers.

The Department has not presented evidence on the real world impact of these contracts and that would justify the statement as fact.

But more importantly, the single relatively minor reference in the SOR to the State's interest in and need to continue protection of the health care safety net ignores the foundational role protecting the safety net played in the construction of the Two-Plan Model from the beginning.

The State's reasoning back in 1993 report "Expanding Medi-Cal Managed Care, Reforming the Health System, Protecting Vulnerable Populations" is just as true now as it was then. Back then, Dr. Molly Coye, then Director of Department of Health Care Services emphasized the State's interest in a viable local health care safety net a number of times in her

cover letter to the report.

For example, Dr. Coye stated that a top State priority in developing the Two-Plan Model was, and I quote "to support the continued existence of a safety net to care for the medically indigent with protections for the continuing relationships between providers and their patients they care for." The regulations undermine the support.

Today, as in 1993, Medi-Cal funding is a bedrock on which local health care safety nets have built and support their care for vulnerable populations, including the medically indigent who are not eligible for Medi-Cal.

According to the California Health Care Foundation's health care almanac for 2010, Medi-Cal accounts for almost two-thirds of net patient revenue for public hospitals statewide. Medi-Cal and Healthy Families accounts for 71 percent of net patient revenues for community clinics. And both types of providers provide significant care to the indigent uninsured.

RESPONSE: In consideration of comments, and after further review, the Department withdraws the proposed repeal of Title 22, CCR Section 53820.

See Introductory Remarks regarding Necessity and Impact.

Comment Number: 2

SUBJECT: Continuative of Care

COMMENT: The principle of continuative of care was also an important factor in how the State's structured the Two-Plan Model. The most important way the State can promote continuative of care is through protecting the safety net, because this pattern of fluctuation is true today as it was back in 1993.

California's experience confirms the high degree of churning in Medi-Cal. According to the Urban Institute Analysis in 2002, National Survey of American's Family, 16 to 19 percent of individuals with incomes below 200 percent, federal poverty level, were uninsured at some period of time during the calendar year.

Those at lower incomes have longer period of uninsureds than those at higher incomes. According to data presented to the Legislative Budget Committee in February of this year, the State anticipated that almost 800,000 Medi-Cal beneficiaries would be expected to discontinue enrollment in this budget year without the

ACA. While the administration contends that a very high percentage of these beneficiaries will no longer be dropped off Medi-Cal into the ACA, both the legislative analysts and the U.C. Berkeley's CALSIM projections strongly dispute those claims.

To provide these individuals and their families with continuative of care, it is critical that when low-income individuals fall off Medi-Cal, there is a strong local safety net for them to fall into. It is precisely these relationships and this continuative of care for Medi-Cal dis-enrollees that would be disrupted by inserting an alternative health care service plan for AHCSP into the Two-Plan Model counties.

There are other categories of individuals that rely on other way to rely on the safety net for continuative of care for theirself and their families. For example, many California families include members of -- who are undocumented, as well as members who are legal residents.

For undocumented immigrants, county hospitals and community clinics and health centers are the main places they can go for care. Introducing an AHCSP that does not provide care to the undocumented members of a family would also undermine continuative of care for these families.

Another category is the poor with severely mentally illness or substance abuse problems, county safety net providers, including community clinics and public hospitals. And clinics are also the place they rely on for help.

Further, Dr. Coye's 1993 letter further states that another important rationale of the
Two-Plan Model is "an incorporating safety net providers in each region into the local planning delivery system for managed care so that they hope to stimulate planning for the eventual integration of all publicly-financed care."

Since 1993, the State, the county, and the federal government, along with nonprofit community clinics and health centers have made major investments towards this goal, beginning with the 1995 LA waiver and continuing into 2010 waiver programs and other initiatives, California has made major investments in the safety net, has made major progress for this objective to help the Two-Plan model and the integration of publicly financed care.

Therefore, on this ground as well, parachuting an AHCSP through State or regional contracts, but divorced from the local planning process or from local safety net providers undermines the substantial investments we have made in the local safety systems.

Ironically, the proposed regulations will disrupt the way that the only plan qualifying for the AHCSP that is Kaiser has begun to play a role in the local health care safety net. In response to the addition of Healthy Families Children to Medi-Cal, all Two-Plan counties have assigned back Kaiser the individuals who were formerly assured by Kaiser under healthy families and is at this point understanding that in two counties the lives have been assigned, but the contracts have not been signed but will be signed soon.

Thus, as things stand, without these proposed regulation, Kaiser's important role for these children's health care is being acknowledged by and incorporated into the local health care safety net planning process in Two-Plan Model counties. The proposed regulation will disrupt these local arrangements and local solutions and in place would introduce an unknown factor statewide or regional contracts for populations potentially much larger than those originally assigned to Kaiser.

My testimony now is focused on the proposed regulations, not only how they not only fail to further the Department's stated intention of promoting continuative of care for Medi-Cal beneficiaries and their families, but instead undermining it, while at the same time undermining the viability of local health care safety net systems the Two-Plan Model was designed to protect.

Instead of supporting the continuing existence of safety net care for the medically indigent and protections to the continuing relationship between providers and patients they care for, the proposal undermines the financial link between Medi-Cal and the indigent that is the foundation of the viability of California safety net.

Instead of recognizing and supporting the fact that "because the eligibility status of Medi-Cal beneficiaries fluctuates frequently and most often between Medi-Cal and medical indigency, a number of counties were exploring the use of Medi-Cal managed health care plans to provide some or all of the services for populations."

The proposal undermines the safety net's coverage for those who fluctuate between Medi-Cal and medical indigency, as well as undermining the continuative of care for families that makes undocumented and legal residents and those with severe behavioral health as well as medical needs.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

Issues related to continuity of care for individuals who lose their Medi-Cal eligibility will be addressed through Covered California and the “Bridge Plan.” See response to “Continuity of Care,” in Comment Letter 10 above.

This regulatory package is not exclusive to the Healthy Families Program transition. Section 53800(c)(1)(A)-(C) specifies the Medi-Cal managed care beneficiaries that shall be eligible to choose an AHSCP for their health care. These regulations are necessary at this time due to the expansion of the Medi-Cal managed care population and limitations of the current health care structure. The Department does encourage subcontracting through existing arrangements. However, this regulatory amendment is necessary because contracts can be terminated at any time, and it is impossible to know whether Local Initiatives will contract with AHCSPs in the future. In addition, since the Department cannot mandate such arrangements, the AHSCP option is necessary to ensure continuity of care for qualifying beneficiaries. This regulatory proposal will only affect beneficiaries who voluntarily enroll in an AHSCP.

Comment Number: 3

SUBJECT: Reference to Comment Letter 15

COMMENT: SEIU 221, 521, 721, and 1021 have submitted written comments also. And I want to just close by briefly outlining the main points in those in the letter. And that is this. The regulations are unnecessary because Healthy Families covered lives referenced in the SOR have already been assigned locally to Kaiser. Contracts are in place in all by two counties. And those we expect to be concluded shortly.

The regulations are overly broad because under the guise of continuative of care, these would sweep beneficiaries who had a Kaiser connection up to twelve months previously but have since lost it and family members who have no Kaiser connections probably do have a local safety net link, and that would be broken. And they are discriminatory because they make only Kaiser not other outside commercial plans eligible for the special State contracting.

And finally, they're disruptive of the way that Kaiser has begun to be integrated into the safety net on a local level by replacing local level arrangements with statewide or regional contracts.

RESPONSE: Please see Comment Letter 15 above.

Comment Number: 4

SUBJECT: Timing

COMMENT: The final point I just want to address is timing. Millions of Californians' health care providers and local health care safety net are on the verge of the biggest health care change in our lifetimes, the implementation of the ACA. As we speak, the Department right now is initiating the major study of the Two-Plan Model. Near the top of many unknowns about the impact of the ACA is how will it effect the health care safety net.

Also up in the air, particularly in view of the 2013 budget changes for healthy care realignment funds is what happens to those excluded from the ACA, undocumented immigrants those without affordable offer of health care coverage, those who miss open enrollment periods, or those who get sick, or others who haven't been able to sign up. Given these enormous pending changes and unknowns, it is simply premature for the Department to propose any piecemeal changes to the Two-Plan Model, especially since the reasons given in the SOR do not justify the proposed changes.

For all these reasons, we urge the Department to withdraw these regulations or for the Office of Administrative Law to deny them. Instead, the Department should work with the Legislature which enacted the Two-Plan Model and up to now has also adopted any formal alterations of the structure of the Medi-Cal managed care plans, as well as advocates, beneficiaries, and health care providers, including safety net hospitals and community clinics to meet the critical challenges and opportunities California's Medi Cal system faces in the future.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

The Department is not aware of this study.

COMMENT LETTER 22 (Health Access California - 6/11/13 – Public Hearing Oral Testimony)

Comment Number: 1

SUBJECT: Lack of Necessity

COMMENT: We did not think that this regulation is necessary. It is limited to one health plan that, as you have already heard, has contracts in place to serve Healthy Family's children. Similarly, while local health plans that contract with Kaiser have previously held onto a higher percentage of the contract for redirection to the safety net, that percentage has now been limited by contract, thus obviating the need for the proposed regulation.

In enacting the 2012-13 budget, the Legislature similarly determined that there was no need for statutory change to correct what had already been corrected by contract. Thus, the Legislature did not authorize the regulations that are

before us today.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

Comment Number: 2

SUBJECT: Lack of Consistency

COMMENT: We would also note a lack of consistency with the statute. Numerous provisions of existing law in the Welfare and Institutions Code create the Two Plan Model in various counties. Yet, in its citation of statutory authority, the Department of Health Care Services fails to reference these provisions of law. We ask how the Department can reconcile the proposed regulation with the existing law, given that it appears not to have considered the law in developing the regulations.

Geographic managed care for Sacramento and San Diego is expressly authorized in the statute. These sections do not apply to other counties. Again, we ask how the Department can reconcile this proposed regulation with the existing provisions of law.

Similarly, when the Legislature chose to expand
managed care to rural areas, it expressly authorized the
Department to take a different approach than the Two-Plan Model. If the administration wishes to undo the Two-Plan Model, it should seek statutory change to do so. We would oppose that statutory change, but the administration cannot do by regulation what is not consistent with the underlying statute.

RESPONSE: See Introductory Remarks regarding Authority.

Comment Number: 3

SUBJECT: Reasonable Alternative

COMMENT: Finally, we would note there is an existing reasonable alternative to the regulations, the contracts with local health plans and the Two-Plan Model. Counties have= already been amended to include contracts with Kaiser. And, thus, we see no need for the regulation.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

COMMENT LETTER 23 (Local Health Plan of California - 6/11/13 – Oral Testimony)

Comment Number: 1

SUBJECT: Lack of Authority

COMMENT: Under the APA authority to adopt the regulations find the provision of law which permits or obligates the agency to adopt, amend, or appeal a regulation.

The Department's April 15th, 2013, Notice of Proposed Rulemaking relies heavily, if not exclusively, on Welfare and Institutions Code Section 14087.3 as providing the Department authority to adopt the proposed regulation.

In particular, the Department relies on a single phrase in Section 14087.3 that states, "at the Director's discretion" the contract may be on an exclusive or non-exclusive basis. The assumption that this phrase in this Section 14087.3 provides the Director with unrestricted authority to contract as the Director sees fit is not a proper reading of that statutory section. And in contrast, the statutory scheme which surrounds Section 14087.3 unquestionably demonstrates that the Legislature is committed to the Two-Plan Model system. Since the statutory scheme is committed to that system and the regulation proposed here would seriously jeopardize that model, the Department, in our view, lacks the authority as defined in the APA to adopt the proposed regulation.

Courts have stated that when engaging in statutory interpretation, the words of the statute must be construed in context, keeping in mind their statutory purpose and the statutes or statutory sections relating to the same subject must be harmonized both internally and with each other to the extent possible.

Now, reading Section 14087.3 is authorizing the Department to deviate from the Two-Plan Model in Two-Plan Model counties cannot be squared with the context in which that section exists or surrounding statutory purpose.

Section 14087.3 is codified in Article 2.7 of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code. Article 2.7 is the article that creates the Two Plan Model system. Other similar portions of Chapter 7 similarly affirm the Legislature's commitment to the Two-Plan Model, some of them referring specifically to the state-mandated Two-Plan Managed Care Model.

To date, the Department has not explained how this particular article in the Welfare and Institutions Code which creates the Two-Plan model also simultaneously authorizes the Department to deviate from that very same system.

In addition, when the Legislature wishes to authorize the Department to contract with more than two plans in a single county, it is unmistakably shown that it knows how to do so expressly. For example, two of the articles, Article 2.91 and Article 2.82 create or -- excuse me – allow the Department to deviate from the Two-Plan Model in San Diego and Sacramento Counties and a host of rural counties.

Courts have firmly stated when the Legislature uses different words as part of the same statutory scheme, those words are presumed to have different meanings. Further, the principle of expressio unius est exclusion alterius, which means the expression of certain things in a statute necessarily involve the exclusion of other things not expressed lead to two conclusions. First, it cannot be presumed that Section 14087.3 empowers the Department to deviate from the Two-Plan Model in Two-Plan Model counties when the Legislature has demonstrated that when it wants to authorize alternative models, it does so expressly, as was the case with San Diego County, Sacramento County, and a host of rural counties.

The words used in Article 2.7 cannot be read as authorizing essentially the same thing as is authorized in Articles 2.91 and 2.82 when the words of those articles are drastically different.

Second, the fact that Two-Plan Model counties were not identified in Article 2.91 which allowed for alternative systems in San Diego and Sacramento Counties -- or 2.82 which allowed for multi-plan models in rural counties – means that the Department lacks the authority with respect to deviate in the Two-Plan Model counties since they were not mentioned in these articles.

Lastly, the Department's assertion of authority to adopt the proposed regulation is contrary to its own long-standing view of its authority to deviate from the
Two-Plan Model. In its 1993 document, "Expanding Medi-Cal Managed Care, Reforming the Health Care System," the Department states there were three compelling reasons for having just one non-governmentally-owned mainstream plan enrolling Medi-Cal beneficiaries in each region.

1. It assures the mainstream plan will have a sufficient number of enrollees to maintain its financial viability.

2. It eliminates the potential for undesirable competition which can adversely effect the quality of care and creating

marketing uses.

And 3. It allows the Department to focus its staff resources to maximize its ability to monitor for quality and access.

For whatever reason, today, the Department now seeks to disregard these compelling reasons and move in a direction that could undermine the Two-Plan Model system and bring to life the three problems the Department identified in 1993 and sought to avoid. Courts have stated continuous administrative interpretation is a persuasive force in a statue's construction. For at least two decades, the Department took the position, as evidenced in its 1993 document, that deviating from the Two-Plan Model was inconsistent with the objectives the Legislature sought to achieve in terms of providing high quality of care to Medi-Cal enrollees, while conserving limited State resources.

The history of that position is, likewise, persuasive in the interpretation of the scope of Section 14087.3, and it contradicts the authority that the Department currently asserts.

RESPONSE: See Introductory Remarks regarding Authority.

Comment Number: 2

SUBJECT: Lack of Necessity

COMMENT: In terms of lack of necessity, under the APA necessity to adopt a regulation as defined by the record of rulemaking proceeding which demonstrates by substantial evidence the need for the regulation to effectuate this statute or court provision or other provision of law, taking into account the totality of the record.

The Department has claimed that this regulation is necessary to address continuity issues for specific categories of Medi-Cal enrollees, most Healthy Families Program enrollees who are moved to Medi-Cal Managed Care.

However, as has been previously noted here today, in every Two-Plan Model County where children are previously enrolled in Kaiser Permanente through the Healthy Families Program that have now been moved to Medi-Cal, those children have already been assigned by the public plan back to Kaiser Permanente. Thus, it is simply untrue that the regulatory change is necessary to deal with continuity issues for specific categories of Medi-Cal enrollees.

Moreover, the Department claims that the regulation is needed to permit individuals who became eligible for Medi-Cal, but

were previously enrolled in Kaiser in the past twelve months, to re-enroll in Kaiser in order to maintain continuity of care. However, continuity of care has already been lost at this point in the individual is no longer enrolled in Kaiser Permanente, most likely due to a loss of coverage through a loss of employment or some other hardship.

Necessity cannot be justified on continuity of care grounds when this continuity of care has already been broken. Even if the regulation could be justified on the basis of continuity of care, it would still be unnecessary because the stated purpose of the proposed regulation has been achieved through the aforementioned contracts that have been or shortly will be executed between Kaiser Permanente and all of the other plans. These contracts are accompanied through an agreement between Kaiser, the Department, and the public plans that accomplishes the stated purpose of the proposed regulatory change.

The Department claims that protections for safety net provider are no longer necessary because safety net providers are now contracted through both commercial plans and local initiatives, even if true, ignores the fact that commercial plans -- the commercial plan benefiting from the change in this regulation, Kaiser operates with the closed delivery system and, thus, does not have significant relationships with traditional safety net providers.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

The 12 month eligibility period is consistent with the 12 month continuity of care period found in the 1115 Demonstration Waiver and California law. See Welfare & Institutions Code Section 14181(a) and 14182(b)(14), incorporating Health & Safety Code Section 1373.96.

Comment Number: 3

SUBJECT: Lack of Clarity and Consistency

COMMENT: In terms of lack of clarity and consistency, clarity is defined as in the APA as the regulation is written or displayed so that the meaning of the regulation itself will be easily understood by those persons directly affected by it.

And consistency is defined as being in harmony with and not in conflict with or contradictory to existing statutes, court decisions, or other provisions of law. As is already noted, there are already provisions of law in place in the form of legally binding contracts between the Department, Kaiser, and the public plans which address the specific circumstances set forth in the proposed regulation.

The Department was aggressive in encouraging the public plans to enter into these contracts and stated these contracts would obviate the need for the Department to consider directly contracting with Kaiser Permanente to meet continuity goals, thus contradicting both the necessity and consistency aspects of the proposed regulation.

Nonetheless, the proposed regulation makes no reference to these existing contracts. And thus, suggests that the Department can contract directly with Kaiser Permanente, despite the existence of these contracts. Therefore, it is unclear whether the regulation would render the existing contracts null and void or whether the Department would acquire the authority to contract with Kaiser, even though the issues have already been addressed in existing contracts, thereby creating duplicative contracts.

The status of existing contracts and the likely effect of the proposed regulation on those contracts can now will be easily understood by Kaiser Permanente or the public plans, even though both would be directly affected by the regulation, which is in violation of the Administrative Procedures Act.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

Comment Number: 4

SUBJECT: Reasonable Alternative

COMMENT: Last, there are more reasonable alternatives for the Department -- that must consider under the Administrative Procedures Act. The Department stated justification, as already noted, has centered largely on continuity of care concerns. However, the Department is accomplishing today through contract which it seeks to accomplish later through regulation. As also previously noted, the majority of the public plans have already executed contracts with Kaiser that address the continuity of care issues identified by the Department.

More importantly, in every Two-Plan Model county where Medi-Cal children were previously enrolled in Kaiser through Healthy Families, those children have already been assigned back by the public plans to Kaiser. Therefore, instead of potentially bringing about the problems identified by the Department back in its 1993 document by deviating from the Two-Plan Model, namely productions in the quality of care and public marketing uses and potentially risking the financial viability of the main stream plans, the Department can continue engaging in the public plan Kaiser Permanente contract process and achieve the same result in a far more reasonable and less burdensome manner.

RESPONSE: There is no reasonable alternative to this regulatory action, which is necessary to support continuity of care. See Introductory Remarks regarding Necessity and Impact.

COMMENT LETTER 24 (L.A. Care Health Plan - 6/11/13 – Oral Testimony)

Comment Number: 1

SUBJECT: Lack of Authority

COMMENT: In terms of lack of authority, the regs rely heavily on Welfare and Institutions Section 14087.3, which gives DHCS the authority to adopt those proposed regulations. In fact, DHSC relies on a single phrase in the section which states, "at the Director's discretion," the contract may be on an exclusive or non-exclusive basis. The assumption is that this phrase provides the Director with unrestricted power to contract with as the Director sees fit. This is not a correct interpretation of that section. Since the statutory scheme is committed to the Two-Plan Model and regulation proposed here would seriously jeopardize that model, DHCS lacks the authority to adopt the proposed regulation.

To date, DHCS has not explained how the article within the W&I Code which creates the Two-Plan Model also simultaneously authorizes the Department to deviate from the very same system it creates. In addition, when the Legislature wishes to authorize DHCS to contract with more than two plans in a single county, it has demonstrated that it knows how to do that expressly through existing statute by the GMC counties which were done in 14089.5 and .07 in the Welfare and Institutions Code.

Also, in regards to the recent designated rural counties, the Legislature also granted explicit statutory authority for DHCS to take different approaches in those counties.

RESPONSE: See Introductory Remarks regarding Authority.

Comment Number: 2

SUBJECT: Necessity

COMMENT: Regarding lack of necessity, DHCS claims the regulatory change is necessary to address continuity issues for specific categories of Medi-Cal enrollees. The Healthy Families members and enrollees are specific to who I'm

speaking to with were moved to Medi-Cal Managed Care. In every Two-Plan Model county where children were previously enrolled in the Healthy Families Program in Kaiser Permanente have now been transition -- that have been transitioned to Medi-Cal, those children have already been assigned by the public plan back to Kaiser Permanente, including those beneficiaries that are currently assigned to L.A. Care. So basically, it's simply untrue that the regulatory change is necessary to deal with continuity issues for specific categories of Medi-Cal enrollees.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

Comment Number: 3

SUBJECT: Safety Net

COMMENT: DHCS claims the protections for safety net providers are were no longer necessary because safety net providers are now contracted through both commercial plans and local initiatives. Even if this is true, it ignores the fact that the commercial plan benefiting from the change in regulation, Kaiser Permanente is a closed delivery system and thus does not have significant relationships with traditional and safety net providers.

By proposing this reg, DHCS is not only undermining the Two-Plan Model structure, but also degrading the safety net provider system by allowing Kaiser Permanente which neither contracts for uses the safety net system to any significant degree.

When planning the Two-Plan Model structure, the Legislature specifically considered and created a role for the safety net. In fact, the Legislature made assurances in writing to traditional safety net providers during the planning and implementation stages of the Two Plan Model. These proposed regs violate the promises made to the safety net as they will not have a role if DHCS ends the Two-Plan Model by allowing additional health plans in the model that have closed systems which do not support the safety net.

In addition, DHCS is inappropriately revising the definition of traditional provider by removing the reference of Medi Cal and stating that Medi-Cal is not a part of the definition of traditional provider. The traditional providers are those that have historically delivered services to Medi-Cal beneficiaries and consistently maintained substantial Medi-Cal portion of the practice. There is no reason why that definition should be revised to remove the word "Medi Cal" from the definition of traditional provider.

RESPONSE: The assumption has been made that this comment is in regard to Section 53820. In consideration of comments, and after further review, the Department withdraws the proposed repeal of Title 22, CCR Section 53820.

See Introductory Remarks regarding Necessity and Impact.

The comment is unspecific in that it does not provide the referenced writings containing the alleged promises, making it impossible for the Department to respond. Further, the Department is not "ending" the Two-Plan Model.

The term defined in existing Section 53810(jj) is "traditional provider" not "traditional Medi-Cal provider." This change was simply made to have Section 53800(b)(C)(2) be consistent with the definition of "traditional provider."

Comment Number: 4

SUBJECT: Clarity, Consistency, and Reasonable Alternative

COMMENT: In terms of lack of clarity and consistency, there are other provisions of law in place in the form of legally binding contracts with DHCS, Kaiser Permanente, and the public plans, which address specific circumstances in the proposed regulation. DHCS was aggressive in encouraging the public plans to enter into these contracts and stated that these contracts would remove the need for DHCS to consider directly contracting with Kaiser Permanente to meet the continuity goals, thus, contradicting both the necessity and consistency aspects of the proposed regulation.

Nonetheless, the proposed regulation makes no reference to these existing contracts and, thus, suggests that the Department can directly contract with Kaiser, despite the existence of these contracts. Therefore, it is unclear whether the regulation would render the existing contracts null and void or whether DHCS would acquire the authority to contract directly with Kaiser Permanente, even though the issue has already been addressed in existing contracts.

We believe there is more reasonable alternatives the Department can take. DHCS has stated justification for the proposed rulemaking has centered largely on continuity of care concerns. However, DHCS is accomplishing that to date through contracts what it seeks to accomplish later through regulation. Most of the public plans have already executed contracts with Kaiser Permanente that address this issue identified by DHCS, and a small number of the remaining public plans that have yet to execute contracts with Kaiser are expected to do so in the very near future.

More importantly, in every Two-Plan Model where Medi-Cal children were previously enrolled in Kaiser through the

Healthy Families Program, including L.A. Care, those children have already been assigned by the public plan back the Kaiser with no disruption in care.

Instead of deviating from the Two-Plan Model, DHCS can instead continue engaging the public plan in Kaiser Permanente contracting process and achieve the same result in a more reasonable and less burdensome manner, while preserving the Two-Plan Model as specifically intended by the Legislature.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

COMMENT LETTER 25 (California Children's Hospital Association - 6/11/13 – Public Hearing Oral Testimony)

Comment Number: 1

SUBJECT: Lack of Authority

COMMENT: The Legislature specifically contemplated and created the Two-Plan Model legislation and local initiative to serve the purpose of expanding managed care, while ensuring the continued viability of the traditional safety net hospitals and providers and clinics.

We believe that the Legislature clearly preserves for itself the primary leadership role in determining when to deviate from this model. When it does so, it accomplishes this through specific legislation and on a limited basis.

I echo previous comments with respect to the questions of the lack of authority and necessity with regard to this change and this effort by DHCS.

RESPONSE: See Introductory Remarks regarding Authority.

Comment Number: 2

SUBJECT: Not The Correct Approach

COMMENT: CCHA believes if a commercial provider is seeking to enter the Two-Plan Model county, it should compete

under the existing Two-Plan Model framework to be the commercial plan in these markets and not circumvent the established process.

RESPONSE: This appears to be a statement rather than a direct comment.
See Introductory Remarks regarding Authority, and Necessity and Impact.

Comment Number: 3

SUBJECT: Safety Net

COMMENT: Finally, local community health plans have a stake in the stability and competitiveness of safety net providers. Their investment in the system demonstrate that commitment. Safety net providers, like children's hospitals, are typically represented on the plan's governing boards and participate on provider advisory boards, quantity improvement committees, and peer review and credentialling committees.

As a result, safety net providers' needs and concerns have a voice in the operations of local community health plans. This is important for preserving the safety net provider's role and provision of care for the patients in these areas.

RESPONSE: This appears to be a statement rather than a direct comment.
See Introductory Remarks regarding Necessity and Impact.

COMMENT LETTER 26 (Local Health Plans of California (LHPC) - 6/11/13 – Public Hearing – Exhibit A)

Comment Number: 1

SUBJECT: Lack of Authority

COMMENT: Lack of Authority

Under the APA, "authority" to adopt a regulation is defined as "the provision of law which permits or obligates the agency to adopt, amend, or repeal a regulation." (Gov. Code,§ 11349, subd. (b).)

The April 15, 2013 Notice of Proposed Rulemaking relies heavily, if not exclusively, on Welfare and Institutions Code, Section 14087.3 as providing DHCS the authority to adopt the proposed regulation. (DHCS Notice of Proposed Rulemaking, Apr. 15, 2013, p. 2.) In particular, DHCS relies on a single phrase in Section 14087.3 which states that, "at the director's discretion," the contract may be on an exclusive or nonexclusive basis. (Ibid.) The assumption that this phrase in Section 14087.3 provides the director with carte blanche, unrestricted power to contract as the director sees fit is not a proper reading of that statutory section; and in contrast, the statutory scheme which surrounds Section 14087.3 unquestionably demonstrates the Legislature's commitment to the two-plan model. Since the statutory scheme is committed to the two-plan model and the regulation proposed here would seriously jeopardize that model, DHCS lacks the authority, as defined in the APA, to adopt the proposed regulation.

When engaging in statutory interpretation, "The words of the statute must be construed in context, keeping in mind the statutory purpose, and statutes or statutory sections relating to the same subject must be harmonized, both internally and with each other, to the extent possible." (Dyna-Med, Inc. v. Fair Emp. & Housing Com. (1987) 43 Cal.3d 1379, 1387.)

Reading Section 14087.3 as authorizing DHCS to deviate from the two-plan model in two-plan model counties cannot be squared with the context in which Section 14087.3 exists or the surrounding statutory purpose; and it cannot be harmonized with statutory sections relating to the same subject. Section 14087.3 is part of the very same article, Article 2.7 (Wel. & Inst. Code, §§ 14087.3-14087.48), which creates the two-plan model system. (See, e.g., Wel. & Inst. Code,§§ 14087.31, 14087.35, 14087.36, 14087.38, creating the mechanisms for the two plan model delivery system.) Other similar portions of Chapter 7 (Wel. & Inst. Code, §§ 14000-14198.2) as Part 3 of Division 9 similarly affirm the Legislature's commitment to the two plan model. (See, e.g., Article 2.81, Wel. & Inst. Code,§§ 14087.96-14087.9725, creating a local initiative in Los Angeles County; and Wel. & Inst. Code, § 14018.7, creating a local initiative in Kern County.) Even beyond that, Welfare and Institutions Code, Section 14087.35 refers explicitly to the "state-mandated two-plan managed care model."

To date, DHCS has simply not explained how the Article within the Welfare and Institutions Code which creates the two-plan model also simultaneously authorizes DHCS to deviate from the very same system it creates.

In addition, when the Legislature wishes to authorize DHCS to contract with more than two plans in a single county, it has unmistakably shown that it knows how to do so expressly. For example, Article 2.91 (commencing with Section 14089, et seq.) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code authorizes multiplan projects in San Diego and Sacramento Counties by way of explicit reference. (See Wel. & Inst. Code,§§ 14089.05 and 14089.07.) The Legislature also recently granted explicit authority to DHCS to take different approaches in designated rural counties in

order to bring managed care to Medi-Cal recipients in those counties. (Wel. & Inst. Code, Div. 9, Part 3, Ch. 7, Article 2.82 [commencing with Section 14087.98].)

"When the Legislature uses different words as part of the same statutory scheme, those words are presumed to have different meanings." (Romano v. Mercury Insurance Co. (2005) 128 Cal.App.4th 1333, 1343.) Furthermore, under the principle of expressio unius est exclusio alterius, "the expression of certain things in a statute necessarily involves the exclusion of other things not expressed." (Dyna-Med, Inc., supra, 34 Cal.3d at 1391 n. 13, citing Henderson v. Mann Theatres Corp. (1976) 65 Cal.App.3d 397, 403.)

Two conclusions flow from these rules of statutory interpretation. First, it cannot be presumed that Section I 4087.3 empowers DHCS to deviate from the two-plan model in two-plan model counties when the Legislature has demonstrated that when it wants to authorize alternative models it does so expressly, as was the case with San Diego and Sacramento Counties, and a host of rural counties. The words used in Article 2.7 (i.e., Section 14087.3) cannot be read as authorizing essentially the same things as Articles 2.91 and 2.82, when the words used in those articles are markedly different. Second, the fact that the two-plan model counties were not identified in either Article 2.91 or Article 2.82- where multiplan models are established - necessarily means that the two-plan model counties are excluded from any authority DHCS may have with respect to other counties to use more than two plans.

Lastly, DHCS's assertion of authority to adopt the proposed regulation is contrary to its own longstanding view of its own authority to deviate from the two-plan model. In its 1993 document, Expanding Medi-Cal Managed Care: Reforming the Health System; Protecting Vulnerable Populations, DHCS stated that there were three "compelling" reasons for having just one non-governmentally owned mainstream plan enrolling Medi-Cal beneficiaries in each region: (1) it assures the mainstream plan will have a sufficient number of enrolled beneficiaries to maintain its financial viability; (2) it eliminates the potential for undesirable competition which can adversely affect the quality of care and create marketing abuses; and (3) it allows DHCS to focus its staff resources to maximize its ability to monitor for quality and access. (Dept. of Health Services, Expanding Medi-Cal Managed Care (1993), at pp. 15-16.)

For whatever reason, DHCS now seeks to completely disregard these "compelling" reasons and move in a direction that could undermine the two-plan model system and bring to life the three problems that DHCS identified in 1993 and sought to avoid. Continuous administrative interpretation is a persuasive force in a statute's construction. (Bates v. State Bd. of Equalization (1969) 275 Cal.App.2d 388, 391.) For at least two decades, DHCS took the position that deviating from the two plan model was inconsistent with the objectives the Legislature sought to achieve in terms of providing high quality care to Medi-Cal enrollees while conserving limited state resources. The history of that position is likewise persuasive in

the interpretation of the scope of Section 14087.3, and it contradicts the claim of authority that DHCS currently asserts.

RESPONSE: These comments were submitted as an Exhibit with the Commenter's oral testimony. There may be a slight variation of the language, however, no new comments or information is presented.

Comment Number: 2

SUBJECT: Lack of Necessity

COMMENT: Lack of Necessity
Under the APA, "necessity" to adopt a regulation is defined as "the record of the rulemaking proceeding demonstrates by substantial evidence the need for a regulation to effectuate the purpose of the statute, court decision, or other provision of law that the regulation implements, interprets, or makes specific, taking into account the totality of the record." (Gov. Code, § 11349, subd. (a).)

DHCS claims the regulatory change is "necessary" to address continuity issues for specific categories of Medi-Cal enrollees, most notably the Healthy Families Program enrollees who were moved to Medi-Cal managed care. However, in every two-plan model county where children were previously enrolled in Kaiser Permanente through Healthy Families but have now been moved to Medi-Cal, those children have already been assigned by the public plan back to Kaiser Permanente. Thus, it is simply untrue that the regulatory change is "necessary" to deal with continuity issues for specific categories of Medi-Cal enrollees.

Moreover, DHCS claims that the regulation is needed to permit individuals who become eligible for Medi-Cal but were previously enrolled in Kaiser Permanente in the past 12 months to reenroll with Kaiser Permanente in order to maintain continuity of care. However, continuity of care has already likely been lost at this point if the individual is no longer enrolled in Kaiser Permanente, most likely due to losing coverage through a loss of employment, etc. "Necessity" simply cannot be justified on continuity of care grounds when the continuity of care has already been broken.

Even if the regulation could be justified on the basis of continuity of care, it would still be unnecessary because the stated purpose of the proposed regulation has already been achieved through contracts that have been or shortly will be executed between Kaiser Permanente and the public plans. These contracts are accompanied by a three way agreement between Kaiser Permanente, DHCS, and the public plans that accomplish the stated purpose of the proposed regulatory change.

DHCS's claims that protections for safety net providers are no longer necessary because safety net providers are now contracted through both commercial plans and local initiatives, even if true, ignores the fact that the commercial plan benefitting from the change in regulation, Kaiser Permanente, operates with a closed delivery system, and thus does not have significant relationships with traditional safety net providers.

RESPONSE: These comments were submitted as an Exhibit with the Commenter's oral testimony. There may be a slight variation of the language, however, no new comments or information is presented.

Comment Number: 3

SUBJECT: Lack of Clarity and Consistency

COMMENT: Lack of Clarity and Consistency
Under the APA, "clarity" means "written or displayed so that the meaning of the regulations will be easily understood by those persons directly affected by them." (Gov. Code, § 11349, subd. (c).) Similarly, "consistency" means "being in harmony with, and not in conflict with or contradictory to, existing statutes, court decisions, or other provisions of law." (See, e.g., County of San Diego v. Bowen
(2008) 166 Cal.App.4'11 501, 516 [regulations must be reviewed for consistency with the law and clarity].)

As noted supra, there are already other provisions of law in place, in the form of legally binding contracts between DHCS, Kaiser Permanente, and the public plans, which address the specific circumstances set forth in the proposed regulation. DHCS was aggressive in encouraging the public plans to enter into these contracts, and stated that these contracts would obviate the need for DHCS to consider directly contracting with Kaiser Permanente to meet continuity goals - thus contradicting both the necessity and consistency aspects of the proposed regulation. Nonetheless, the proposed regulation makes no reference to these existing contracts and thus suggests that DHCS can contract directly with Kaiser Permanente despite the existence of these contracts.

Therefore, it is unclear whether the regulation would render the existing contracts null and void, or whether DHCS would acquire the authority to contract directly with Kaiser Permanente even though the issue has already been addressed in existing contracts; i.e., creating duplicative contracts. The status of the existing contracts, and the likely effect of the proposed regulation on those contracts, "cannot be easily understood by" Kaiser Permanente or the public plans even though both will be directly affected by the proposed regulation, in violation of Gov. Code, § 11349, subdivision (c).

RESPONSE: These comments were submitted as an Exhibit with the Commenter's oral testimony. There may be a slight variation of the language, however, no new comments or information is presented.

Comment Number: 4

SUBJECT: More Reasonable Alternatives

COMMENT: More Reasonable Alternatives
Under the APA, DHCS must also determine that no reasonable alternative has been identified which would be as effective and less burdensome to affected parties than the proposed action. (Gov. Code, § 11346.5 subd. (a)(13).)

DHCS's stated justification for the proposed rulemaking has centered largely on continuity of care concerns. However, as noted supra, DHCS is already accomplishing today through contract what it seeks to accomplish later through regulation. The vast majority of public plans have already executed contracts with Kaiser Permanente that address the continuity of care issues identified by DHCS; and the small handful of remaining public plans who have yet to execute contracts with Kaiser Permanente are expected to do so in the very near future.

More importantly, in every two-plan model county where Medi-Cal children were previously enrolled in Kaiser Permanente through Healthy Families, those children have already been assigned by the public plan back to Kaiser Permanente.

Therefore, instead of burdening the public with potential reductions in the quality of care and marketing abuses - and mainstream plans in two-plan model counties with risks to their financial viability - by deviating from the two-plan model (see Dept. of Health Services, Expanding Medi-Cal Managed Care (1993), at pp. 15-16), DHCS can instead continue engaging in the public plan/Kaiser Permanente contracting process and achieve the same result in a far more reasonable and less burdensome manner.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

COMMENT LETTER 27 (L.A. Care Health Plan - 6/11/13 – Public Hearing – Exhibit B)

Comment Number: 1

SUBJECT: Lack of Authority

COMMENT: The April 15, 2013 Notice of Proposed Rulemaking relies heavily, if not exclusively, on Welfare and Institutions Code, Section 14087.3 as providing DHCS the authority to adopt the proposed regulation (DHCS Notice of Proposed Rulemaking, Apr. 15, 2013, p. 2.). In particular, DHCS relies on a single phrase in Section 14087.3 which states that, "at the director's discretion," the contract may be on an exclusive or nonexclusive basis. (Ibid.) The assumption that this phrase in Section 14087.3 provides the director with carte blanche, unrestricted power to contract as the director sees fit is not a proper reading of that statutory section; and in contrast, the statutory scheme which surrounds Section 14087.3 unquestionably demonstrates the Legislature's commitment to the two-plan model.

Since the statutory scheme is committed to the two-plan model and the regulation proposed here would seriously jeopardize that model, DHCS lacks the authority, as defined in the APA, to adopt the proposed regulation.

Reading Section 14087.3 as authorizing DHCS to deviate from the two-plan model in two-plan model counties cannot be squared with the context in which Section 14087.3 exists or the surrounding statutory purpose; and it cannot be harmonized with statutory sections relating to the same subject. Section 14087.3 is part of the very same article, Article 2.7 (Welfare and Institutions Code, Sections 14087.3-14087.48), which creates the two-plan model system. Other similar portions of Chapter 7 (Welfare and Institutions Code, Sections 14000-14198.2) of Part 3 of Division 9 similarly affirm the Legislature's commitment to the two-plan model. Even beyond that, Welfare and Institutions Code, Section 14087.35 refers explicitly to the "state-mandated two-plan managed care model."

To date, DHCS has simply not explained how the Article within the Welfare and Institutions Code which creates the two-plan model also simultaneously authorizes DHCS to deviate from the very same system it creates.

In addition, when the Legislature wishes to authorize DHCS to contract with more than two plans in a single county, it has unmistakably shown that it knows how to do so expressly. For example, Article 2.91 (commencing with Section 14089, et seq.) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code authorizes multi-plan projects in San Diego and Sacramento Counties by way of explicit reference. (See Welfare and Institutions Code, Sections 14089.05 and 14089.07.) The Legislature also recently granted explicit authority to DHCS to take different approaches in designated rural counties in order to bring managed care to Medi-Cal recipients in those counties. (Welfare and Institutions Code, Division 9, Part 3, Chapter 7,Article 2.82 [commencing with Section 14087.98].)

Two conclusions flow from these rules of statutory interpretation. First, it cannot be presumed that Section 14087.3 empowers DHCS to deviate from the two-plan model counties when the Legislature has demonstrated that when it wants

to authorize alternative models it does so expressly, as was the case with San Diego and Sacramento counties, and a host of rural counties. The words used in Article 2.7 (i.e., Section 14087.3) cannot be read as authorizing essentially the same thing as Articles 2.91 and 2.82, when the words used in those articles are markedly different. Second, the fact that the two-plan model counties were not identified in either Article 2.91 or Article 2.82-where multi- plan models are established-necessarily means that the two-plan model counties are excluded from any authority DHCS may have with respect to other counties to use more than two plans.

Lastly, DHCS' assertion of authority to adopt the proposed regulation is contrary to its own longstanding view of its own authority to deviate from the two-plan model. In its 1993 document, Expanding Medi-Cal Managed Care: Reforming the Health System; Protecting Vulnerable Populations, DHCS stated that there were three "compelling" reasons for having just one non-governmentally owned mainstream plan enrolling Medi-Cal beneficiaries in each region: (1) it assures the mainstream plan will have a sufficient number of enrolled beneficiaries to maintain its financial viability; (2) it eliminates the potential for undesirable competition which can adversely affect the quality of care and create marketing abuses; and (3) it allows DHCS to focus its staff resources to maximize its ability to monitor for quality and access. (Department of Health Services, Expanding Medi-Cal Managed Care (1993), at pp. 15-16.)

For whatever reason, DHCS now seeks to disregard these "compelling" reasons and move in a direction that could undermine the two-plan model system and bring to life the three problems that DHCS identified in 1993 and sought to avoid. For at least two decades, DHCS took the position that deviating from the two-plan model was inconsistent with the objectives the Legislature sought to achieve in terms of providing high quality care to Medi-Cal enrollees while conserving limited state resources. The history of that position is likewise persuasive in the interpretation of the scope of Section 14087.3, and it contradicts the claim of authority that DHCS currently asserts.

RESPONSE: See Introductory Remarks regarding Authority.

Comment Number: 2

SUBJECT: Lack of Necessity

COMMENT: DHCS claims the regulatory change is "necessary" to address continuity issues for specific categories of Medi-Cal enrollees, most notably the Healthy Families Program enrollees who were moved to Medi-Cal managed care. However, in every two-plan model county where children were previously enrolled in Kaiser Permanente through Healthy Families but have now been transitioned to Medi-Cal, those children have already been assigned by the public plan back

to Kaiser Permanente, including those beneficiaries assigned to L.A. Care. Thus, it is simply untrue that the regulatory change is "necessary" to deal with continuity issues for specific categories of Medi-Cal enrollees.

Moreover, DHCS claims that the regulation is needed to permit individuals who become eligible for Medi-Cal, but were previously enrolled in Kaiser Permanente in the past 12 months, to re-enroll with Kaiser Permanente in order to maintain continuity of care. However, continuity of care has already likely been lost at this point if the individual is no longer enrolled in Kaiser Permanente, most likely due to losing coverage through a loss of employment, etc.

Even if the regulation could be justified on the basis of continuity of care, it would still be unnecessary because the stated purpose of the proposed regulation has already been achieved through contracts that have been, or shortly will be, executed between Kaiser Permanente and the public plans. These contracts are accompanied by a three way agreement between Kaiser Permanente, DHCS, and the public plans that accomplish the stated purpose of the proposed regulatory change.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

The 12 month eligibility period is consistent with the 12 month continuity of care period found in the 1115 Demonstration Waiver and California law. See Welfare & Institutions Code section 14181(a) and 14182(b)(14), incorporating Health & Safety Code section 1373.96.

Comment Number: 3

SUBJECT: Safety Net

COMMENT: DHCS claims that protections for safety-net providers are no longer necessary because safety-net providers are now contracted through both commercial plans and local initiatives. Even if this were true, it ignores the fact that the commercial plan benefitting from the change in regulation, Kaiser Permanente, operates with a closed delivery system, and thus does not have significant relationships with traditional and safety-net providers. By proposing this regulation, DHCS is not only undermining the two-plan model structure but is also degrading the safety-net provider system by allowing Kaiser Permanente which neither contracts nor uses the safety-net system to any significant degree.

When planning the two-plan model structure, the Legislature specifically considered and created a role for the safety net. In fact, the Legislature made assurances to traditional and safety-net providers during the planning and implementation

stages of the two-plan model. These proposed regulations violate the promises made to the safety net, as they will not have a role if DHCS ends the two-plan model by allowing additional health plans in the model that have closed systems which do not support the safety net. (See Department of Health Services, Expanding Medi-Cal Managed Care (1993).

In addition, DHCS is inappropriately revising the definition of "traditional provider" by removing the reference of Medi-Cal and stating that Medi-Cal is not part of the definition of "traditional provider." The 1993 document entitled, Expanding Medi-Cal Managed Care, specifically defined traditional providers as those providers which historically have delivered services to Medi-Cal beneficiaries and consistently maintained a substantial Medi-Cal portion of their practice. (See Department of Health Services, Expanding Medi-Cal Managed Care (1993), p. 23). There is no reason why the definition should be revised to remove the word "Medi-Cal" from the definition of traditional provider.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

Comment Number: 4

SUBJECT: Lack of Clarity and Consistency

COMMENT: There are already other provisions of law in place, in the form of legally binding contracts between DHCS, Kaiser Permanente, and the public plans, which address the specific circumstances set forth in the proposed regulation. DHCS was aggressive in encouraging the public plans to enter into these contracts, and stated that these contracts would obviate the need for DHCS to consider directly contracting with Kaiser Permanente to meet continuity goals-thus contradicting both the necessity and consistency aspects of the proposed regulation. Nonetheless, the proposed regulation makes no reference to these existing contracts and thus suggests that DHCS can contract directly with Kaiser Permanente despite the existence of these contracts.

Therefore, it is unclear whether the regulation would render the existing contracts null and void, or whether DHCS would acquire the authority to contract directly with Kaiser Permanente even though the issue has already been addressed in existing contracts; i.e., creating duplicative contracts. The status of the existing contracts, and the likely effect of the proposed regulation on those contracts, "cannot be easily understood by" Kaiser Permanente or the public plans even though both will be directly affected by the proposed regulation, in violation of Government Code, Section 11349, subdivision (c).

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

Comment Number: 5

SUBJECT: More Reasonable Alternatives

COMMENT: DHCS' stated justification for the proposed rulemaking has centered largely on continuity of care concerns. However, DHCS is already accomplishing today through contract what it seeks to accomplish later through regulation. The vast majority of public plans have already executed contracts with Kaiser Permanente that address the continuity of care issues identified by DHCS; and the small number of remaining public plans that have yet to execute contracts with Kaiser Permanente, are expected to do so in the very near future.

More importantly, in every two-plan model where Medi-Cal children were previously enrolled in Kaiser Permanente through Healthy Families, including L.A. Care, those children have already been assigned by the public plan back to Kaiser Permanente, with no disruption in care.

Therefore, instead of burdening the public with potential reductions in the quality of care and marketing abuses-and mainstream plans in two-plan model counties with risks to their financial viability- by deviating from the two-plan model (see Department of Health Services, Expanding Medi-Cal Managed Care (1993), at pp. 15-16), DHCS can instead continue engaging in the public plan/Kaiser Permanente contracting process and achieve the same result in a far more reasonable and less burdensome manner.

RESPONSE: See Introductory Remarks regarding Necessity and Impact.

Comment Number: 6

SUBJECT: Maximum Enrollment

COMMENT: DHCS proposes to repeal Welfare and Institutions Code Section 53820- Maximum Enrollment Levels, citing that the purpose of this section is no longer necessary because the managed care model has evolved. DHCS further states this protection is no longer necessary because safety-net providers are now contracted through both the Commercial Plans and the Local Initiatives. However, just because a health plan has a contact with a safety-net provider, doesn't guarantee usage of the safety-net provider. In fact, Kaiser Permanente does not have any significant number of safety net provider contracts - therefore, s rationale for eliminating the maximum enrollment levels is disingenuous. In

addition, enrollment levels are still necessary in startup managed care regions and the ability to establish enrollment levels is still very much needed today.

RESPONSE: In consideration of comments, and after further review, the Department withdraws the proposed repeal of Title 22, CCR Section 53820.