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 2.9. Primary Care Provider Case Management [14088 - 14088.25] *(Article 2.9 added by Stats. 1982, Ch. 328, Sec. 20.)*

14088. (a) The purpose of this article is to ensure that the Medi-Cal program shall be operated in the most cost-effective and efficient manner possible with the optimum number of Medi-Cal providers, and shall ensure quality of care and known access to services.

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

(1) “Primary care provider” means either of the following:

(A) (i) Any internist, general practitioner, obstetrician-gynecologist, pediatrician, family physician and surgeon, nonphysician medical practitioner, or any primary care clinic, rural health clinic, community clinic or hospital outpatient clinic currently enrolled in the Medi-Cal program, which agrees to provide case management to Medi-Cal beneficiaries.

(ii) For purposes of this subparagraph, “family physician” means a primary care physician and surgeon who renders continued comprehensive and preventative health care services to individuals and families, and who has received specialized training in an approved family medicine residency for three years after graduation from an accredited medical school.

(B) A county or other political subdivision that employs, operates, or contracts with, any of the primary care providers listed in subparagraph (A), and that agrees to use that primary care provider for the purposes of contracting under this article.

(2) “Primary care case management” means responsibility for the provision of referral, consultation, ordering of therapy, admission to hospitals, followup care, and prepayment approval of referred services.

(3) “Designation form” or “form” means a form supplied by the department to be executed by a Medi-Cal beneficiary and a primary care provider or other entity eligible pursuant to this article who has entered into a contract with the department pursuant to this article, setting forth the beneficiary’s choice of contractor and an agreement to be limited by the case management decisions of that contractor and the contractor’s agreement to be responsible for that beneficiary’s case management and medical care, as specified in this article.

(4) “Emergency services” means health care services rendered by an eligible Medi-Cal provider to a Medi-Cal beneficiary for those health services required for alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical conditions which if not immediately diagnosed and treated could lead to disability or death.

(5) “Modified primary care case management” means primary care case management wherein capitated services are limited to primary care practitioner office visits only.

(6) “Service area” means an area designated by either a single federal Postal ZIP Code or by two or more Postal ZIP Codes that are contiguous.

(c) For purposes of Medi-Cal managed care plans, as defined in subdivision (m) of Section 14016.5, “nonphysician medical practitioner” means a physician assistant performing services under physician and surgeon supervision in compliance with Chapter

7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code, a certified nurse-midwife performing services under physician and surgeon supervision in compliance with Article 2.5 (commencing with Section 2746) of Chapter 6 of Division 2 of the Business and Professions Code, or a nurse practitioner performing services in collaboration with a physician and surgeon pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code.

(Amended by Stats. 2019, Ch. 632, Sec. 16. (AB 1622) Effective January 1, 2020.)

14088.05. For purposes of this article, “primary care case management plan” means a primary care provider or other entity who has contracted with the department pursuant to this article.

(Amended by Stats. 1995, Ch. 859, Sec. 3. Effective January 1, 1996.)

14088.2. The primary care provider or other entity eligible pursuant to this article with whom a contract has been entered into pursuant to this article shall have responsibility for providing for case management as defined, pursuant to Section 14088.

(Amended by Stats. 1992, Ch. 1212, Sec. 3. Effective January 1, 1993.)

14088.4. (a) No reimbursement shall be provided, for any beneficiary receiving case management services, for any services covered by the contract entered into pursuant to this article, except emergency services and dental services, not authorized pursuant to case management decisions made by the appropriate contractor.

(b) Notwithstanding subdivision (a), a provider shall be reimbursed for covered services rendered to a beneficiary, when the department’s automated eligibility verification system, developed pursuant to Section 14042, fails to indicate that the beneficiary is subject to receiving case management services, provided that claims for these services meet all other requirements for valid claims under the program.

(Amended by Stats. 1992, Ch. 1212, Sec. 5. Effective January 1, 1993.)

14088.5. The beneficiary shall be permitted to disenroll from any contract entered into pursuant to this article upon request, except where prohibited under the provisions of any federal waivers obtained by the department.

(Amended by Stats. 1992, Ch. 1212, Sec. 6. Effective January 1, 1993.)

14088.6. In order to achieve maximum cost savings, the Legislature hereby determines that an expedited contract process for contracts under this article is necessary. Therefore, contracts under this article may be on a nonbid basis and shall be exempt from the provisions of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(Amended by Stats. 1998, Ch. 834, Sec. 6. Effective January 1, 1999.)

14088.7. Primary care providers and other entities with whom a contract has been entered into pursuant to this article shall be exempt from Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code for purposes of carrying out the contracts.

(Amended by Stats. 1992, Ch. 1212, Sec. 7. Effective January 1, 1993.)

14088.8. (a) The department may establish modified primary care case management contracts pursuant to this article. This authority shall be subject to the department seeking and obtaining all necessary federal waivers to implement this section.

(b) In establishing modified primary care case management contracts pursuant to this article, the department may enter into contracts with providers whose application to develop a full primary care case management contract has been accepted by the department and who are working with the department to document, develop, and install the required systems, policies, and procedures. These contracts may provide for the following:

(1) The modified primary care case management contract would have effect only until the contractor’s full primary care case management contract is executed.

(2) The scope of services covered and the case management and utilization control responsibilities of the contractor may be more limited than under a full primary care case management.

(3) Formal enrollment of Medi-Cal beneficiaries with the contractor would occur but the contractor could be reimbursed on a fee-for-service basis for the services the contractor provides to them. Beneficiaries enrolling under the modified primary care case management contract would remain enrolled under the full primary care case management contract entered into by the contractor.

(4) Contractor quality of care requirements could be modified to reflect the contractor’s fee-for-service managed care mode of health care delivery.

(5) Evaluation by the department of the contractor's efficiency, case management effectiveness and the calculation of any savings and savings sharing would reflect the temporary fee-for-service approach under which the contractor is operating.

(c) Contracts shall not be entered into by the department unless the waivers or revision to any existing waiver are granted by the federal government. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented, but provisions for which waivers are either obtained or found to be unnecessary shall be unaffected by the inability to obtain federal waivers for other provisions.

(Amended by Stats. 1992, Ch. 722, Sec. 81. Effective September 15, 1992.)

14088.85. (a) The department may enter into primary care case management contracts with primary care providers that serve persons infected with human immunodeficiency virus (HIV). Except as otherwise provided in this section, contracts made pursuant to this section shall be subject to all the requirements of this article and regulations of the department.

(b) Primary care providers contracted with pursuant to this section may provide services exclusively to Medi-Cal eligible persons infected with HIV.

(c) Capitation payment rates for primary care providers under this section shall be calculated based on the equivalent fee-for-service costs of providing care to HIV infected patients rather than on the equivalent fee-for-service cost of providing care to all Medi-Cal patients.

(Added by Stats. 1992, Ch. 34, Sec. 1. Effective April 20, 1992.)

14088.12. Primary care case management contractors shall establish, maintain, and conduct an active, ongoing outreach and recruitment effort to add primary care and specialty providers to their networks to the extent necessary to meet the health care needs of their enrollees. Contractors shall submit to the department documentation regarding the participation and availability of primary care and specialty providers added to their network on or after enactment of this section. The department may enter into primary care case management contracts with children's hospitals.

(Added by Stats. 1992, Ch. 722, Sec. 78. Effective September 15, 1992.)

14088.13. The department shall approve those Medi-Cal services for which the contractor is at risk that shall be provided in any contract or contracts for services under the primary care provider case management program. Medi-Cal services provided under any contract or contracts for services under this article shall be subject to review and approval by the department.

(Added by Stats. 1988, Ch. 1348, Sec. 11.)

14088.14. The department may enter into contracts pursuant to this article with nurse practitioners, acting within the scope of practice of a nurse practitioner, certified nurse midwives, acting within the scope of practice of a certified nurse midwife, and, for the purpose of providing services to populations with special medical problems, with any physician who has specialized in an area of medicine relevant to the special population to be served and who is currently enrolled in the Medi-Cal program.

(Amended by Stats. 2007, Ch. 188, Sec. 55. Effective August 24, 2007.)

14088.15. A plan shall not use false advertising or false statements to induce enrollment. No solicitation of enrollees shall include the granting or offering of any monetary or other valuable consideration for enrollment.

(Added by Stats. 1992, Ch. 1056, Sec. 3. Effective September 29, 1992.)

14088.16. The department or a county which has contracted for the provision of services pursuant to this article may, within service areas designated by the department, enter into contracts with primary care providers. The contracts shall be on a capitated rate or risk-sharing basis, or a combination of both. The rate of payment for services shall not vary solely according to the category of licensure of the facility in which the services are rendered by providers within each service area. The rate of payment established under the contract shall not exceed the total per capita amount which the department estimates would be payable for all services and requirements covered under the contract if all such services and requirements were to be furnished Medi-Cal beneficiaries under the Medi-Cal fee-for-service program.

Prior to entering into any contract for primary care case management under this chapter, the department shall provide public notice of its intent to enter into such a contract. Furthermore, the department shall develop specific criteria for evaluating potential contractors which ensure that all types of primary care providers are given equal consideration in the contractor selection process.

(Added by renumbering Section 14088.1 by Stats. 1988, Ch. 1348, Sec. 7.)

14088.17. (a) The department may contract under this article, on an exclusive or nonexclusive basis, with an established professional organization with a membership which consists of physicians who engage in the types of practices or who provide services in the locations set forth in subdivision (a) of Section 14088.

(b) (1) A contract under this section shall be implemented in a manner consistent with any federal waivers which are obtained by the department to enable such an arrangement.

(2) Where federal waivers permit restrictions on beneficiary freedom of choice, the contract shall provide covered Medi-Cal beneficiaries with an initial choice of a primary care physician and a procedure through which a beneficiary may change primary care physicians with good cause.

(c) This section shall apply only to the provision of services to beneficiaries who, for purposes of Medi-Cal eligibility determination, are residents of Lake County, Mendocino County, or Sonoma County.

(Added by Stats. 1988, Ch. 745, Sec. 1.)

14088.18. (a) In order to increase the number of nonprofit providers under this article, the department may enter into contracts each fiscal year under this section with eligible nonprofit organizations to provide a one-time interest-bearing loan, repayable at the Pooled Money Investment Account rate, to that eligible organization.

(b) Contracts entered into pursuant to this section shall be limited to contracts within those counties where the department does not have contracts authorized by this article on the effective date of this section.

(c) Any loan entered into pursuant to this section shall not exceed one hundred thousand dollars ($100,000).

(d) The department shall adopt standards and procedures for loan applications and repayment of the loans made pursuant to this section.

(e) The department shall make no loan pursuant to this section until the department has made savings payments to contractors who have entered into contracts under this article on or before the effective date of this section.

(f) For purposes of this section, “eligible nonprofit organization” means any organization which meets all of the following requirements:

(1) The organization is exempt from taxation under Section 501(c)(3) or 501(c)(25)(C)(iii) of the federal Internal Revenue Code.

(2) The organization is organized to provide health care to the medically underserved and to provide services in service areas.

(Amended by Stats. 1998, Ch. 834, Sec. 5. Effective January 1, 1999.)

14088.19. (a) The department may enter into primary care case management contracts pursuant to this article with any health care service plan that is licensed by the Director of the Department of Managed Health Care pursuant to 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 terms of the contracts entered into pursuant to this section shall be exempt from those provisions of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code that regulate health care service plan contracts. Nothing in this section shall preclude the Director of the Department of Managed Health Care from otherwise regulating a health care service plan subject to the Knox-Keene Health Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(b) When a health care service plan enters into a contract pursuant to this article and also pursuant to Chapter 8 (commencing with Section 14200), there shall be no duplication of service areas between the two contracts without prior written approval by the department.

(Amended by Stats. 2000, Ch. 857, Sec. 87. Effective January 1, 2001.)

14088.22. Sections 14408, 14409, 14410, and 14411 shall apply to primary care case management plans.

(Amended by Stats. 1995, Ch. 859, Sec. 4. Effective January 1, 1996.)

14088.23. (a) The department may apply one or more of the following sanctions against any contractor for failure to comply with the requirements of this article, regulations adopted by the department, the contract between the contractor and the department, or for other good cause shown. Good cause includes, but is not necessarily limited to, three repeated and uncorrected findings of serious deficiencies that have the potential to endanger patient care, as defined by the department in accordance with this section, identified in the medical audits conducted by the department:

(1) Terminate the contract.

(2) Suspend enrollment and marketing activities.

(3) Require the contractor to suspend or terminate personnel of the contractor or to terminate participation by subcontractors specified by the department.

(4) Impose civil penalties not to exceed ten thousand dollars ($10,000) per violation pursuant to regulations adopted by the director. Unless imposed in error, penalties shall not be returned to the plan.

(5) Take other appropriate action as determined necessary by the department.

(b) The department shall give the contractor and any other persons who may be directly interested not less than 30 days' notice of its intention to impose any of the sanctions authorized by this section.

(c) The notice required by subdivision (b) shall be written, and shall specify each requirement that has not been met, the proposed effective date of the sanction or sanctions, and the amount and duration of each proposed sanction.

(d) (1) Within five working days after the receipt of the written notice required by subdivision (b), the contractor may submit notice of its intent to comply with the requirements specified in the written notice.

(2) If the contractor submits the notice of intent authorized by paragraph (1), the department shall allow the contractor to demonstrate its compliance with the requirements specified in the department's written notice. Substantial compliance shall be achieved within 30 calendar days from the date of the submission of the notice of intent to comply by the contractor. Within 15 days following the completion of the 30-day compliance correction period, the department shall review the corrective actions taken by the contractor and, if appropriate, approve those actions.

(3) If a contractor subject to notice to apply sanctions under subdivision (b) does not demonstrate appropriate corrective compliance within the 30-day corrective action period or does not submit a notice of intent to comply with the requirements specified in the notice required by subdivision (b), the department shall notify the contractor, in writing, of the effective date and terms of the sanction or sanctions applied pursuant to this section.

(4) The department may make one or more of the following temporary suspension orders as an immediate sanction: temporarily suspend enrollment activities, temporarily suspend marketing activities, require the contractor temporarily to suspend specified personnel of the contractor, or require the contractor temporarily to suspend participation by a specified subcontractor. The temporary suspension orders may be effective beginning on the first day after the expiration of the 30-day compliance correction period, if the contractor submitted a notice of intent to comply, but has not demonstrated appropriate corrective action, or beginning on the first day after the notice required by subdivision (b) if the contractor did not submit a notice of intent to comply. All other sanctions shall be effective no earlier than 20 days after the notice specified in paragraph (3).

(5) If the department issues a temporary suspension order as an immediate sanction, it shall notify the contractor of the nature and effective date of the temporary suspension and at the same time shall serve the provider with an accusation. Upon receipt of a notice of defense filed by the contractor, the department shall, within 15 days, set the matter for hearing, which shall be held as soon as possible, but not later than 30 days after receipt of the notice of hearing by the contractor. The hearing may be continued at the request of the contractor if a continuance is necessary to permit presentation of an adequate defense. The temporary suspension order shall remain in effect until the hearing is completed and the department has made a final determination on the merits. However, the temporary suspension order shall be deemed vacated if the director fails to make a final determination on the merits within 60 days after the original hearing has been completed.

(6) A contractor may request a hearing in connection with any sanctions applied pursuant to this section, other than those contained in a temporary suspension order, within 15 working days after the notice of the effective date of the sanctions has been given pursuant to paragraph (3), by sending a letter so stating to the address specified in the notice. The department shall stay implementation of the sanction upon receipt of the request for a hearing. Implementation of the sanction shall remain stayed until the effective date of the final decision of the department.

(7) Except as otherwise provided herein, all hearings to review the imposition of sanctions, including temporary suspension orders, shall be held pursuant to the procedures set forth in Section 100171 of the Health and Safety Code.

(e) The department may collect civil penalties imposed pursuant to this section by withholding the amount of the penalty from capitation payments owed by the department to the contractor.

(Amended by Stats. 1997, Ch. 220, Sec. 35. Effective August 4, 1997.)

14088.25. (a) The department may conduct onsite reviews of a provider or facility that has agreed with the primary care case management contractor or a potential contractor to provide services to beneficiaries enrolled with the contractor. These reviews may be for purposes such as evaluating the capabilities of potential contractors, monitoring quality of care, investigating complaints, and ensuring contractor compliance with the terms of the contract entered into pursuant to this article.

(b) Prior to adding a provider or facility to an existing network of providers and facilities, the primary care case management contractor shall submit a complete prequalification package to the department. The department shall provide to the contractor written acknowledgment that the package is complete within 10 working days.

(c) (1) If the provider or facility proposed for addition to the contractor's existing network is currently enrolled in the Medi-Cal program, the provider or facility may begin treating beneficiaries enrolled with the contractor immediately upon the contractor's receipt of the acknowledgment required by subdivision (b), subject to paragraph (2) and subdivision (d).

(2) Whenever warranted, the department may rescind the privilege provided for in paragraph (1) by advance notification to the contractor, pending the onsite review required by subdivision (d). Notification shall be in writing and describe the conditions that support the rescission of the privilege.

(d) (1) The department shall conduct an onsite review of the provider or facility within a reasonable period of time after receipt of the package, which shall be not more than 60 days after receipt of the package, unless there are extenuating circumstances.

(2) The department shall notify the contractor in writing of the department's final decision on the request to add the provider or facility to the contractor's existing network within 10 working days of the date of the review.

(e) In the conduct of the onsite review of the provider or facility, the department shall not condition approval of the site on adherence by the provider or facility to requirements that are not contained in any statute, regulation, or commonly accepted community standard of medical practice that directly applies to the category of provider or facility being inspected. This subdivision does not, however, relieve the contractor of any obligations under the contract entered into pursuant to this article.

(Amended by Stats. 2007, Ch. 188, Sec. 56. Effective August 24, 2007.)