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 2.81. Managed Health Care System for Los Angeles County [14087.96 - 14087.9730] *(Article 2.81 added by Stats. 1994, Ch. 632, Sec. 2.5.)*

14087.96. The following definitions shall apply for purposes of this article:

(a) “County” means the County of Los Angeles.

(b) “Board of supervisors” means the Board of Supervisors of the County of Los Angeles.

(c) “Commission” means the separate public agency established by the board of supervisors to operate a local initiative for health care in the county.

(d) “Local initiative” means the health plan or plans and other health care programs owned or operated by the commission established under this article, and operated pursuant to the strategic plan.

(e) “Medi-Cal managed care programs” means all those components of the Medi-Cal program that involve the restriction of access for Medi-Cal patients to particular providers or health plans and that involve managed care principles, including, but not limited to, programs such as those described in Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Chapter 8 (commencing with Section 14200), including pilot programs under Article 7 (commencing with Section 14490) thereof.

(f) “Health care consumer” means a Medi-Cal beneficiary or any other person eligible to receive health care services under the local initiative, including parents, legal guardians, or conservators of Medi-Cal beneficiaries and people who will receive health care services under the local initiative.

(g) “Health care consumer advocate” means an individual who, whether in a paid or unpaid capacity, represents the interests of Medi-Cal beneficiaries or people who will receive health care under the local initiative.

(h) “Strategic plan” means the report issued on March 31, 1993, by the State Department of Health Services, entitled “The State Department of Health Services’ Plan for Expanding Medi-Cal Managed Care: Protecting Vulnerable Populations” or the report, as subsequently revised or amended.

(Amended by Stats. 2004, Ch. 454, Sec. 1. Effective January 1, 2005.)

14087.9605. (a) The board of supervisors may, by ordinance, resolution, or other action, establish a commission in order to meet the problems of delivery of publicly assisted medical care in the county and demonstrate ways of promoting quality care and cost efficiency. The health care services provided by the commission shall include, but are not limited to, services covered under this chapter provided on a coordinated managed care basis. The commission shall operate the local initiative that provides or arranges for the delivery of health care services in all or part of the geographic area of the county, in a manner that is consistent with managed care principles, techniques, and practices directed at ensuring cost-effective and adequate access to quality care, without discrimination on the basis of medical condition, diagnosis, or illness, in an amount, duration, and scope that is sufficient to reasonably achieve its purpose for enrollees in the local initiative. If the board of supervisors establishes a commission, all rights, powers, duties, privileges, and immunities vested in the county pursuant to the contract with the department under this article shall be vested in the commission.

(b) (1) The commission shall be considered a public entity that is a local unit of government and that is separate from the county, shall file the statement required by Section 53051 of the Government Code, and shall be considered a public entity for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code. The commission, members of the commission, and employees of the commission shall be protected by the immunities applicable to public entities and public employees governed by

Part 2 (commencing with Section 814) of Division 3.6 of Title 1 of the Government Code, except as provided by other statutes or regulations that apply expressly to the commission.

(2) The commission shall have all power necessary and appropriate to do all of the following:

(A) Operate programs involving health care services, including, but not limited to, the power to own and operate one or more health plans.

(B) To enter into agreements with any public or private entity or entities to provide or arrange for health care services on a capitated or noncapitated basis.

(C) To acquire, possess, and dispose of real or personal property.

(D) To employ personnel and contract for services required to meet its obligations.

(E) To sue or be sued.

(F) To enter into agreements under Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code.

(3) The commission may enter into contracts with public and private health care providers to provide health care and related services to individuals enrolled in any health plan or health program operated as part of the local initiative.

(c) Nothing in this section shall be construed to authorize the commission to operate any health care program other than the local initiative described in the strategic plan as it currently exists or as it may be amended by the department.

(Amended by Stats. 2004, Ch. 228, Sec. 12.7. Effective August 16, 2004.)

14087.961. Governance of the commission shall be vested in a governing body consisting of 13 members, each of whom shall have a fiduciary duty to act in the best interest of the commission and the local initiative, nominated by the following entities, and appointed by the board of supervisors:

(a) Four members shall be nominated by the board of supervisors to represent the County of Los Angeles. No more than one member nominated by the board of supervisors shall be a member of the board of supervisors and each remaining member nominated by the board of supervisors shall possess experience as a health care administrator or as a health care provider.

(b) One member shall be a representative of private hospitals that have Medi-Cal disproportionate share status, or if that status no longer exists, that serve an equivalent patient population, who shall be nominated by the Hospital Association of Southern California.

(c) One member shall be a representative of private hospitals that do not have Medi-Cal disproportionate share status, who shall be nominated by the Hospital Association of Southern California.

(d) One member shall be a representative of free and community clinics, who shall be nominated by the Community Clinics Association of Los Angeles County.

(e) One member shall be a representative of federally qualified health centers, who shall be nominated by the Community Clinics Association of Los Angeles County, or if that status no longer exists, an equivalent group of health centers.

(f) One member shall be a physician representative, who shall be nominated by the Los Angeles County Medical Association, in consultation with other physician associations within the county.

(g) One member shall be a representative of Knox–Keene licensed prepaid health plans, who shall be nominated by the California Association of Health Plans.

(h) One member shall represent health care consumers, and at the time of being nominated, shall be a health care consumer. The initial nominee shall be nominated by the working group on the role of the consumer for the first nominee, and thereafter, by a process determined by the community advisory committee under which only health care consumers may nominate and vote for appointees.

(i) One member shall be a health care consumer advocate, who shall represent health care consumers. The initial nominee shall be nominated by the working group on the role of the consumer for the first nominee, and thereafter, by a process determined by the community advisory committee under which only health care consumers may nominate and vote for appointees.

(j) One member shall be a children's health care provider representative, who shall be nominated by the Children's Planning Council as the coordinating entity for organizations and agencies providing direct services to, or advocacy for, children and families within the county.

(Amended by Stats. 2004, Ch. 454, Sec. 2. Effective January 1, 2005.)

14087.9615. (a) The composition of the 13-member governing body of the commission, as prescribed in Section 14087.961, shall be subject to alteration upon a two-thirds vote of the full membership of the governing body, if the action is also concurred in by an affirmative vote of at least four members of the board of supervisors; provided, however, no change in the composition of the governing board shall result in the elimination of representation by the county, private physicians, hospitals, and other providers, clinics, or consumers and consumer advocates.

(b) Notwithstanding subdivision (a), no governing body member shall be removed except as provided in Section 14087.964.

(Added by Stats. 1994, Ch. 632, Sec. 2.5. Effective September 20, 1994.)

14087.962. Members of the governing body shall either reside, be employed, or provide services in the geographic area served by the local initiative. Nominees shall be appointed to the governing body by the board of supervisors. The board of supervisors shall not deny appointment to a nominee described in subdivisions (b) to (j), inclusive, of Section 14087.961 without specific cause as set forth in Section 14087.964.

(Added by Stats. 1994, Ch. 632, Sec. 2.5. Effective September 20, 1994.)

14087.9625. (a) Members of the governing body of the commission shall serve four-year terms.

(b) Individuals shall be limited to serving on the governing body for two consecutive four-year terms or a maximum of 10 years.

(Amended by Stats. 2004, Ch. 454, Sec. 3. Effective January 1, 2005.)

14087.963. (a) The governing body of the commission shall establish rules for its proceedings. There shall be at least six meetings per year.

(b) (1) Each governing body member shall be entitled to one hundred dollars ($100) remuneration from commission funds for each governing body meeting attended, and may receive similar remuneration for attending meetings of committees of the governing body, except that the total remuneration for each governing body member for all meetings shall not exceed the sum of four hundred dollars ($400) per month, plus actual expenses incurred in attending these meetings at rates payable to county officers and employees.

(2) The per meeting rate and monthly limit of one hundred dollars ($100) and four hundred dollars ($400), respectively, may be increased by the governing body, subject to approval by the board of supervisors.

(Added by Stats. 1994, Ch. 632, Sec. 2.5. Effective September 20, 1994.)

14087.9635. (a) A majority of the members of the governing body shall constitute a quorum for the transaction of business, and all official acts of the governing body shall require the affirmative vote of a majority of the members present and voting.

(b) No official act shall be approved with less than the affirmative vote of four members of the governing body, unless the number of members prohibited from voting because of conflicts of interest precludes adequate participation in the vote.

(Added by Stats. 1994, Ch. 632, Sec. 2.5. Effective September 20, 1994.)

14087.964. A member of the governing body shall be removed from office if a majority of the members present and voting find that one or more of the following causes for removal exists:

(a) The member neither lives in, nor is employed in, the geographic area served by the local initiative.

(b) The member has been convicted of a crime involving corruption or any felony.

(c) The member has failed to attend three consecutive governing body meetings or a majority of the meetings in the most recent calendar year.

(d) The member has failed to discharge legal obligations as a member of a public agency.

(e) A request for removal has been submitted by the appropriate nominating entity in accordance with Section 14087.9645.

(Added by Stats. 1994, Ch. 632, Sec. 2.5. Effective September 20, 1994.)

14087.9645. A member of the governing body may be removed at the request of the entity that nominated the member. The entity that nominated a member may request removal of that member for any of the following reasons:

(a) Any of the causes listed in Section 14087.964.

(b) The member no longer meets the qualifications for office or the criteria applied by the nominating entity in selecting the member as its nominee.

(Added by Stats. 1994, Ch. 632, Sec. 2.5. Effective September 20, 1994.)

14087.965. (a) A request for removal under Section 14087.9645 shall be adopted by the nominating entity in the same manner as the nomination was adopted and shall be confirmed by a written request for removal delivered to the governing body, setting forth the grounds for removal.

(b) A removal under subdivision (a) shall be effective upon action by the governing body, that shall be taken at the first meeting following receipt of the written request.

(c) The nominating entity shall be legally responsible for improper removals.

(d) A nominating entity that requests removal of a governing body member shall nominate a successor within 60 days after the effective date of the removal.

(Added by Stats. 1994, Ch. 632, Sec. 2.5. Effective September 20, 1994.)

14087.9655. (a) The governing body shall establish a technical advisory committee to provide technical expertise to the governing body.

(b) Members of the committee shall include a medical school representative, an epidemiologist, a pharmacist, a representative of a nursing association, a home health care representative, a long-term care provider, a mental health care provider, a medical rehabilitation provider, and an expert on health care quality, or, in the alternative, other persons with health care expertise.

(c) The technical advisory committee shall meet on a regular basis, and shall make recommendations and reports to the governing body.

(Amended by Stats. 2001, Ch. 528, Sec. 1. Effective January 1, 2002.)

14087.9657. (a) The governing body shall establish a children's health consultant advisory committee to provide to the governing body expertise on child, adolescent, and maternal health issues.

(b) Members of the committee shall include representatives of government health departments and school districts in the geographic area served by the local initiative, as well as medical professionals with background in pediatrics and obstetric care, or, in the alternative, other persons with health care expertise.

(c) The children's health consultant advisory committee shall meet on a regular basis, and shall make recommendations and reports to the governing body.

(Added by Stats. 2001, Ch. 528, Sec. 2. Effective January 1, 2002.)

14087.966. (a) The governing body for each geographic region served by the local initiative shall establish a regional community advisory committee to ensure community involvement.

(b) Each regional community advisory committee shall have no more than 35 members, a majority of whom shall be consumers and consumer advocates, but may also include providers.

(c) (1) The chairpersons of the regional community advisory committees shall comprise an executive community advisory committee.

(2) It is the intent of the Legislature that a majority of the executive community advisory committee shall be consumers and consumer advocates, plus two at-large members.

(d) The executive community advisory committee shall make recommendations, and shall report on its activities, to the governing body and shall be able to place matters of the governing body's agenda for consideration.

(Amended by Stats. 2004, Ch. 454, Sec. 4. Effective January 1, 2005.)

14087.9665. (a) The commission may borrow or receive funds from any person or entity as necessary to cover development costs and other actual or projected obligations of the local initiative.

(b) The county may lend funds to the commission upon such terms as the board of supervisors may establish.

(c) Notwithstanding any other provision of law, both the county and the commission shall be eligible to receive funding under subdivision (p) of Section 14163, and the local initiative shall be considered for all purposes to satisfy the requirements of subdivision (p) of Section 14163.

(Added by Stats. 1994, Ch. 632, Sec. 2.5. Effective September 20, 1994.)

14087.967. 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, and shall include payment provisions on any basis negotiated between the department and the commission. In addition, health plans or programs operated by the commission as part of the local initiative may also include, but are not limited to, individuals covered under Title 18 of the Social Security Act (Subchapter 18 (commencing with

Section 1395) of Chapter 7 of Title 42 of the United States Code), individuals employed by public agencies and private businesses, and uninsured or indigent patients.

(Added by Stats. 1994, Ch. 632, Sec. 2.5. Effective September 20, 1994.)

14087.9675. (a) The auditor-controller of the county, at those intervals the auditor-controller deems appropriate, but no less frequently than annually, shall conduct a review of the fiscal condition of the commission, report the findings to the commission and the board of supervisors, and provide a copy of the findings to any public agency upon request.

(b) At the county auditor-controller's discretion, other operational or financial audits of the commission may be conducted.

(c) Upon the written request of the county auditor-controller, the commission shall provide full access to all commission records and documents as necessary to allow the county auditor-controller to perform the activities authorized by this section.

(Added by Stats. 1994, Ch. 632, Sec. 2.5. Effective September 20, 1994.)

14087.968. Notwithstanding any other provision of law, the county shall not be liable for any damages or losses, whether financial or in any other form, that may result from the reliance of any person, entity, or agency on the actions or omissions of, or the findings made by, the auditor-controller under this section.

(Added by Stats. 1994, Ch. 632, Sec. 2.5. Effective September 20, 1994.)

14087.9685. (a) Notwithstanding any other provision of law, any obligation of the commission and its local initiative, statutory, contractual, or otherwise, shall be an obligation solely of the commission and shall not be an obligation of the county or of the state. Except as otherwise provided in this article, neither the county nor the state shall be liable for any act or omission of the commission.

(b) Except as agreed to by contract with the county, no liability of the commission shall become an obligation of the county upon either termination of the commission and its local initiative or the liquidation or disposition of the commission's remaining assets.

(c) All claims for money damages against the commission shall be governed by Part 3 (commencing with Section 900) and Part 4 (commencing with Section 940) of Division 3.6 of Title 1 of the Government Code, except as otherwise provided by other statutes or regulations that expressly apply to the commission.

(Added by Stats. 1994, Ch. 632, Sec. 2.5. Effective September 20, 1994.)

14087.969. (a) Notwithstanding any other provision of law, neither a member of the governing body of the commission nor a member of any advisory panel to the governing body shall be deemed to be interested in a contract or amendment to a contract entered into by the commission within the meaning of Article 4 (commencing with Section 1090) of Chapter 1 of Division 4 of Title 1 of the Government Code if all of the following conditions are satisfied:

(1) The board of supervisors or the governing body appointed the member to represent the interests of the county, physicians, health care practitioners, hospitals, pharmacies, other health care organizations, consumers, or consumer advocates. For purposes of this section, each group whose interests are described in this paragraph shall be referred to as a stakeholder.

(2) The contract or the contract as amended authorizes individuals or organizations in the same stakeholder group that the member was appointed to represent to provide services under the local initiative.

(3) The contract or the contract as amended contains substantially the same terms and conditions as contracts entered into with other individuals or organizations in the same stakeholder group that the member was appointed to represent.

(4) The contract or the contract as amended does not specifically authorize the member or the member's organization, as defined in paragraph (1) of subdivision (e), to provide services under the local initiative.

(b) If paragraphs (1) to (3), inclusive, of subdivision (a) are satisfied but the contract or the contract as amended would specifically authorize the member or the member's organization to provide services under the local initiative, the contract approved by the governing body of the commission shall be deemed to comply with Section 1090 of the Government Code if the member abstains from voting on the contract or amendment to the contract, the member discloses the interest to the governing body or the advisory panel, whichever is applicable, the governing body or advisory panel notes the disclosure and the abstention in its official records, the member does not influence or attempt to influence the governing body, the advisory panel, or any member of the governing body or advisory panel to enter into the particular contract or the contract as amended, and the governing body or advisory panel authorizes the contract or amendment to the contract in good faith only by a vote of its membership sufficient for the purpose without counting the vote of the member.

(c) Notwithstanding any other provision of law, income from a contractor under the local initiative to a member or to a member's organization, as defined in paragraph (1) of subdivision (e), which is unrelated income, as defined in paragraph (2) of subdivision (e), shall not cause the member of the governing body of the commission or the member of the advisory panel to the governing body to

be deemed to be interested in the contract or amendment to the contract for purposes of Article 4 (commencing with Section 1090) of Chapter 1 of Division 4 of Title 1 of the Government Code, if the contract or the contract as amended contains substantially the same terms and conditions as contracts entered into with other contractors in the same stakeholder group that is the source of the unrelated income.

(d) If the particular contract or the contract as amended does not contain substantially the same terms and conditions as contracts entered into with other contractors in the same stakeholder group that is the source of the unrelated income, the contract approved by the governing body of the commission shall be deemed to comply with Section 1090 of the Government Code if the member abstains from voting on the contract or amendment to the contract, the member discloses the interest to the governing body or the advisory panel, whichever is applicable, the governing body or advisory panel notes the disclosure and abstention in its official records, the member does not influence or attempt to influence the governing body to enter into the particular contract or the contract as amended, and the governing body or advisory panel authorizes the contract or amendment to the contract in good faith only by a vote of its membership sufficient for that purpose without counting the vote of the member.

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

(1) “Member’s organization” means an entity for which the member serves as an employee, officer, board member, or consultant, or in which the member has any other financial interest for purposes of Article 4 (commencing with Section 1090) of Chapter 1 of Division 4 of Title 1 of the Government Code.

(2) “Unrelated income” means income that is not related to, or is not for providing services under, the local initiative.

(Amended by Stats. 2004, Ch. 454, Sec. 5. Effective January 1, 2005.)

14087.9695. The department, if at no state General Fund expense, may take all appropriate steps, in cooperation with the county and the commission, to obtain approval for a demonstration or pilot project under applicable federal laws, including, but not limited to, Section 1315 of Title 42 of the United States Code, in connection with the local initiative in the county. The project may include Medi-Cal coverage for enrollees in the local initiative who otherwise would not be covered under the Medi-Cal program. The project shall not be used to curtail existing rights with respect to eligibility and services for the Medi-Cal population, nor to obtain federal waivers of the payment provisions applicable to federally qualified health centers or noninstitutional providers under paragraphs (10), (13), (30), and (37) of subsection (a) of Section 1396a of Title 42 of the United States Code.

(Added by Stats. 1994, Ch. 632, Sec. 2.5. Effective September 20, 1994.)

14087.9697. In any transfer of functions from county employees to the commission, the commission shall continue to recognize the employee organization that represented the employees performing those functions at the time of the transfer of duties. The commission shall also be bound by the terms of any memorandum of understanding that is in effect as of the date of the transfer of functions for the duration thereof, or until replaced by a subsequent memorandum of understanding.

(Added by Stats. 1994, Ch. 632, Sec. 2.5. Effective September 20, 1994.)

14087.97. The commission shall be deemed to be a public agency that is a local unit of government for purposes of all grant programs and other funding and loan guarantee programs.

(Added by Stats. 1994, Ch. 632, Sec. 2.5. Effective September 20, 1994.)

14087.9705. (a) The commission shall obtain licensure as a health care service plan under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code.

(b) Commencing on the date that the commission first receives Medi-Cal capitated payments for the provision of health care services to Medi-Cal beneficiaries and the commission is in full compliance with all of the requirements regarding tangible net equity applicable to a health care service plan licensed under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code, all of the following provisions shall apply:

(1) The commission is authorized to select and design its automated management information system, subject to the requirement that the department, in cooperation with the commission, prior to making capitated payments, approve the system. The department shall test the system to ensure that the system is capable of producing detailed, accurate, and timely financial information on the financial condition of the commission, and any other information that is generally required by the department in its contracts with other local initiatives and with health care service plans.

(2) In addition to the reports required by the Department of Managed Health Care under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code and the rules of the Director of the Department of Managed Health Care adopted and promulgated thereunder, the commission shall provide, on a monthly basis, to the department, the Department of Managed Health Care, and the members of the commission a copy of the automated report described in subdivision (a) and a projection of assets and liabilities, including those that have been incurred but not reported, with an explanation of material

increases or decreases in current or projected assets and liabilities. The explanation of increases and decreases in assets or liabilities shall be provided, upon request, to a hospital, independent physicians' practice association, or community clinic that has contracted with the commission to provide health care services.

(3) In addition to the reporting and notification requirements to which the commission is subject under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code, the chief executive officer or director of the commission shall immediately notify the department, the Department of Managed Health Care, and the members of the commission, in writing, of any fact or facts that, in the chief executive officer's or director's reasonable and prudent judgment, is likely to result in the commission being unable to meet its financial obligations. The written notice shall describe the fact or facts, the anticipated financial consequences, and the actions that will be taken to address the anticipated consequences.

(4) In no event shall the Department of Managed Health Care waive or vary, nor shall the department request the Department of Managed Health Care to waive or vary, the tangible net equity requirements for a commission under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code after three years after the date of the commencement of capitated payments to the commission. Until the commission is in compliance with all of the tangible net equity requirements under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code and the rules of the Director of the Department of Managed Health Care adopted and promulgated thereunder, the commission shall develop a stop-loss program that is appropriate to the risks of the commission. The stop-loss program shall be subject to the approval of the department and the Department of Managed Health Care.

(5) In the event the commission votes to file a petition of bankruptcy, or the board of supervisors notifies the department that it intends to terminate the commission, the department shall immediately transfer the commission's Medi-Cal beneficiaries to other managed care contractors, when the contractors are available, and the contractors are able to demonstrate that they can absorb the increased enrollment without detriment to the provision of health care services to their existing enrollees. To the extent that other managed care providers are unavailable or the department determines that the transfer to the other contractors to a fee-for-service reimbursement system is in the best interest of any particular beneficiary, the department shall make that transfer to the fee-for-service system, pending the availability of managed care contractors that can demonstrate that they can absorb the increased enrollment without detriment to the provision of health care services to their existing enrollees, or until the department determines that providing care to any particular beneficiary pursuant to a fee-for-service reimbursement system is no longer necessary to protect the continuity of care or other interests of the beneficiary. Beneficiaries who have been or who are scheduled to be transferred to a fee-for-service reimbursement system or managed care contractor may make a choice to be enrolled in another managed care system, if one is available, in full compliance with federal freedom-of-choice requirements.

(6) The commission shall submit to a review of financial records when the department determines, based on data reported by the commission or other data received by the department, that the commission will not be able to meet its financial obligations to health care providers contracting with the commission. If the department, pursuant to a review of financial records under this paragraph, determines that the commission will not be able to meet its financial obligation to contracting health care providers for the provision of health care services, the Director of Health Services shall immediately terminate the contract between the commission and the department and shall immediately transfer the commission's Medi-Cal beneficiaries in accordance with paragraph (5) in order to ensure uninterrupted provision of health care services to beneficiaries and to minimize financial disruption. Beneficiary eligibility for Medi-Cal shall not be affected by this action. Beneficiaries who have been or who are scheduled to be transferred under paragraph (5) may make a choice to be enrolled in another managed care plan, if one is available, in full compliance with federal freedom-of-choice requirements.

(7) It is the intent of the Legislature that the department shall implement Medi-Cal capitated enrollments in a manner that ensures that appropriate levels of health care services will be provided to Medi-Cal beneficiaries and that appropriate levels of administrative services will be furnished to health care providers. The contract between the department and the commission shall authorize the department to administer the number of covered Medi-Cal enrollments in a manner that ensures that the commission's provider network and administrative structure are able to provide appropriate and timely services to beneficiaries and to participating providers.

(8) In the event a commission is terminated, files for bankruptcy, or otherwise no longer functions for the purposes for which it was established, the county shall, with respect to compensation for provision of health care services to beneficiaries, occupy no greater or lesser status than any other health care provider in the disbursement of assets of the commission.

(9) Nothing in this section shall be construed to impair or diminish the authority of the Director of the Department of Managed Health Care under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code, nor shall any thing in this section be construed to reduce or otherwise limit the obligation of a commission licensed as a health care plan under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code to comply with the requirements of that chapter, and the rules of the Director of the Department of Managed Health Care adopted thereunder.

(Amended by Stats. 2000, Ch. 857, Sec. 86. Effective January 1, 2001.)

14087.971. (a) Contracts under this article between the department and the commission 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.

(b) It is the intent of the Legislature that the county shall, with respect to its medical facilities and programs, occupy no greater or lesser status than any other health care provider in negotiating with the commission for contracts to provide health care services.

(Added by Stats. 1994, Ch. 632, Sec. 2.5. Effective September 20, 1994.)

14087.9715. The Legislature intends that implementation of this article shall involve consultation and cooperative activities among various agencies of the state and county, and the commission. The Legislature finds and declares that those activities are in furtherance of the state's goals and efforts. The activities of the commission and its local initiative shall be recognized as state action for purposes of all statutes and regulations relating to business competition.

(Added by Stats. 1994, Ch. 632, Sec. 2.5. Effective September 20, 1994.)

14087.972. Neither the commission nor its local initiative shall be considered to be an agency, division, department, or instrumentality of the county, and neither the commission nor its local initiative shall be subject to the personnel, procurement, or other operational rules of the county.

(Added by Stats. 1994, Ch. 632, Sec. 2.5. Effective September 20, 1994.)

14087.9722. (a) If the commission established pursuant to this article no longer functions for the purposes for which it was established, when the commission's existing obligations have been satisfied or the commission's assets have been exhausted, the board of supervisors may, by ordinance, resolution, or other action, terminate the commission.

(b) Prior to the termination of the commission, the board of supervisors shall notify the department of its intent to terminate the commission. Within 30 days of the notification, the department shall conduct an audit of the records of the commission to determine the liabilities and assets of the commission. The department shall report its findings to the board of supervisors within 10 days of the completion of the audit. The board of supervisors shall prepare a plan to liquidate or otherwise dispose of the assets of the commission and to pay the liabilities of the commission to the extent of the commission's assets, and shall present the plan to the department within 30 days after receiving the department's audit findings.

(c) Upon termination of the commission by the board of supervisors, the county shall manage any remaining assets of the commission until superseded by a plan approved by the department.

(d) All assets of the commission remaining after the payment of the liabilities of the commission pursuant to subdivision (b) shall be disposed of pursuant to the contract entered into between the state and the commission pursuant to Section 14087.

(Added by Stats. 1994, Ch. 632, Sec. 2.5. Effective September 20, 1994.)

14087.9725. (a) Nothing in this article shall be construed as amending the requirements of Section 17000.

(b) 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.

(Added by Stats. 1994, Ch. 632, Sec. 2.5. Effective September 20, 1994.)

14087.9730. (a) In an effort to determine whether children's access to, and utilization of, vision care services can be increased by providing vision care services at schools, the department shall establish a pilot program in the County of Los Angeles that enables school districts to allow students enrolled in Medi-Cal managed care plans to receive vision care services at the schoolsite through the use of a mobile vision service provider. The vision care services available under this pilot program are limited to vision examinations and providing eyeglasses.

(b) The Medi-Cal managed care plans in the County of Los Angeles shall jointly identify and develop standards and participation criteria that the participating mobile vision service provider shall meet in order to be deemed qualified to participate in the pilot program, in consultation with the department and consistent with any applicable federal requirements governing Medicaid managed care contracts. In the event the Medi-Cal managed care plans have not developed standards and participation criteria by January 1, 2015, or by the scheduled start date of the pilot program if later, the department shall determine the standards and participating criteria for purposes of this pilot program.

(c) This section shall not be construed to preclude Los Angeles County school district students not enrolled in Medi-Cal managed care from accessing vision care services from a mobile vision service provider participating in this pilot program.

(d) Under the pilot program, if a school district in the County of Los Angeles enters into a written memorandum of understanding with a mobile vision care service provider allowing the provider to offer the vision care services described in this section to students, all of the following shall apply:

(1) The two Medi-Cal managed care plans in the County of Los Angeles shall contract with one or more mobile vision care service providers that meets the standards and participation criteria developed pursuant to subdivision (b) for the delivery of those vision care services to any student enrolled in the Medi-Cal managed care plan who chooses to receive his or her vision care services from the provider at that schoolsite. This contracting requirement is contingent upon agreement between each of the two Medi-Cal managed care plans in the County of Los Angeles and a mobile vision care service provider with respect to reimbursement rates applicable to the services under this pilot.

(2) Neither this pilot program nor the Medi-Cal managed care plan shall require that a Medi-Cal beneficiary receive the vision care services described in this section through a mobile vision care provider onsite at the school.

(3) Prior to a Medi-Cal beneficiary receiving mobile vision care services at the schoolsite, the parents, guardians, or legal representative of the student shall consent in writing to the Medi-Cal beneficiary receiving the services through a mobile vision care provider onsite at the school.

(e) An optometrist or ophthalmologist prescribing glasses to a Medi-Cal managed care beneficiary as part of services provided at a schoolsite by a mobile vision care service provider pursuant to this pilot program shall be enrolled in the Medi-Cal program as an Ordering/Referring/Prescribing provider. For any other purposes under the pilot program, the licensed health professional shall satisfy all requirements for enrollment as a provider in the Medi-Cal program.

(f) (1) The Medi-Cal managed care plan shall compensate the mobile vision services provider for the cost of the vision examination, dispensing of the lenses, and eyeglass frames.

(2) Ophthalmic eyeglasses lenses prescribed by optometrists or ophthalmologists for a Medi-Cal managed care plan enrollee as part of the services provided at a schoolsite by a mobile vision services provider shall be fabricated through optical laboratories the department contracts with pursuant to subdivision (b) of Section 14105.3.

(g) (1) The department shall annually adjust capitation rates for the Medi-Cal managed care plans operating in the County of Los Angeles as necessary to account for projected changes in the costs and utilization of the services provided pursuant to this section by mobile vision service providers.

(2) Capitation rate adjustments pursuant to this section shall be actuarially based and developed using projections of contingent events including targeted populations who will receive these services, and shall otherwise be in accordance with requirements necessary to secure federal financial participation.

(3) Capitation rate adjustments pursuant to this section shall be limited to those related to vision examinations, dispensing of lenses, and eyeglass frames. The fabrication of optical lenses pursuant to this section shall be paid on a fee-for-service basis in accordance with the department's applicable contract under subdivision (b) of Section 14105.3.

(h) The pilot program shall last three years, starting no sooner than January 1, 2015, and concluding December 31, 2017, or three years from the start date of the pilot if later. The department shall evaluate the impact of the pilot program on access to, and utilization of, vision care services by children by monitoring the managed care plan utilization data for vision services, as well as the lens fabrication data.

(i) The department may terminate the pilot program at any time with 90 days advance notice to the Medi-Cal managed care plans for reasons that include, but are not limited to, any of the following:

(1) The department determines that the pilot program is resulting in a lower level of access to, or use of, vision care services for children under the participating health plans.

(2) The department determines that the pilot program is resulting in fraud, waste, or abuse of Medi-Cal funds.

(3) The department determines there is a lack of funding for the vision care services provided in the pilot program.

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

(k) The department shall obtain any federal approvals necessary to implement this section and to obtain federal matching funds to the maximum extent permitted by federal law.

(l) This section shall be implemented only if and to the extent all federal approvals are obtained and federal financial participation is available.

(m) This section shall be implemented only to the extent an annual appropriation is made available to the department each fiscal year for the specific purpose of implementing this section.

(n) If the department determines, pursuant to subdivision (h), that the pilot program is having a positive impact on access and utilization and that additional funds are available, the director may extend the pilot program described in this section to Medi-Cal

managed care plans in other counties and applicable local jurisdictions. Any extension shall be implemented only to the extent that any additional and necessary federal approvals are obtained, and if sufficient funds are made available to participating plans for this purpose. The department may accept funding from private foundations in order to implement an extension under this subdivision to the extent that federal financial participation is available.

(o) The department shall post on its Internet Web site a notice that has terminated or expanded the pilot program, including identification of the geographic locations, and shall notify appropriate fiscal and policy committees of both houses of the Legislature.

(Added by Stats. 2014, Ch. 40, Sec. 4. (SB 870) Effective June 20, 2014. Note: See related declaration of intent in Stats. 2014, Ch. 40, Sec. 11.)