WELFARE AND INSTITUTIONS CODE - WIC

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

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

CHAPTER 7. Basic Health Care [14000 - 14199.87] *(Chapter 7 added by Stats. 1965, 2nd Ex. Sess., Ch. 4.)*

ARTICLE 2.91. Geographic Managed Care Pilot Project [14089 - 14089.8] *(Heading of Article 2.91 amended by Stats. 1991, Ch. 95, Sec. 7.)*

14089. (a) The purpose of this article is to provide a comprehensive program of managed health care plan services to Medi-Cal recipients residing in clearly defined geographical areas. It is, further, the purpose of this article to create maximum accessibility to health care services by permitting Medi-Cal recipients the option of choosing from among two or more managed health care plans or fee-for-service managed case arrangements, including, but not limited to, health maintenance organizations, prepaid health plans, and primary care case management plans. Independent practice associations, health insurance carriers, private foundations, and university medical centers systems, not-for-profit clinics, and other primary care providers, may be offered as choices to Medi-Cal recipients under this article if they are organized and operated as managed care plans, for the provision of preventive managed health care plan services.

(b) The department may seek proposals and then shall enter into contracts based on relative costs, extent of coverage offered, quality of health services to be provided, financial stability of the health care plan or carrier, recipient access to services, cost-containment strategies, peer and community participation in quality control, emphasis on preventive and managed health care services and the ability of the health plan to meet all requirements for both of the following:

(1) Certification, where legally required, by the Director of the Department of Managed Health Care and the Insurance Commissioner.

(2) Compliance with all of the following:

(A) The health plan shall satisfy all applicable state and federal legal requirements for participation as a Medi-Cal managed care contractor.

(B) The health plan shall meet any standards established by the department for the implementation of this article.

(C) The health plan receives the approval of the department to participate in the pilot project under this article.

(c) (1) (A) The proposals shall be for the provision of preventive and managed health care services to specified eligible populations on a capitated, prepaid, or postpayment basis.

(B) Enrollment in a Medi-Cal managed health care plan under this article shall be voluntary for beneficiaries eligible for the federal Supplemental Security Income for the Aged, Blind, and Disabled Program (Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code).

(2) The cost of each program established under this section shall not exceed the total amount that the department estimates it would pay for all services and requirements within the same geographic area under the fee-for-service Medi-Cal program.

(d) (1) An eligible beneficiary shall be entitled to enroll in any health care plan contracted for pursuant to this article that is in effect for the geographic area in which the beneficiary resides. The department shall make available to recipients information summarizing the benefits and limitations of each health care plan available pursuant to this section in the geographic area in which the recipient resides. A Medi-Cal or CalWORKs applicant or beneficiary shall be informed of the health care options available regarding methods of receiving Medi-Cal benefits. The county shall ensure that each beneficiary is informed of these options and informed that a health care options presentation is available.

(2) No later than 30 days following the date a Medi-Cal or CalWORKs recipient is informed of the health care options described in paragraph (1), the recipient shall indicate the recipient's choice, in writing, of one of the available health care plans and the recipient's choice of primary care provider or clinic contracting with the selected health care plan. Notwithstanding the 30-day deadline set forth in this paragraph, if a beneficiary requests a directory for the entire service area within 30 days of the date of receiving an enrollment form, the deadline for choosing a plan shall be extended an additional 30 days from the date of that request.

(3) The health care options information described in this subdivision shall include the following elements:

(A) Each beneficiary or eligible applicant shall be provided, at a minimum, with the name, address, telephone number, and specialty, if any, of each primary care provider, by specialty or clinic participating in each managed health care plan option through a personalized provider directory for that beneficiary or applicant. This information shall be presented under the geographic area designations by the name of the primary care provider and clinic, and shall be updated based on information electronically provided monthly by the health care plans to the department, setting forth changes in the health care plan provider network. The geographic areas shall be based on the applicant's residence address, the minor applicant's school address, the applicant's work address, or any other factor deemed appropriate by the department, in consultation with health plan representatives, legislative staff, and consumer stakeholders. In addition, directories of the entire service area, including, but not limited to, the name, address, and telephone number of each primary care provider and hospital, of all Geographic Managed Care health plan provider networks shall be made available to beneficiaries or applicants who request them from the health care options contractor. Each personalized provider directory shall include information regarding the availability of a directory of the entire service area, provide telephone numbers for the beneficiary to request a directory of the entire service area, and include a postage-paid mail card to send for a directory of the entire service area. The personalized provider directory shall be implemented as a pilot project in Sacramento County pursuant to this article, and in Los Angeles County (Two-Plan Model) pursuant to Article 2.7 (commencing with Section 14087.305). The content, form, and geographic areas used shall be determined by the department in consultation with a workgroup to include health plan representatives, legislative staff, and consumer stakeholders, with an emphasis on the inclusion of stakeholders from Los Angeles and Sacramento Counties. The personalized provider directories may include a section for each health plan. Prior to implementation of the pilot project, the department, in consultation with consumer stakeholders, legislative staff, and health plans, shall determine the parameters, methodology, and evaluation process of the pilot project. The pilot project shall thereafter be in effect for a minimum of two years. Following two years of operation as a pilot project in two counties, the department, in consultation with consumer stakeholders, legislative staff, and health plans, shall determine whether to implement personalized provider directories as a permanent program statewide. If necessary, the pilot project shall continue beyond the initial two-year period until this determination is made. This pilot project shall only be implemented to the extent that it is budget neutral to the department.

(B) Each beneficiary or eligible applicant shall be informed that the beneficiary or applicant may choose to continue an established patient-provider relationship in a managed care option, if the treating provider is a primary care provider or clinic contracting with any of the health plans available and has the available capacity and agrees to continue to treat that beneficiary or eligible applicant.

(C) Each beneficiary or eligible applicant shall be informed that if the beneficiary or applicant fails to make a choice, the beneficiary or applicant shall be assigned to, and enrolled in, a health care plan.

(4) At the time the beneficiary or eligible applicant selects a health care plan, the department shall, when applicable, encourage the beneficiary or eligible applicant to also indicate, in writing, that person's choice of primary care provider or clinic contracting with the selected health care plan.

(5) Commencing with the implementation of a geographic managed care project in a designated county, a Medi-Cal or CalWORKs beneficiary who does not make a choice of health care plans in accordance with paragraph (2), shall be assigned to and enrolled in an appropriate health care plan providing service within the area in which the beneficiary resides.

(6) If a beneficiary or eligible applicant does not choose a primary care provider or clinic, or does not select a primary care provider who is available, the health care plan selected by or assigned to the beneficiary shall ensure that the beneficiary selects a primary care provider or clinic within 30 days after enrollment or is assigned to a primary care provider within 40 days after enrollment.

(7) A Medi-Cal or CalWORKs beneficiary dissatisfied with the primary care provider or health care plan shall be allowed to select or be assigned to another primary care provider within the same health care plan. In addition, the beneficiary shall be allowed to select or be assigned to another health care plan contracted for pursuant to this article that is in effect for the geographic area in which the beneficiary resides in accordance with Section 1903(m)(2)(F)(ii) of the Social Security Act.

(8) The department or its contractor shall notify a health care plan when it has been selected by or assigned to a beneficiary. The health care plan that has been selected or assigned by a beneficiary shall notify the primary care provider that has been selected

or assigned. The health care plan shall also notify the beneficiary of the health care plan and primary care provider selected or assigned.

(9) This section shall be implemented in a manner consistent with any federal waiver that is required to be obtained by the department to implement this section.

(e) A participating county may include within the plan or plans providing coverage pursuant to this section, employees of county government, and others who reside in the geographic area and who depend upon county funds for all or part of their health care costs.

(f) Funds may be provided to prospective contractors to assist in the design, development, and installation of appropriate programs. The award of these funds shall be based on criteria established by the department.

(g) In implementing this article, the department may enter into contracts for the provision of essential administrative and other services. Contracts entered into under this subdivision may be on a noncompetitive bid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(h) Notwithstanding any other provision of law, on and after the effective date of the act adding this subdivision, the department shall have exclusive authority to set the rates, terms, and conditions of geographic managed care contracts and contract amendments under this article. As of that date, all references to this article to the negotiator or to the California Medical Assistance Commission shall be deemed to mean the department.

(i) Notwithstanding Section 7926.220 of the Government Code, a contract or contract amendments executed by both parties after the effective date of the act adding this subdivision shall be considered a public record for purposes of the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code) and shall be disclosed upon request. This subdivision includes contracts that reveal the department's rates of payment for health care services, the rates themselves, and rate manuals.

(Amended by Stats. 2021, Ch. 615, Sec. 445. (AB 474) Effective January 1, 2022. Operative January 1, 2023, pursuant to Sec. 463 of Stats. 2021, Ch. 615.)

14089.05. (a) (1) The department may implement a multiplan project in the County of San Diego, upon approval of the Board of Supervisors of the County of San Diego, for the provision of benefits under this chapter to eligible Medi-Cal recipients. The multiplan project implemented in the County of San Diego pursuant to this section shall provide diagnostic, therapeutic, and preventive services provided under the Medi-Cal program, and additional benefits including, but not limited to, medical-related transportation, comprehensive patient management, and referral to other support services.

(2) The County of San Diego shall be eligible to receive funds transferred pursuant to paragraph (1) of subdivision (p) of Section 14163 for the development and implementation of this section. These funds in the amount allocated by the department for the County of San Diego shall be paid by the department upon the enactment of this section to the County of San Diego to reimburse a portion of the costs of the development of the project. To the full extent permitted by state and federal law, these funds shall be distributed by the department for expenditure by the County of San Diego in a manner that qualifies for federal financial participation under the Medicaid program and the department shall expedite the payment of the federal funds to the County of San Diego. The department shall seek additional state, federal, and other funds to pay for costs that are incurred by the County of San Diego to develop the multiplan project in excess of the payment required by this section, and the department shall assist the county in obtaining the additional funds.

(b) (1) The County of San Diego may establish an advisory board composed of consumer representatives and health care professionals' representatives. The board shall advise the Health and Human Services Agency of the County of San Diego and review and comment on all aspects of the implementation of the multiplan project. The advisory board shall advise on the implementation of the state Medi-Cal policy as it pertains to Medi-Cal managed care plans in the County of San Diego. Each supervisor of the board of supervisors shall appoint at least one member to the advisory board with each supervisor to appoint an equal number of members from their district. The advisory board shall vote on all pilot project policies and issues that are submitted to the board of supervisors.

(2) Notwithstanding any other law, a member of the advisory board established pursuant to this section shall not be deemed to be interested in a contract entered into by the department within the meaning of Article 4 (commencing with Section 1090) of Chapter 1 of Division 4 of Title 1 of the Government Code if the member is a Medi-Cal recipient or if all of the following apply:

(A) The member was appointed to represent the interests of physicians, health care practitioners, hospitals, pharmacies, or other health care organizations.

(B) The contract authorizes the member or the organization the member represents to provide Medi-Cal services under the multiplan project.

(C) The contract contains substantially the same terms and conditions as contracts entered into with other individuals or organizations the member was appointed to represent.

(D) The member does not influence or attempt to influence the advisory board or another member of the advisory board to recommend that the department enter into the contract in which the member is interested.

(E) The member discloses the interest to the advisory board and abstains from voting on any recommendation on the contract.

(F) The advisory board notes the member's disclosure and abstention in its official records.

(3) Members of the advisory board shall not be paid compensation for activities relating to their duties as members, but members who are Medi-Cal recipients shall be reimbursed an appropriate amount by the County of San Diego for their travel and child care expenses incurred in performing their duties under this section. Members of the advisory board who are Medi-Cal recipients may also be reimbursed by the County of San Diego for their time in performing their duties under this section, at the discretion of the county.

(c) At the discretion of the department, the County of San Diego, the department, or other appropriate entities may perform any of the following in a manner that accomplishes the integration of the intake of eligible beneficiaries to the project, the assessment of beneficiary individual and family needs and circumstances, and the timely referral of beneficiaries to health care and other services to respond to their individual and family needs:

(1) Determine the eligibility of Medi-Cal applicants and recipients in a manner and environment that is accessible to the recipients and applicants.

(2) Perform enrollment activities in a manner that ensures that recipients be given the opportunity to select the provider of their choice in a manner and environment that is accessible to the recipients.

(3) The department may negotiate and amend its contract with the county to provide for specified quality improvement activities, and may require each of the health plans to participate in those activities. The department shall also participate in the county's quality improvement activities.

(d) Notwithstanding Section 14089 or any other provision of law, the County of San Diego, when contracting with the department pursuant to this section or Section 14089, shall not be liable for damages for injury to persons or property arising out of the actions or inactions of the department, the department's other contractors, or providers of health care or other services, or Medi-Cal recipients. This section shall not relieve the County of San Diego from liability arising out of its actions or inactions.

(e) The County of San Diego, when contracting with the department pursuant to Section 14089 or this section, shall have no legal duty to provide health care or other services to Medi-Cal recipients, and shall have no financial responsibility for the department's other contractors or providers of health care or other services, except to the extent specifically set forth in contracts between the department and the county.

(f) Notwithstanding Section 14089.6, the department may terminate any existing managed care contract with either a prepaid health plan or a primary care case management plan for services in the County of San Diego in accordance with the terms and conditions set forth in the existing contract, at any time that the department determines that termination is in the best interest of the state. The department shall notify an existing prepaid health plan at least 90 days prior to termination. The department shall notify a primary care case management plan at least 30 days prior to termination.

(g) All contracts entered into by the department and the County of San Diego pursuant to Section 14089 or this section shall not be for the benefit of any third party, and no third-party beneficiary relationship shall be established between the county and any other party, except as may be specifically set forth in contracts between the department and the County of San Diego.

(h) (1) For purposes of this section, "multiplan project" means a program authorized by this section in which a number of Knox-Keene licensed health plans designated by the county and approved by the department shall be the only Medi-Cal managed care health plans authorized to operate within the County of San Diego, with the exception of special projects approved by the department.

(2) Designated health plans shall include, but not be limited to, health plans sponsored by traditional Medi-Cal physicians, neighborhood health centers, community clinics, health systems, including hospitals and other providers, or a combination thereof.

(3) Participating health plans shall first be designated by the county for approval by the department. Health plans approved by the department shall be eligible to contract with the department. Designation by the county and approval by the department provides the health plan only with the opportunity to compete for a contract and does not guarantee a contract with the state.

(4) Designation requirements imposed by the county shall not conflict with the requirements imposed by the department, the federal Medicaid program, and the Medi-Cal program, and may not impose stricter requirements, without the department's approval, than those imposed by the department, the federal Medicaid program, and the Medi-Cal program.

(5) Designation of health plans by the county will continue for the term of the Medi-Cal contract.

(i) Nothing in this section relieves the county of duties or liabilities imposed by Part 5 (commencing with Section 17000) or that it has assumed through contract with entities other than the department.

(j) Indian health facilities in the County of San Diego may contract directly with the department as Medi-Cal fee-for-service case management providers apart from the geographic managed care program or may participate in the network of one or more of the geographic managed care plans. Indian health service facilities that contract with the department as fee-for-service case management providers may enroll Medi-Cal recipients, including, but not limited to, recipients who are in any of the geographic managed care mandatory enrollment aid codes.

(Amended by Stats. 2024, Ch. 134, Sec. 1. (SB 1257) Effective January 1, 2025.)

14089.07. (a) The Sacramento County Department of Health and Human Services may establish a stakeholder advisory committee to provide input on the delivery of health care services provided in the county pursuant to this article, Section 14182, and Part 3.6 (commencing with Section 15909). The advisory committee shall include, but not be limited to, Medi-Cal beneficiaries, patient representatives, health care providers, and representatives of Medi-Cal managed care health plans.

(b) The advisory committee may submit written input to the State Department of Health Care Services regarding policies that improve coordination with traditional and safety net providers, enhance the capacity of the county's health care delivery system, and improve health care services and health outcomes.

(c) The advisory committee may request, in writing, and receive final reports submitted to the department by any managed care health plan operating in Sacramento County as long as the report is not exempt from disclosure pursuant to Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code, or any other contractual, statutory, or legal exemption, or privilege. The advisory committee may review and provide written comments to the department on these reports, that may include issues such as evaluation of access, quality, and consumer protections.

(d) No state General Fund moneys shall be used to fund advisory committee costs, nor to fund any related administrative costs incurred by the county.

(Amended by Stats. 2021, Ch. 615, Sec. 446. (AB 474) Effective January 1, 2022. Operative January 1, 2023, pursuant to Sec. 463 of Stats. 2021, Ch. 615.)

14089.08. (a) Sacramento County may establish a stakeholder advisory committee to provide input on the delivery of oral health and dental care services, including prevention and education services, dental managed care, and fee-for-service Denti-Cal. The advisory committee shall include, but not be limited to, local nonprofit organizations, representatives from the First Five Sacramento Commission, representatives and members of the local dental society, local health and human services representatives, representatives of Medi-Cal dental managed care plans, Medi-Cal enrollees, and other interested individuals. The advisory committee may meet on a monthly basis.

(b) The advisory committee may submit written input to the State Department of Health Care Services or the Sacramento County Board of Supervisors, as applicable, regarding policies that improve the delivery of oral health and dental services in Sacramento under the Medi-Cal program or county-administered health care system.

(c) The State Department of Health Care Services shall meet periodically, but at least on a quarterly basis, with the advisory committee to facilitate communication, dissemination of information, and improvements in the provision of oral health and dental care services under the Medi-Cal program in the County of Sacramento. The dissemination of information shall include data reported from performance measures and benchmarks used by the department.

(d) The advisory committee may meet periodically, but at least twice annually, with the Sacramento County Department of Health and Human Services advisory committee established pursuant to Section 14089.07.

(e) No state General Fund moneys shall be used to fund advisory committee costs or to fund any related administrative costs incurred by the county.

(Added by Stats. 2012, Ch. 23, Sec. 79. (AB 1467) Effective June 27, 2012.)

14089.09. (a) It is the intent of the Legislature to improve access to oral health and dental care services provided to Medi-Cal beneficiaries enrolled in dental health managed care plans in the Counties of Sacramento and Los Angeles through implementation of performance contracting to ensure dental health plans meet quality criteria and timely access to dental care, as contained in Section 14459.6, and implementation of a beneficiary dental exception process for Medi-Cal beneficiaries in the County of Sacramento to access dental care through fee-for-service Denti-Cal when applicable.

(b) (1) The Director of Health Care Services shall exercise his or her authority under Section 14131.15 to establish a beneficiary dental exception (BDE) process, as described in paragraph (2), for Medi-Cal beneficiaries mandatorily enrolled in dental health plans in the County of Sacramento. The BDE process shall be implemented no later than July 1, 2012, and shall be in effect for as long as

mandatory enrollment for dental care is in effect in the County of Sacramento. The department shall consult with the advisory committee established pursuant to Section 14089.08 regarding potential modifications to the BDE process. For purposes of emergency access to dental care issues, the department shall establish specific processes under the BDE to accommodate for these issues.

(2) The BDE shall be available to Medi-Cal dental managed care beneficiaries in the County of Sacramento who are unable to secure access to services through their managed care plan, in accordance with applicable contractual timeframes and in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code). The BDE shall allow a beneficiary to opt-out of Medi-Cal dental managed care and move into fee-for-service Denti-Cal where the beneficiary may select his or her own dental provider on an ongoing basis. The beneficiary shall remain in fee-for-service Denti-Cal until the time he or she chooses to opt in to a dental managed care arrangement.

(3) Beneficiaries shall be notified of the BDE option, which shall include the process for access to emergency visits, through a letter from the department detailing the process, directions on how to fill out the BDE form, and where to access the BDE form. A hard copy of the BDE form shall accompany the letter from the department. The BDE form, directions on how to fill out the BDE form, and a description of the process shall also be posted on the department's Internet Web site for easy access by beneficiaries and the public. The department shall also notify and inform dental managed care plans of the BDE process and its operation.

(4) Upon receipt of the BDE form, the department shall have no more than three business days to contact the beneficiary. The department shall, within five business days from the date of contact with the beneficiary, work with the beneficiary and the dental plan to schedule an appointment within the applicable contractual timeframes and in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(A) If an appointment is not available, the department shall approve and process the BDE and move the beneficiary into fee-for-service Denti-Cal.

(B) If an appointment is available, the beneficiary shall receive from the department a followup telephone call after the appointment to assess how the visit went and to determine if there is a need for any additional followup.

(5) Based on the followup as identified in subparagraph (B) of paragraph (4), to the extent no additional access issues to contractually required services are identified, the BDE shall be closed and the beneficiary shall remain in the selected dental plan.

(c) The department shall take all necessary steps to implement the BDE process as described in this section and shall, monthly, publicly report on the department's Internet Web site the number of individuals requesting the BDE and the specific outcome of each request, including, but not limited to, summary data on the types of visits subject to the BDE process, the services provided, description of timely access to care, the delivery system in which services were provided, beneficiary satisfaction, and the department's perspective of the outcome. The information provided on the department's Internet Web site shall be deidentified in accordance with the Health Insurance Portability and Availability Act of 1996 (HIPAA), including Section 164.514 of Title 45 of the Code of Federal Regulations, and shall not contain any personally indentifiable information according to the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code).

(d) The department shall consult with stakeholders in the development of the BDE form and related materials.

(Added by Stats. 2012, Ch. 23, Sec. 80. (AB 1467) Effective June 27, 2012.)

14089.1. In accordance with procedures required by Section 14408, all marketing activities shall require prior approval of the department.

(Added by Stats. 1984, Ch. 1509, Sec. 2.)

14089.2. In accordance with procedures required by Chapter 8 (commencing with Section 14200), each contract with a capitated health system shall provide for a grievance procedure under which Medi-Cal beneficiaries may submit their grievances. The department shall establish standards for these procedures to include appeals to an entity other than the capitated health system.

(Added by Stats. 1984, Ch. 1509, Sec. 3.)

14089.3. The department shall not contract with insurance carriers, organized health systems, or provider organizations, that employ or subcontract with plans that employ providers under suspension from the Medicare or Medi-Cal program.

(Added by Stats. 1984, Ch. 1509, Sec. 4.)

14089.4. The department may consult with the Department of Insurance or the Department of Managed Health Care, and shall consult with the Division of Medi-Cal Fraud and Elder Abuse within the Office of the Attorney General, the appropriate licensing boards, and the laboratory field services unit of the department, for the purposes of determining the qualifications, performance capability, and financial stability of prospective contractors.

(Amended by Stats. 2021, Ch. 554, Sec. 10. (SB 823) Effective January 1, 2022.)

14089.5. (a) The department or its authorized agents shall conduct periodic audits or review, including onsite audits or review, to monitor compliance with Article 4 (commencing with Section 14400) of Chapter 8 with regard to any contract made pursuant to this article. These reviews may be conducted with or without notice and may include assistance by the Attorney General if requested.

(b) The department may terminate a contract, in whole or in part, when the director determines that this action is necessary to protect the health of the beneficiaries or the funds appropriated to carry out the Medi-Cal program.

(Added by Stats. 1984, Ch. 1509, Sec. 6.)

14089.6. Current prepaid health plan and primary care case management contracts entered into by the department pursuant to Chapter 7 (commencing with Section 14088) and Chapter 8 (commencing with Section 14200) shall not be terminated solely due to the implementation of this article in areas served by prepaid health plans and primary care case management contractors. Upon expiration of these contracts, the department shall enter into good faith negotiations for one renewal of these contracts. These plans may continue to serve their Medi-Cal enrollees and to enroll new beneficiaries. Upon expiration or final termination of these renewal contracts and subject to compliance with all applicable requirements prepaid health plan and primary care case management contractors in the areas shall be allowed the opportunity to participate as new contractors under this article.

(Amended by Stats. 1991, Ch. 95, Sec. 9. Effective June 30, 1991.)

14089.7. (a) The department may adopt emergency regulations to implement this article in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The initial adoption of emergency regulations and one readoption of the initial regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Initial emergency regulations and the first readoption of those regulations shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and the first readoption of those regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations and each shall remain in effect for no more than 180 days.

(b) All regulations adopted pursuant to this section prior to the repeal and addition of this section by the act adding this section shall remain in full force and effect unless they are repealed or amended by the department in accordance with the Administrative Procedure Act.

(Repealed and added by Stats. 2001, Ch. 171, Sec. 41. Effective August 10, 2001.)

14089.8. (a) In order to achieve maximum cost savings, the Legislature finds and declares that an expedited contract process for contracts under this article is necessary.

(b) Contracts under this article shall be on a nonbid basis, and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(Amended by Stats. 1998, Ch. 834, Sec. 8. Effective January 1, 1999.)