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 2.6. Selective Provider Contracts [14081 - 14087.29] *(Article 2.6 added by Stats. 1982, Ch. 328, Sec. 17.)*

14081. It is the purpose of this article to ensure that the Medi-Cal program shall be operated in the most cost-effective and efficient manner possible with the optimum number of inpatient hospital service providers. In order to carry out this purpose it is the specific intent of the Legislature that the special negotiator have maximum discretion and flexibility in order to select among various methods of arranging for the provision of health services while achieving significant cost savings. This article shall be the exclusive means of providing inpatient hospital services to recipients qualifying for such care under this chapter.

All previously eligible hospitals may continue to participate in the Medi-Cal program and receive reimbursement for the provision of inpatient hospital services under this article until the special negotiator has negotiated contracts with a sufficient number of hospitals to assure bed capacity to meet the needs of Medi-Cal beneficiaries in an area and notifies the hospital that it is no longer eligible to serve Medi-Cal inpatients except as provided for in Section 14087. A determination by the negotiator under this section shall not require a hearing under Section 14123 or any other section.

(Amended by Stats. 1982, Ch. 1594, Sec. 35. Effective September 30, 1982.)

14081.1. (a) The Legislature finds and declares the need to improve the reporting relationship between the state and hospitals eligible to contract with the state for the provision of inpatient services to Medi-Cal eligible persons as provided for in the Medi-Cal reform legislation enacted during the 1981–82 Legislative Session.

(b) Existing statutes require hospitals to file a multiplicity of reports with various state agencies for a variety of purposes, including, but not limited to, the development of Medi-Cal reimbursement rates for inpatient services. The Medi-Cal reform legislation enacted during the 1981–82 Legislative Session significantly altered the manner in which hospitals are reimbursed under the program for these services, thereby establishing the opportunity to redefine and restructure the existing hospital reporting requirements.

(c) It is the Legislature's intent, therefore, that the existing reporting requirements be reviewed and revised for efficiency, wherever possible, with consideration given to the development of a consolidated, single, multipurpose report for use by all state agencies.

(d) It is the Legislature's further intent that, in determining these efficiencies, the purposes for which the reports are required be preserved.

(Added by Stats. 1983, Ch. 1120, Sec. 1.)

14081.5. Hospitals that are not selected for contracting under this article and that have negotiated in good faith to obtain a contract need not fulfill preexisting obligations relating to the provision of inpatient services to Medi-Cal beneficiaries arising under Section 15459 of the Government Code, and subdivision (j) of Section 129050 of, paragraph (4) of subdivision (b) of Section 127175 of, the Health and Safety Code, so long as this article remains in effect.

(Amended by Stats. 1996, Ch. 1023, Sec. 470. Effective September 29, 1996.)

14082. Notwithstanding any other provision of law, the Governor shall designate a person in his office to act as a special negotiator to negotiate rates, terms, and conditions for contracts with hospitals for inpatient services to be rendered to Medi-Cal program beneficiaries. The negotiator may also, if he or she deems it expedient, call for bids, in lieu of negotiations. The special negotiator shall consider, when contracting, the total funds appropriated for inpatient hospital services.

The department and every other state agency concerned with health care or public social services shall provide such assistance as the negotiator may require. The department shall enter into contracts with hospitals and shall be bound by the rates, terms, and conditions negotiated by the negotiator.

The negotiator shall have the powers of a head of a department pursuant to Chapter 2 (commencing with Section 11150) of Part 1 of Division 3 of Title 2 of the Government Code, except, that he or she shall adopt only such rules and regulations pursuant to Section 11152 of the Government Code as are necessary to carry out those duties specifically conferred upon the negotiator by Articles 2.6 (commencing with Section 14081), 2.8 (commencing with Section 14087.5), 2.91 (commencing with Section 14089), and 2.92 (commencing with Section 14090) of this chapter.

The negotiator shall adopt such regulations as emergency regulations in accordance with the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. For the purposes of the Administrative Procedure Act, the adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare.

Notwithstanding the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, emergency regulations adopted in accordance with this section shall not be subject to the review and approval of the Office of Administrative Law. These regulations shall become effective immediately upon filing with the Secretary of State.

In addition to the powers specified in this section, the negotiator has the authority to negotiate contracts under Article 2.8 (commencing with Section 14087.5), Article 2.91 (commencing with Section 14089), and Article 2.92 (commencing with Section 14090) of this chapter. Also, the California Medical Assistance Commission shall have the authority to enter into contracts for the provision of acute inpatient hospital services for the care of County Medical Services Program beneficiaries pursuant to Section 16809 of the Welfare and Institutions Code.

Nothing in this article or the Budget Act of 1984 prohibits the negotiator from adjusting rates paid to hospitals to reflect inflation, provided that such adjustments are determined during the negotiating process.

The amendment of this section made at the 1983–84 Regular Session of the Legislature does not constitute a change in, but is declaratory of, the existing law.

(Amended by Stats. 1992, Ch. 722, Sec. 68.5. Effective September 15, 1992.)

14082.5. The negotiator provided for in Section 14082 shall serve in such capacity for the 1982–83 fiscal year, after which his or her functions shall be assumed by the California Medical Assistance Commission. Commencing on July 1, 1983, any reference in this article or in Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of this chapter to the negotiator shall be deemed to be references to the California Medical Assistance Commission.

As of July 1, 1983, the negotiator shall serve as the executive director of the commission.

(Added by Stats. 1982, Ch. 328, Sec. 17. Effective June 30, 1982.)

14083. The factors to be considered by the negotiator in negotiating contracts under this article, or in drawing specifications for competitive bidding, include, but are not limited to, all of the following:

(a) Beneficiary access.

(b) Utilization controls.

(c) Ability to render quality services efficiently and economically.

(d) Demonstrated ability to provide or arrange needed specialized services.

(e) Protection against fraud and abuse.

(f) Any other factor which would reduce costs, promote access, or enhance the quality of care.

(g) The capacity to provide a given tertiary service, such as specialized children's services, on a regional basis.

(h) Recognition of the variations in severity of illness and complexity of care.

(i) Existing labor-management collective bargaining agreements.

(j) The situation of county hospitals and university medical centers contracting with counties for provision of health care to indigent persons entitled to care under Section 17000, which are burdened to a greater extent than private hospitals with bad debts, indirect costs, medical education programs, and capital needs.

(k) The special circumstances of hospitals serving a disproportionate number of Medi-Cal beneficiaries and patients who are not covered by other third-party payers, including the costs associated with assuring an adequate supply of registered nurses.

(l) The costs of providing complex emergency services, including the costs of meeting and maintaining state and local requirements for trauma center designation.

(m) The hospital does any of the following:

(1) Provides additional obstetrical beds.

(2) Contracts with one or more comprehensive perinatal providers.

(3) Permits certified nurse midwives, subject to hospital rules, and consistent with existing laws and regulations, to admit patients to the health facility.

(4) Expands overall obstetrical services in the hospital.

(n) The special circumstances of hospitals whose Medi-Cal inpatient utilization rate exceeds the mean Medicaid inpatient utilization rate by at least one-half of one standard deviation.

(o) The ability and capacity of the contracting hospital in a closed health facility planning area to provide health care services to beneficiaries who are in life-threatening or emergency situations, but have been sufficiently stabilized at another noncontracting facility in order to facilitate transportation to the contracting hospital.

(p) The ability of the contracting hospital to provide a secure environment for the provision of health care services. In this regard, the negotiator shall consider additional security measures that the contracting hospital may have taken to provide a secure environment, including, but not limited to, the use of detection equipment or procedures to detect lethal weapons, the appropriate use of surveillance cameras, limiting access of unauthorized personnel to the emergency department, installation of bullet proof glass as appropriate in designated areas, the use of emergency “panic” buttons to alert local law enforcement agencies, and assigning full-time security personnel to the emergency department.

(Amended by Stats. 2010, Ch. 328, Sec. 244. (SB 1330) Effective January 1, 2011.)

14083.5. In addition to considering factors specified in Section 14083, the negotiator, in negotiating contracts under this article, or in drawing specifications for competitive bidding, shall give special consideration to the reimbursement issues faced by hospitals caring for Medi-Cal beneficiaries who are receiving treatment for acquired immune deficiency syndrome (AIDS).

(Added by Stats. 1987, Ch. 1470, Sec. 1. Effective September 30, 1987.)

14084. (a) Payments to the contractor may be either on a capitation or prepayment basis, or on a combination of both methods of payment, or such other methods as the negotiator determines to be feasible. Hospitals may assume all or part of the risk of utilization of services, or costs of services, or both.

(b) The department shall insure that the system for reimbursing contracting hospitals is capable of making contract payments in the manner determined pursuant to subdivision (a). At a minimum, the department shall insure that the reimbursement system is capable of making contract payments on a per diem and a per case basis.

(Amended by Stats. 1983, Ch. 1315, Sec. 2.)

14085. All utilization controls applied to inpatient hospital services by the director in accordance with Section 14133.1 shall continue to be applied to inpatient hospital services rendered under this article, except that the director may waive utilization controls which are no longer necessary in the case of hospitals entering into negotiated, capitated, at-risk contracts under this article.

(Added by Stats. 1982, Ch. 328, Sec. 17. Effective June 30, 1982.)

14085.5. (a) Each disproportionate share hospital contracting to provide services under this article or contracting with a county organized health system, and which has or would have met the state criteria developed pursuant to the federal medicaid requirements regarding disproportionate hospitals for the three most recent years prior to submitting final plans for an eligible project in accordance with subparagraph (C) of paragraph (1) of subdivision (b), may, in addition to the rate of payment provided for in the contract entered into under this article, receive supplemental reimbursement to the extent provided for in this section.

(b) (1) (A) A hospital qualifying pursuant to subdivision (a) shall submit documentation regarding debt service on revenue bonds used for financing the construction, renovation, or replacement of hospital facilities, including buildings and fixed equipment.

(B) Qualified hospitals may submit debt service instruments to the department and to the commission regarding debt issued for new capital projects.

(C) Eligible projects shall include those new capital projects funded by new debt for which final plans have been submitted to the Office of the State Architect and the Office of Statewide Health Planning and Development after September 1, 1988, and prior to June 30, 1994, except that projects submitted between September 1, 1988, and June 30, 1989, shall be eligible only if the submitting hospital had all of the following additional characteristics during the 1989 calendar year:

(i) No less than 400 general acute care licensed beds.

(ii) An average Medi-Cal patient census of not less than 30 percent of the total patient days.

(iii) No less than 50,000 emergency department visits.

(iv) An existing basic emergency department, obstetrical services, and a neonatal intensive care unit.

(D) The department shall confirm in writing hospital and project eligibility for partial financing under this section.

(E) Department advisory letters, conditioned on hospital and project conformity to plans, may be requested by hospitals prior to final plan submission.

(F) Capital projects receiving partial financing under this section shall finance the upgrading or construction of buildings and equipment to a level required by currently accepted medical practice standards, including projects designed to correct Joint Commission on Accreditation of Hospitals and Health Systems fire and life safety, seismic, or other related regulatory standards.

(2) Projects may also expand service capacity as needed to maintain current or reasonably foreseeable necessary bed capacity to meet the needs of Medi-Cal beneficiaries after giving consideration to bed capacity needed for other patients, including unsponsored patients.

(3) (A) Debt service shall only be paid for projects, or for that portion of projects, that are available and accessible to patients treated under this article or by successor programs.

(B) Each project shall cost at least five million dollars ($5,000,000) or, if less than five million dollars ($5,000,000), the project shall be necessary for retention of federal and state licensing and certification and for meeting fire and life safety, seismic, or other related regulatory standards.

(4) Supplemental reimbursement payments shall commence no later than 30 days after receipt of the certificate of occupancy by the hospital.

(5) (A) The state shall pledge to, and agree with, the holders of any revenue bonds issued to finance projects qualifying under this section that until debt service on the revenue bonds is fully paid, or until the supplemental rate is no longer required as provided by this section, the state will not limit or alter the rights vested in the hospital to receive supplemental reimbursement pursuant to this section.

(B) The state shall pledge, and the hospital shall, as a condition of encumbering supplemental reimbursement payments received pursuant to this section, pledge that supplemental reimbursement payments shall be used for the payment of debt service on the revenue bonds. The hospital shall include its pledge and the agreement with the state in any agreement with the holders of the revenue bonds.

(c) The hospital's supplemental reimbursement for a project qualifying pursuant to subdivisions (a) and (b) shall be calculated as follows:

(1) For any fiscal year for which the hospital is eligible to receive reimbursement, the hospital shall report to the department the amount of debt service on the revenue bonds issued to finance the project.

(2) (A) The department shall use the medicaid inpatient utilization rate as determined pursuant to Section 4112 of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) to determine the ratio of the hospital's total paid Medi-Cal patient days to total patient days.

(B) (i) Notwithstanding any other provision of law, in determining the hospital's medicaid inpatient utilization rate for the purposes of this section, the department shall include in both the numerator and denominator all Medi-Cal inpatient days of care provided by the hospital after December 31, 1994, to Medi-Cal beneficiaries who are enrolled in prepaid health plans contracting with the department. Where reliable data regarding those days are available from Medi-Cal prepaid health plans contracting with participating hospitals for services rendered prior to January 1, 1995, that data may be used by the department in the calculations.

(ii) For purposes of this section, Medi-Cal prepaid health plan programs, and the days relating thereto, shall include, but not be limited to, the programs listed in paragraph (1) of subdivision (b) of Section 14105.985, Section 14089, and any prepaid programs implemented under Section 14087.3, including the two-plan model described in the report issued on March 31, 1993, by the department, entitled "The State Department of Health Services' Plan for Expanding Medi-Cal Managed Care: Protecting Vulnerable Populations."

(3) (A) (i) The supplemental Medi-Cal reimbursement to the hospital for each fiscal year shall equal the amount determined annually in paragraph (1) multiplied by the percentage figure determined in paragraph (2). In no instance shall the percentage figure determined pursuant to the ratio derived under paragraph (2) be decreased by more than 10 percent of the initial ratio determined pursuant to paragraph (2) prior to the retirement of the debt.

(ii) Hospitals whose Medi-Cal ratio falls below 90 percent of the initial level established at the point of final plan submission shall at least maintain the volume of Medi-Cal utilization which was recorded at the time of final plan submission unless forces beyond the hospital's control have decreased the absolute volume of care.

(B) (i) In no instance shall the total amount of reimbursement received under this section combined with that received from all other sources dedicated exclusively to debt service exceed 100 percent of the debt service over the life of the loan.

(ii) A hospital qualifying for and receiving supplemental Medi-Cal reimbursement shall continue to receive the reimbursement until the qualifying loan is paid off, or the hospital is terminated as a Medi-Cal selective contractor and the hospital does not contract with a county organized health system.

(iii) It is the intent of the Legislature that the state and the qualifying hospital shall negotiate in good faith for rates sufficient to ensure continued hospital participation in the program and to ensure adequate access to services for Medi-Cal beneficiaries.

(iv) The state shall not terminate a contract with a qualified provider for the purpose of terminating the capital supplement.

(v) If negotiations fail to permit continuation of a contract of a hospital qualifying for the supplemental Medi-Cal reimbursement, the supplemental Medi-Cal reimbursement shall cease as of the date of discontinuance of the selective provider contract.

(4) In order to ensure provision of qualified supplemental payments to disproportionate share hospitals contracting with county organized health systems, the department shall make the qualified supplemental payments directly to these hospitals.

(5) Funding for these supplemental payments shall be separately appropriated as a line item in the Budget Act for each fiscal year for any project for which a request for payment is received after April 1 of each fiscal year. The department shall request a deficiency appropriation if funds for the payment are not appropriated in the Budget Act.

(6) (A) Paragraphs (1) to (4), inclusive, shall be incorporated into an amendment to any contract entered into by a hospital pursuant to this article.

(B) (i) Any contract amendment required by paragraph (A) shall include a payment methodology based on inpatient hospital services rendered to Medi-Cal patients, either on a per diem basis, a per-discharge basis, or any other federally permissible basis, and which is consistent with the hospital's Medi-Cal contract.

(ii) The payment methodology specified in clause (i) shall ensure that the hospital, on an annual basis, receives the amount of supplemental reimbursement calculated pursuant to paragraph (3), excluding only the federal portion of costs which have been determined by the federal government not to be allowable under Title XIX of the federal Social Security Act (Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code).

(iii) The payment methodology specified in clause (i) shall contain a retrospective adjustment mechanism to ensure that, regardless of the payment methodology, the department shall pay the hospital the full amount owed to the hospital for the year, as determined pursuant to this section.

(7) In negotiating contracts with hospitals receiving payments under this section, the commission shall take appropriate steps to ensure the duplicate payments are not made to the hospital for the debt service costs relating to the eligible project.

(d) All reimbursement received by a hospital pursuant to this section shall be placed in a special account, the funds in which shall be used exclusively for the payment of debt service on the revenue bonds issued to finance the project.

(e) If contracting under this section is superseded by other arrangements for payment of inpatient hospital services, the successor program shall include separate reimbursement, as determined pursuant to paragraph (3) of subdivision (c).

(f) (1) For purposes of this section, "revenue bonds" are defined as that term is defined in subdivision (c) of Section 15459 of the Government Code, and shall also include general obligation bonds issued by or on behalf of eligible hospitals for projects of more than five million dollars ($5,000,000).

(2) (A) The aggregate principal amount of general obligation bonds to be issued as revenue bonds under this subdivision for the anticipated allowable portion of projects shall not, in any fiscal year, exceed a statewide amount established in the Medi-Cal estimates submitted to the fiscal committees of the Legislature pursuant to Section 14100.5, or as otherwise statutorily determined by the Legislature.

(B) In preparing Medi-Cal estimates, the department shall consider, but need not include, all actual and anticipated projects.

(g) (1) The department shall promptly seek any necessary federal approvals for the implementation of this section, and, if necessary to obtain federal approval, the department may, for federal purposes, limit the program to those costs which are allowable

expenditures under Title XIX of the federal Social Security Act (Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code), subject to paragraph (2).

(2) The department shall continue to be responsible for the reimbursement of eligible providers from state funds for the amount of supplemental reimbursement pursuant to paragraph (3) of subdivision (c), excluding only the federal portion of costs which have been determined by the federal government not to be allowable under Title XIX of the federal Social Security Act.

(h) (1) A hospital receiving supplemental reimbursement pursuant to this section shall be liable for any reduced federal financial participation resulting from the implementation of this section.

(2) The department shall submit claims for federal financial participation for all elements of the supplemental reimbursements which are allowable expenditures under federal law.

(3) The department shall, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims for federal financial participation will include only those expenditures which are allowable under federal law.

(4) (A) The department may require that hospitals receiving supplemental reimbursement submit data necessary for the department to determine the appropriate amounts to claim as expenditures qualifying for federal financial participation.

(B) Unless otherwise permitted by federal law, the total statewide payment under the selective provider contracting program, in the aggregate on an annual basis, shall not exceed an amount that would otherwise have been paid under the Medi-Cal program on a statewide basis for the same services, in the aggregate on an annual basis, if the contracting program were not implemented.

(i) (1) Subject to paragraph (2), any hospital that met the criteria specified in subdivision (a) at the time it submitted its final plans for an eligible project in accordance with subparagraph (C) of paragraph (1) of subdivision (b) shall continue to receive reimbursement as set forth in this section irrespective of whether or not the hospital qualifies as a disproportionate share hospital after submission of its final plans.

(2) A hospital that fails to meet the criteria for disproportionate share status on or before June 30, 2002, shall be required to submit data to the department that demonstrates that the hospital failed to meet the criteria for a disproportionate share hospital because its low-income utilization rate, as determined pursuant to Section 4112 of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203), does not exceed 25 percent due to one or more of the following factors:

(A) An increase in outpatient utilization.

(B) A decrease in the average length of stay for Medi-Cal beneficiaries or charity care patients due to technological advances in the provision of care.

(C) Increased implementation within the state of Medi-Cal prepaid health plan programs.

(D) The level of reimbursement that the hospital receives for outpatient visits.

(E) Other circumstances beyond the hospital's control that affect the hospital's ability to meet the criteria for disproportionate status, even though the hospital continues to have a mission to provide care to Medi-Cal and charity care patients.

(Amended by Stats. 2001, Ch. 745, Sec. 248. Effective October 12, 2001.)

14085.51. (a) A disproportionate share hospital that qualifies under Section 14085.5 that has submitted final plans for an eligible capital project in accordance with subparagraph (C) of paragraph (1) of subdivision (b) of Section 14085.5 may submit substitute final plans and shall qualify for supplemental reimbursement under Section 14085.5 for the revised capital project as described in the substitute final plans if all of the following conditions are met:

(1) The substituted capital project continues to meet the requirements for eligible projects as specified in Section 14085.5.

(2) The hospital provides written notification to the department of the status of the project on or before January 1 of each year commencing January 1, 1999. This notification shall, at a minimum, include a narrative description of the project, identification of medical services to be provided, documentation substantiating service needs, projected construction timeframes, and total estimated revised capital project costs.

(3) The substitute final plans are submitted to the Office of Statewide Health Planning and Development prior to June 30, 1995, or, where debt was issued prior to July 1, 1996, for the capital project for which the plans were originally submitted, the substitute final plans are submitted to the Office of Statewide Health Planning and Development prior to December 31, 2000.

(b) The revised capital project may provide for any one or more of the following:

(1) A reduction in size and scope of the original project plan.

(2) Tenant interior improvements for the entire building not specified in the original project plan.

(3) Modifications to the foundation, structural frame, and building exterior shell, commonly known as the shell and core.

(4) Modifications necessary to comply with current seismic safety standards.

(c) The supplemental reimbursement under Section 14085.5 for the revised capital project shall be no greater than the supplemental reimbursement for the original capital project as evidenced by the architects' and engineers' certified cost estimate of the original plan submission and the substitute plan submission.

(d) (1) A project, if eligible under the criteria set forth in this section and Section 14085.5, shall commence construction on or before January 1, 2002.

(2) In addition, the project shall be licensed for operation and available for occupancy on or before January 1, 2009.

(Amended by Stats. 1997, Ch. 723, Sec. 1. Effective January 1, 1998.)

14085.52. (a) A disproportionate share hospital that qualifies under Section 14085.5 that has submitted final plans for an eligible capital project in accordance with subparagraph (C) of paragraph (1) of subdivision (b) of Section 14085.5 may submit revised plans and shall qualify for supplemental reimbursement under Section 14085.5 for the revised capital project as described in the revised plans if all of the following conditions are met:

(1) The revised capital project continues to meet all other requirements for eligibility as specified in Section 14085.5.

(2) The revised plans are submitted to the Office of Statewide Health Planning and Development prior to December 31, 1996.

(3) The modifications in the revised plans are necessary to comply with current seismic safety standards.

(b) The supplemental reimbursement under Section 14085.5 for the revised capital project shall be no greater than the supplemental reimbursement for the original capital project as evidenced by the architects' and engineers' certified cost estimate of the original plan submission and substitute plans submitted between July 1, 1994, and June 30, 1995, whichever is less.

(Added by Stats. 1996, Ch. 55, Sec. 1. Effective June 6, 1996.)

14085.53. (a) The Alameda Health System may revise plans submitted in accordance with subparagraph (C) of paragraph (1) of subdivision (b) of Section 14085.5 for the Alameda Health System capital project and submit those revised plans pursuant to this section. The revised capital project plans shall qualify for supplemental reimbursement under Section 14085.5 for the revised capital project as described in the revised plans, notwithstanding the assignment of a different permit number, if all of the following conditions are met:

(1) The revised capital project continues to meet all other requirements for eligibility as specified in Section 14085.5.

(2) The revised plans are submitted to the Office of Statewide Health Planning and Development prior to June 30, 1997.

(3) The modifications do not involve a deviation from the original capital project plan's stated architectural building footprint.

(b) The revised capital project plan for the Alameda Health System may provide for any or all or any combination of the following:

(1) A reduction in size and scope of the original project plan.

(2) Tenant interior improvements for the entire building not specified in the original project plan.

(3) Modifications to the foundation, structural frame, and building exterior shell, commonly known as the shell and core.

(4) Modifications necessary to comply with current seismic safety standards.

(c) The revised capital project plans for the Alameda Health System, as described in this section, shall qualify for supplemental reimbursement as calculated pursuant to subdivision (c) of Section 14085.5, as limited by this section. The initial Medi-Cal inpatient utilization rate for the Alameda Health System, for purposes of calculating the supplemental reimbursement, shall be that which was established at the point of the original project plan submission. The supplemental reimbursement shall be based on actual costs of the revised capital project eligible for reimbursement under Section 14085.5. However, in no event shall the supplemental reimbursement for the revised capital project exceed 85 percent of the supplemental reimbursement for that portion of the original Alameda Health System capital project that qualified for the supplemental reimbursement, the original qualifying amount that was

sixty-two million six hundred ninety-six thousand three hundred forty dollars ($62,696,340), as indicated by the budgetary estimate as prepared and submitted by Alameda County to the department July 11, 1994.

(Amended by Stats. 2014, Ch. 46, Sec. 4. (SB 1352) Effective January 1, 2015.)

14085.54. (a) The Los Angeles County University of Southern California (LAC-USC) Medical Center may submit revised final plans to the Office of Statewide Health Planning and Development to replace the original capital expenditure project plans that met the initial eligibility requirements provided for under Section 14085.5 if all of the following conditions are met:

(1) The revised capital expenditure project meets all other requirements for eligibility as specified in Section 14085.5.

(2) The revised plans are submitted to the Office of Statewide Health Planning and Development on or before December 31, 2002, except that, with respect to a facility in the San Gabriel Valley of not less than 80 beds, the revised plans may be submitted not later than December 31, 2003.

(3) The scope of the capital project shall consist of two facilities with not less than a total of 680 beds.

(b) Funding under Section 14085.5 shall not be provided unless all of the conditions specified in subdivision (a) are met.

(c) The revised plans for the LAC-USC Medical Center capital expenditure project may provide for one or more of the following variations from the original capital expenditure project plan submission:

(1) Total revisions or reconfigurations, or reductions in size and scope.

(2) Reduction in, or modification of, some or all inpatient project components.

(3) Tenant interior improvements not specified in the original capital expenditure project plan submission.

(4) Modifications to the foundation, structural frame, and building exterior shell, commonly known as the shell and core.

(5) Modifications necessary to comply with current seismic safety standards.

(6) Expansion of outpatient service facilities that operate under the LAC-USC Medical Center license.

(d) The revised capital expenditure project may provide for an additional inpatient service site to the current LAC-USC Medical Center only if the additional inpatient service site meets both of the following criteria:

(1) The San Gabriel Valley site is owned and operated by the County of Los Angeles.

(2) The San Gabriel Valley site is consolidated under the LAC-USC Medical Center license.

(e) (1) Supplemental reimbursement for the revised capital expenditure project for LAC-USC Medical Center, as described in this section, shall be calculated pursuant to subdivision (c) of Section 14085.5, as authorized and limited by this section. The initial Medi-Cal inpatient utilization rate for the LAC-USC Medical Center, for purposes of calculating the supplemental reimbursement, shall be that which was established at the point of the original capital expenditure project plan submission. The revised capital expenditure project costs, including project costs related to the additional inpatient service site, eligible for supplemental reimbursement under this section shall not exceed 85 percent of the project costs, including all eligible construction, architectural and engineering, design, management and consultant costs that would have qualified for supplemental reimbursement under the original capital project. The Legislature finds that the original qualifying amount was one billion two hundred sixty-nine million seven hundred thirty-five thousand dollars ($1,269,735,000).

(2) Notwithstanding any other provision of this section, any portion of the revised capital expenditure project for which the County of Los Angeles is reimbursed by the Federal Emergency Management Agency and the Office of Emergency Services shall not be considered eligible project costs for purposes of determining supplemental reimbursement under Section 14085.5.

(3) The department shall seek a Medicaid state plan amendment in order to maximize federal financial participation. However, if the department is unable to obtain federal financial participation at the Medi-Cal inpatient adjustment rate as described in paragraph (1), the state shall fully fund any amount that would otherwise be funded under this section, but for which federal financial participation cannot be obtained.

(f) The LAC-USC Medical Center shall provide written notification to the department of the status of the project on or before January 1 of each year, commencing January 1, 2002. This notification shall, at a minimum, include a narrative description of the project,

identification of services to be provided, documentation substantiating service needs, projected construction timeframes, and total estimated revised capital project costs.

(g) The project, if eligible under the criteria set forth in this section and Section 14085.5, shall commence construction at both facilities referred to in subdivision (a) on or before January 1, 2004.

(h) In addition to the requirements of subdivision (f), the project shall be licensed for operation and available for occupancy on or before January 1, 2009.

(i) On or before August 15, 2001, the County of Los Angeles may withdraw any revised final plans that are submitted pursuant to this section prior to that date if the Board of Supervisors of Los Angeles County finds that insufficient funds are available to carry out the capital expenditure project described in this section.

(Amended by Stats. 2013, Ch. 352, Sec. 538. (AB 1317) Effective September 26, 2013. Operative July 1, 2013, by Sec. 543 of Ch. 352.)

14085.55. Notwithstanding subparagraph (C) of paragraph (1) of subdivision (b) of Section 14085.5, eligible projects shall include those new capital projects funded by new debt for which final plans for the foundation, frame, and building shell, commonly known as the shell and core, have been submitted to the Office of the State Architect and the Office of Statewide Health Planning and Development after September 1, 1988, and prior to June 30, 1994, and for which final plans for tenant improvements have been submitted to the Office of the State Architect and the Office of Statewide Health Planning and Development after September 1, 1988, and prior to January 1, 1995.

(Added by Stats. 1994, Ch. 1283, Sec. 1. Effective January 1, 1995.)

14085.56. (a) For the purposes of this section, “Los Medanos site,” means the site of the former Los Medanos Medical Center.

(b) Contra Costa County Regional Medical Center may construct or renovate, or both, at the former Los Medanos site, and the construction or renovation, or both, may be considered eligible for supplemental reimbursement under Section 14085.5, if the Los Medanos site meets both of the following conditions:

(1) The site is owned or leased, and operated, by Contra Costa County.

(2) The site is consolidated under the Contra Costa County Regional Medical Center general acute care license.

(c) Contra Costa County Regional Medical Center shall qualify to receive supplemental reimbursement for revised final plans for construction or renovation, or both, submitted to the Office of Statewide Health Planning and Development on or before November 30, 1998, for the Los Medanos site, and shall qualify for supplemental reimbursement under Section 14085.5 for the revised capital project if the revised capital project continues to meet the requirements for eligibility specified in Section 14085.5, as modified by this section.

(d) The revised final plans may provide for a capital project with one or more of the following variations from the original capital project plan submission:

(1) Total revision or reconfiguration, or a reduction in size and scope.

(2) Modifications necessary to comply with current seismic safety standards.

(3) Expansion of outpatient service facilities.

(4) Modifications to the foundation, structural frame, and building exterior shell, commonly known as the shell and core.

(e) For purposes of calculating supplemental reimbursement pursuant to Section 14085.5 for a revised capital project complying with this section, the initial Medi-Cal inpatient utilization rate shall be that which is determined at the time of submission of the revised capital project plan.

(f) For purposes of determining supplemental reimbursement under Section 14085.5 for a revised capital project complying with this section, supplemental reimbursement shall be based on actual costs of the revised capital project eligible for reimbursement under Section 14085.5. However, in no event shall the revised capital project costs be considered eligible for supplemental reimbursement for the construction or renovation, or both, of the Los Medanos site if these costs exceed eight million five hundred ten thousand dollars ($8,510,000).

(g) Supplemental reimbursement paid under this section for construction shall not duplicate any reimbursement received by the Contra Costa County Regional Medical Center for services provided at the Los Medanos site.

(h) Subject to subdivisions (g) and (h) of Section 14085.5, Contra Costa County Regional Medical Center shall receive supplemental reimbursement under this section for debt service associated with the revised capital project over the lesser of the following periods:

(1) The life of the revenue bonds.

(2) The period during which the Los Medanos site is either leased or owned by Contra Costa County.

(Added by Stats. 2000, Ch. 846, Sec. 1. Effective January 1, 2001.)

14085.57. (a) A designated public hospital, as defined in subdivision (d) of Section 14166.1, that is contracting to provide services under this article, and that has or would have fulfilled the criteria set forth in Section 14105.98 or subparagraph (B) of paragraph (1) of subdivision (c) of Section 14166.3 for the three most recent years prior to submitting final plans for an eligible project in accordance with paragraph (3) of subdivision (b), may receive supplemental reimbursement to the extent provided for in Section 14085.5, subject to subdivision (c), in addition to the rate of payment provided for in the contract entered into under this article.

(b) (1) A hospital qualifying pursuant to subdivision (a) that elects to receive reimbursement under this section shall submit documentation to the department regarding debt service on general obligation bonds or revenue bonds used for financing the construction, renovation, or replacement of hospital facilities, including buildings and fixed equipment.

(2) A hospital qualifying pursuant to subdivision (a) shall remain open for the life of the supplemental reimbursements provided for pursuant to this section.

(3) (A) Eligible projects shall include those new capital projects funded by new debt for which final plans have been submitted to the Office of Statewide Health Planning and Development after January 1, 2007, and prior to December 31, 2011.

(B) Eligible projects that may receive supplemental reimbursement pursuant to subdivision (a) are limited to projects related to meeting seismic safety deadlines.

(c) No expenditure of state funds, either from the General Fund or any special fund, shall be made for the nonfederal share of the supplemental reimbursement provided for in this section. The department shall, for designated public hospitals that meet the criteria in subdivision (a), claim federal expenditures through the use of certified public expenditures or intergovernmental transfers, as necessary and appropriate.

(d) The department shall promptly seek any necessary, and all available, federal approvals for the implementation of this section. This section shall be implemented only to the extent that federal approval and federal financial participation are available.

(Amended by Stats. 2010, Ch. 328, Sec. 245. (SB 1330) Effective January 1, 2011.)

14086. (a) The provisions of this article relating to contracts with hospitals, to be negotiated or let out to bid by the negotiator, shall apply only to hospitals and shall not apply to hospital inpatient services rendered by health maintenance organizations and other organized health systems, contracting with the department under this chapter or Chapter 8 (commencing with Section 14200).

(b) The provisions of this article shall also not apply to state hospitals or out-of-state hospitals. These hospitals shall continue to be eligible for reimbursement in accordance with the state plan adopted by the department under Section 14105.1.

(Amended by Stats. 1993, Ch. 69, Sec. 51. Effective June 30, 1993.)

14087. The provisions of this article shall not, however, be construed to preclude an otherwise qualified hospital from obtaining reimbursement as determined by the department based on the state plan adopted by the department under Section 14105.1, for any of the following:

(a) Providing stabilizing services as required to program beneficiaries located in a closed health facility planning area who are in a life threatening or emergency situation before the beneficiary may be transported to a contracting hospital.

(b) If a beneficiary is located in a closed health facility planning area and experiencing a life threatening or emergency situation but cannot be stabilized sufficiently to facilitate a transfer to a contracting facility, those health services medically necessary for alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical conditions which, if not immediately diagnosed and treated, could lead to significant disability or death.

(c) Providing services to beneficiaries who are also eligible for benefits under the federal program of hospital insurance for the aged and disabled.

(d) Providing services to beneficiaries who live or reside farther than the community travel time standard from a contract hospital, as defined by the department, if the hospital providing services is closer than a contract hospital.

(e) Managed care plans making payments to a contract hospital shall not release any information regarding the reimbursement paid to the hospital when the rate is a Medi-Cal contract rate negotiated pursuant to article 2.6 (commencing with Section 14081), except to the department.

(f) Nothing in this section shall be construed as limiting reimbursement for medically necessary care following stabilization, in the event that a contract hospital does not accept transfer of the patient or pending the transfer to a contract hospital.

(Amended by Stats. 1992, Ch. 722, Sec. 72. Effective September 15, 1992.)

14087.1. The department or its authorized agents shall conduct periodic audits or reviews, including onsite audits or reviews, of performance under any contract made pursuant to this article. These audits or reviews may evaluate the following:

(a) Level and quality of care, and the necessity and appropriateness of the services provided.

(b) Internal procedures for assuring efficiency, economy and quality of care.

(c) Grievances relating to medical care and their disposition.

(d) Financial records only when determined necessary by the department to protect public funds.

(Amended by Stats. 1982, Ch. 1594, Sec. 41. Effective September 30, 1982.)

14087.10. Any contract hospital that provides the services required by a Medi-Cal beneficiary and has a physician with staff privileges who is willing to accept the Medi-Cal beneficiary and has the appropriate bed, personnel, and equipment necessary to treat the Medi-Cal beneficiary shall accept the transfer of the Medi-Cal beneficiary from a noncontract hospital.

(Added by Stats. 1992, Ch. 722, Sec. 76. Effective September 15, 1992.)

14087.101. For administrative costs incurred after January 1, 2004, the director may recover any administrative costs incurred by a health plan authorized by this article deemed excessive pursuant to Section 1300.78 of Title 28 of the California Code of Regulations. Health plans that compensate their subcontractors on a capitated basis shall comply with Section 1300.78 of Title 28 of the California Code of Regulations, regarding administrative costs, considering the combined administrative cost for the Medi-Cal business of the health plan and its capitated subcontractors, that are Knox-Keene licensed health care service plans. The recovery of excess administrative cost shall be made in accordance with Sections 14087.103 and 14087.105.

(Added by Stats. 2003, Ch. 230, Sec. 60. Effective August 11, 2003.)

14087.103. The department shall notify the health plan of the director's decision to seek recovery of excess administrative costs pursuant to Section 14087.101 at least 30 days prior to initiating the recovery process. The department may recover excess administrative costs immediately after the 30-day notification period, if the health plan does not file an appeal. A health plan may dispute or appeal the director's decision in accordance with the disputes section of the health plan's contract with the department for services under this article. If a health plan elects to dispute or appeal the director's decision, the director may recover any administrative costs deemed excessive, but only after the health plan has had the opportunity to exhaust all appeal procedures provided for in the disputes section of the health plan's contract with the department.

(Added by Stats. 2003, Ch. 230, Sec. 61. Effective August 11, 2003.)

14087.105. When it has been determined that the director may recover any administrative costs deemed excessive pursuant to Section 14087.103, the director may recover any excess administrative costs through an offset against any amount currently due to the health plan under this chapter. The director may also recover any administrative costs deemed excessive by means of a repayment agreement executed between that health plan and the director, and by any other means available at law.

(Added by Stats. 2003, Ch. 230, Sec. 62. Effective August 11, 2003.)

14087.11. (a) The provisions of this section shall be applicable to any county that seeks to provide or arrange for the provision of health care services provided under Article 2.8 and to Santa Barbara County if it seeks to provide or arrange the provision of health care services pursuant to Section 14499.5.

(b) For an enrollee diagnosed with cancer and accepted into a phase I, phase II, phase III, or phase IV clinical trial for cancer, every County Organized Health System contract that is issued, amended, delivered, or renewed in this state, shall provide coverage for all routine patient care costs related to the clinical trial if the enrollee's treating physician, who is providing covered health care services to the enrollee under the enrollee's County Organized Health System contract, recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the enrollee. For purposes of this section, physicians that are providing care under a subcontract with an entity under contract with a County Organized Health System shall be considered to be physicians providing covered health care services to the enrollee under the County Organized Health System contract. For purposes of this section, a clinical trial's endpoints shall not be defined exclusively to test toxicity, but shall have a therapeutic intent.

(c) (1) "Routine patient care costs" means the costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered by the County Organized Health System if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program, including:

(A) Health care services typically provided absent a clinical trial.

(B) Health care services required solely for the provision of the investigational drug, item, device, or service.

(C) Health care services required for the clinically appropriate monitoring of the investigational item or service.

(D) Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service.

(E) Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

(2) For purposes of this section, “routine patient care costs” does not include the costs associated with the provision of any of the following:

(A) Drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated with the clinical trial.

(B) Services other than health care services, such as travel, housing, companion expenses, and other nonclinical expenses, that an enrollee may require as a result of the treatment being provided for purposes of the clinical trial.

(C) Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.

(D) Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the enrollee’s County Organized Health System.

(E) Health care services customarily provided by the research sponsors free of charge for any enrollee in the trial.

(d) The treatment shall be provided in a clinical trial that either:

(1) Involves a drug that is exempt under federal regulations from a new drug application.

(2) Is approved by one of the following:

(A) One of the National Institutes of Health.

(B) The federal Food and Drug Administration, in the form of an investigational new drug application.

(C) The United States Department of Defense.

(D) The United States Veterans’ Administration.

(e) In the case of health care services provided by a participating provider, the payment rate shall be at the agreed-upon rate. In the case of a nonparticipating provider, the payment shall be at the negotiated rate the plan would otherwise pay to a participating provider for the same services, less any applicable copayments and deductibles.

(f) Nothing in this section shall be construed to prohibit a County Organized Health System from restricting coverage for clinical trials to participating hospitals and physicians in California unless the protocol for the clinical trial is not provided for at a California hospital or by a California physician.

(g) The provision of services when required by this section shall not, in itself, give rise to liability on the part of the County Organized Health System.

(h) Nothing in this section shall be construed to otherwise limit or modify any existing requirements under the provisions of this chapter.

(Added by Stats. 2001, Ch. 172, Sec. 3. Effective January 1, 2002.)

14087.2. It is the intent of the Legislature that children’s hospitals need not contract under the provisions of this article until October 31, 1984. Services provided by these hospitals prior to November 1, 1984, shall be reimbursed according to the state plan in effect on January 1, 1984. Children’s hospitals are defined as those hospitals where 30 percent of the infants and children served by the single institution qualify for Medi-Cal payment systems and the institution serves primarily children.

If a children’s hospital elects to contract pursuant to this article in the 1982–83 or 1983–84 fiscal year, the negotiator shall give consideration to the special services provided in this hospital, including those services provided to children. The California Medical Assistance Commission shall continue to extend this consideration to these hospitals following the 1983–84 fiscal year.

(Amended by Stats. 2004, Ch. 193, Sec. 240. Effective January 1, 2005.)

14087.21. Commencing November 1, 1984, reimbursement to children’s hospitals shall be on a basis that reflects the relative severity of pediatric diagnostic case types. For the purposes of this section, “children’s hospital” means those hospitals where 30

percent of the infants and children served by the single institution qualify for Medi-Cal payment systems, and the institution serves primarily children.

(Amended by Stats. 1989, Ch. 325, Sec. 1. Effective September 8, 1989.)

14087.23. (a) Notwithstanding any other provision of law, and except as provided in subdivision (b), a county-operated community clinic, exempt from licensure under Section 1206 of the Health and Safety Code, which is operated by a county which, on or before November 30, 1997, ceased to operate a county-operated hospital with an outpatient department, shall be reimbursed for Medi-Cal services using the same methodology used for reimbursement of a licensed surgical center, to the extent federal financial participation is available.

(b) Providers that are independently billing for physician services provided in clinics described in subdivision (a) shall be subject to the reduction in reimbursement consistent with physician services provided in an outpatient hospital department.

(Added by Stats. 2001, Ch. 526, Sec. 1. Effective January 1, 2002.)

14087.25. 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 6 (commencing with Section 14780), Part 5.5, Division 3 of the Government Code.

(Added by Stats. 1982, Ch. 328, Sec. 17. Effective June 30, 1982.)

14087.26. In negotiating contracts pursuant to this article, the negotiator may designate a specific group of hospitals as the negotiating unit. The Legislature finds and declares that, in any case where the negotiator designates a group of hospitals for purposes of negotiation there is a compelling state interest in negotiating on this basis, thereby exempting such negotiations from federal antitrust provisions.

(Added by Stats. 1982, Ch. 328, Sec. 17. Effective June 30, 1982.)

14087.27. (a) Notwithstanding any other provision of law, judicial review pursuant to Section 1085 of the Code of Civil Procedure, shall be available to resolve disputes relating to the terms, performance, or termination of contracts entered into pursuant to this article, or any act, failure to act, conduct, order, or decision of the special hospital negotiator or the commission which violate the provisions of this article.

(b) Subdivision (a) shall not apply to recoupment efforts based on an audit or review of hospital performance of the terms and conditions of the negotiated contract. These recoupment efforts shall be reviewable pursuant to Section 14171.

(c) As an alternative for a contract hospital, to the remedy provided in subdivision (a), contracts entered into pursuant to this article shall provide for administrative review of disputes relating to performance under the contracts. The proceedings for review of the disputes shall be conducted by an independent hearing examiner who shall render a proposed decision. The final decision shall be rendered by the director.

(d) Venue for judicial review pursuant to this section shall lie only in counties in which the Attorney General maintains an office.

(Amended by Stats. 1982, Ch. 1594, Sec. 43. Effective September 30, 1982.)

14087.28. (a) A hospital contracting with the Medi-Cal program pursuant to this chapter shall not deny medical staff membership or clinical privileges for reasons other than a physician's individual qualifications as determined by professional and ethical criteria, uniformly applied to all medical staff applicants and members. Determination of medical staff membership or clinical privileges shall not be made upon the basis of any of the following:

(1) The existence of a contract with the hospital or with others.

(2) Membership in, or affiliation with, any society, medical group, or teaching facility, or upon the basis of any criteria lacking professional justification, such as any basis listed in subdivision (a) of Section 12940 of the Government Code, as those bases are defined in Sections 12926 and 12926.1 of the Government Code, except as otherwise provided in Section 12940 of the Government Code.

(b) The special negotiator may authorize a contracting hospital to impose reasonable limitations on the granting of medical staff membership or clinical privileges to permit an exclusive contract for the provision of pathology, radiology, and anesthesiology services, except for consulting services requested by the admitting physician.

(Amended by Stats. 2004, Ch. 788, Sec. 35. Effective January 1, 2005.)

14087.29. Hospitals or groups of hospitals with which a contract has been entered into pursuant to this article shall be exempt from the provisions of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code for purposes of carrying

out the contracts.

(Added by Stats. 1982, Ch. 1594, Sec. 44. Effective September 30, 1982.)