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 2.7. Contracts for Medi-Cal Services and Case Management [14087.3 - 14087.48] *(Heading of Article 2.7 amended by Stats. 1992, Ch. 722, Sec. 73.)*

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

(1) Perform targeted case management of selected services or beneficiary populations where it is expected that case management will reduce program expenditures.

(2) Provide for delivery of services in a manner consistent with managed care principles, techniques, and practices directed at ensuring the most cost-effective and appropriate scope, duration, and level of care.

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

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

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

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

(C) Linking beneficiaries with cost-effective providers.

(5) Provide for:

(A) Medi-Cal managed care plans contracting under this chapter or Chapter 8 (commencing with Section 14200) to share in the efficiencies and economies realized by those contracts.

(B) Effective coordination between contractors operating under this article and Medi-Cal managed care plans in the management of health care provided to Medi-Cal beneficiaries.

(6) Permit individual physicians, groups of physicians, or other providers to participate in a manner that supports the organized system mode of operation.

(7) Encourage group practices with relationships with hospitals having low unit costs.

(b) The director may require individual physicians, groups of physicians, or other providers as a condition of participation under the Medi-Cal program, to enter into capitated contracts pursuant to this section in order to correct or prevent irregular or abusive billing practices. No physician, groups of physicians, or other providers shall be reimbursed for services rendered to Medi-Cal beneficiaries if the physician, group of physicians, or other providers has declined to enter into a contract required by the director pursuant to this section.

(c) The department shall seek federal waivers necessary to allow for federal financial participation under this section.

(d) (1) Notwithstanding the provisions of this chapter, the department shall determine preliminary per capita rates of payment for services provided to Medi-Cal beneficiaries enrolled in a managed care program contracting in areas specified by the director for expansion of the Medi-Cal managed care program under this section, or Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, or 14087.96. The department shall provide to each managed care plan the preliminary contract rates and source documents at least 60 days prior to the effective date of each new rate period.

(2) On or before June 1, 1999, the department shall enter into a memorandum of understanding with the managed care plans subject to paragraph (1) regarding the development of capitation rates. This memorandum of understanding, which is intended to ensure that capitation rates become effective in a timely manner and remain stable throughout the rate year, shall establish all of the following:

(A) A process and timetable for the managed care plans to review and comment on any modifications in the rate development methodology.

(B) A process and timetable for managed care plans to provide comments on the draft rates.

(C) A process and timetable for the department to respond to managed care plan comments on the draft rates.

(D) A process and timetable to managed care finalize capitation rates.

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

14087.301. When entering into contracts with health care service plans that provide comprehensive dental benefits to Medi-Cal beneficiaries on an at-risk basis, the department may require that the health care service plans pay for the costs of the administrative and regulatory oversight required to monitor the contract compliance terms of the agreement with the department.

(Added by Stats. 1999, Ch. 146, Sec. 43. Effective July 22, 1999.)

14087.305. (a) In areas specified by the director for expansion of the Medi-Cal managed care program under Section 14087.3 and where the department is contracting with a prepaid health plan that is contracting with, governed, owned or operated by a county board of supervisors, a county special commission or county health authority authorized by Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.96, a Medi-Cal or California Work Opportunity and Responsibility for Kids (CalWORKs) applicant or beneficiary shall be informed of the health care options available regarding methods of receiving Medi-Cal benefits. The county shall ensure that each beneficiary is informed of these options and informed that a health care options presentation is available.

(b) The managed care options information described in subdivision (a) shall include the following elements:

(1) Each beneficiary or eligible applicant shall be provided, at a minimum, with the name, address, telephone number, and specialty, if any, of each primary care provider, by specialty, or clinic, participating in each managed care health plan option through a personalized provider directory for that beneficiary or applicant. This information shall be presented under the geographic area designations, by the name of the primary care provider and clinic and shall be updated based on information electronically provided monthly by the health care plans to the department, setting forth any changes in the health care plan's provider network. The geographic areas shall be based on the applicant's residence address, the minor applicant's school address, the applicant's work address, or any other factor deemed appropriate by the department, in consultation with health plan representatives, legislative staff, and consumer stakeholders. In addition, directories of the entire service area of the local initiative and commercial plan provider networks, including, but not limited to, the name, address, and telephone number of each primary care provider and hospital, shall be made available to beneficiaries or applicants who request them from the health care options contractor. Each personalized provider directory shall include information regarding the availability of a directory of the entire service area, provide telephone numbers for the beneficiary to request a directory of the entire service area, and include a postage-paid mail card to send for a directory of the entire service area. The personalized provider directory shall be implemented as a pilot project in Los Angeles County pursuant to this article, and in Sacramento County (Geographic Managed Care Model) pursuant to Article 2.91 (commencing with Section 14089). The content, form, and the geographic areas used in the personalized provider directories shall be determined by the department, in consultation with a workgroup to include health plan representatives, legislative staff, and consumer stakeholders, with an emphasis on the inclusion of stakeholders from Los Angeles and Sacramento Counties. The personalized provider directories may include a section for each health plan. Prior to implementation of the pilot project, the department, in consultation with consumer stakeholders, legislative staff, and health plans, shall determine the parameters, methodology, and evaluation process of the pilot project. The pilot project shall thereafter be in effect for a minimum of two years. Following two years of operation as a pilot project in two counties, the department, in consultation with consumer stakeholders, legislative staff, and health plans, shall determine whether to implement personalized provider directories as a permanent program statewide. If necessary, the pilot project shall continue beyond the initial two-year period until this determination is made. This pilot project shall only be implemented to the extent that it is budget neutral to the department.

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

(3) Each beneficiary or eligible applicant shall be informed that if he or she fails to make a choice, he or she shall be assigned to, and enrolled in, a prepaid health plan.

(c) No later than 30 days following the date a Medi-Cal or CalWORKs beneficiary or applicant is determined eligible for Medi-Cal, the beneficiary shall indicate his or her choice, in writing, from among the available prepaid health plans in the region and his or her choice of primary care provider or clinic contracting with the selected prepaid health plan. Notwithstanding the 30-day deadline set forth in this subdivision, if a beneficiary requests a directory for the entire service area within 30 days of receiving an enrollment form, the deadline for choosing a plan shall be extended an additional 30 days from the date of the request.

(d) At the time the beneficiary or eligible applicant selects a prepaid health plan, the department shall, when applicable, encourage the beneficiary or eligible applicant to also indicate, in writing, his or her choice of primary care provider or clinic contracting with the selected prepaid health plan.

(e) In areas specified by the director for expansion of the Medi-Cal managed care program under Section 14087.3, and where the department is contracting with a prepaid health plan that is contracting with, governed, owned or operated by a county board of supervisors, a county special commission or county health authority authorized by Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.96, a Medi-Cal or CalWORKs beneficiary who does not make a choice of managed care plans, shall be assigned to and enrolled in an appropriate Medi-Cal prepaid health plan providing service within the area in which the beneficiary resides.

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

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

(h) The department or its contractor shall notify a prepaid health plan when it has been selected by or assigned to a beneficiary. The prepaid health plan that has been selected by or assigned to a beneficiary shall notify the primary care provider that has been selected or assigned. The prepaid health plan shall also notify the beneficiary of the prepaid health plan and primary care provider or clinic selected or assigned.

(i) (1) The managed health care plan shall have a valid Medi-Cal contract, adequate capacity, and appropriate staffing to provide health care services to the beneficiary.

(2) The department shall establish standards for all of the following:

(A) The maximum distances a beneficiary is required to travel to obtain primary care services from the managed care plan, in which the beneficiary is enrolled.

(B) The conditions under which a primary care service site shall be accessible by public transportation.

(C) The conditions under which a managed care plan shall provide nonmedical transportation to a primary care service site.

(3) In developing the standards required by paragraph (2) the department shall take into account, on a geographic basis, the means of transportation used and distances typically traveled by Medi-Cal beneficiaries to obtain fee-for-service primary care services and the experience of managed care plans in delivering services to Medi-Cal enrollees. The department shall also consider the provider's ability to render culturally and linguistically appropriate services.

(j) To the extent possible, the arrangements for carrying out subdivision (e) shall provide for the equitable distribution of Medi-Cal beneficiaries among participating prepaid health plans, or managed care plans.

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

(Amended by Stats. 2012, Ch. 728, Sec. 200. (SB 71) Effective January 1, 2013.)

14087.31. (a) It is necessary that a special commission be established in the Counties of Tulare and San Joaquin in order to meet the problems of delivery of publicly assisted medical care in the county and to demonstrate ways of promoting quality care and cost efficiency. Because there is no general law under which such a commission could be formed, the adoption of a special act and the formation of a special commission is required.

(b) (1) The Board of Supervisors of the County of Tulare and the County of San Joaquin may, for each respective county, by ordinance, establish a commission to negotiate and enter into contracts authorized by Section 14087.3, and to arrange for the provision of health care services provided pursuant to this chapter. If the board of supervisors elects to enact this ordinance, all rights, powers, duties, privileges, and immunities vested in a county contracting with the department under this article shall be vested in the county commission.

(2) Health plans operated by the commission may also include, but are not limited to, individuals covered under Title XVIII of the Social Security Act (Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code), individuals and groups entitled to coverage under other publicly supported programs, individuals and groups employed by public agencies or private businesses, and uninsured or indigent persons.

(c) The enabling ordinance shall specify the membership of the county commission, the qualifications for individual members, the manner of appointment, selection, or removal of commissioners, and how long they shall serve, and any other matters as the board of supervisors deems necessary or convenient for the conduct of the county commission's activities. Members of the commission shall be appointed by the county board of supervisors to represent the interests of the public, county, beneficiaries, physicians, hospitals, other health care providers, or other health care organizations. The commission so established shall be considered an entity separate from the county and shall file a statement required by Section 53051 of the Government Code. The commission shall have the power to acquire, possess, and dispose of real or personal property, as may be necessary for the performance of its functions, to employ personnel and contract for services required to meet its obligations, to sue or be sued, and to enter into agreements under Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code. Any obligations of a commission, statutory, contractual or otherwise, shall be obligations solely of the commission and shall not be the obligations of the county or of the state.

(d) Upon creation, the commission may borrow from the county, and the county may lend the commission, funds or issue revenue anticipation notes to obtain those funds necessary to commence operations. Prior to commencement of operations, the commission shall be licensed 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).

(e) In the event a commission may no longer function for the purposes for which it is established, at the time as the commission's then existing obligations have been satisfied or the commission's assets have been exhausted, the board of supervisors may, by ordinance, terminate the commission.

(f) Prior to the termination of the commission, the board of supervisors shall notify the department of its intent to terminate the commission. The department shall conduct an audit of the commission's records within 30 days of the notification to determine the liabilities and assets of the commission. The department shall report its findings to the board within 10 days of completion of the audit. The board 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 present the plan to the department within 30 days upon receipt of these findings.

(g) Any assets of the commission shall be disposed of pursuant to provisions contained in the contract entered into between the state and the commission pursuant to Section 14087.

(h) (1) It is the intent of the Legislature that if a commission is formed pursuant to this section, the county shall, with respect to its medical facilities and programs, occupy no greater or lesser status than any other health care provider with similar cost structure and patient population including, but not limited to, considerations of indigent care burden, capital requirements, graduate medical education, and disproportionate share status, in negotiating with the commission for contracts to provide health care services.

(2) Contracts 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.

(3) Nothing in this subdivision shall be construed to interfere with or limit the commission from giving preference in negotiating to disproportionate share hospitals or other providers of health care to medically indigent or uninsured persons.

(i) Upon termination of the commission by the board, the county shall manage any remaining assets of the commission until superseded by a department approved plan. Any liabilities of the commission shall not become obligations of the county upon either the termination of the commission or the liquidation or disposition of the commission's remaining assets.

(j) (1) The commission shall be considered a public entity for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code.

(2) The commission, its members, and employees, are protected by the immunities applicable to public entities and public employees governed by Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, except as provided by other statutes or regulations that apply expressly to the commission.

(k) Notwithstanding any other provision of law, a member of the commission shall not be deemed to be interested in 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 apply:

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

(2) The contract authorizes the member or the organization the member represents to provide services to Medi-Cal beneficiaries under the commission's programs.

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

(4) The member does not influence or attempt to influence the commission or another member of the commission to enter into the contract in which the member is interested.

(5) The member discloses the interest to the commission and abstains from voting on the contract.

(6) The commission notes the member's disclosure and abstention in its official records and authorized the contract in good faith by a vote of its membership sufficient for the purpose without counting the vote of the interested member.

(l) All claims for money or 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 provided by other statutes or regulations that expressly apply to the commission.

(m) Notwithstanding any other provision of law, except as otherwise provided in this section, a county shall not be liable for any act or omission of the commission.

(n) For the purposes of this section, "commission" means an entity separate from the county that meets the requirements of state and federal law and the quality, cost, and access criteria established by the department.

(o) The transfer of responsibility for health care services shall not relieve the county of its responsibility for indigent care pursuant to Section 17000.

(p) Notwithstanding any other provision of law, the commission may meet in closed session to consider and take action on matters pertaining to contracts and contract negotiations by commission staff with providers of health care services concerning all matters related to rates of payment.

(q) Notwithstanding Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code and Article 2 (commencing with Section 54340) of Chapter 6 of Division 2 of Title 5 of the Government Code, or any other provision of law, any "peer review body," as defined in paragraph (1) of subdivision (a) of Section 805 of the Business and Professions Code, formed pursuant to the powers granted to the commission authorized by this section, may, at its discretion and without notice to the public, meet in closed session, so long as the purpose of the meeting is the peer review body's discharge of its responsibility to evaluate and improve the quality of care rendered by health facilities of health practitioners, pursuant to the powers granted the commission. The peer review body and its members shall receive to the fullest extent all immunities, privileges, and protections available to these peer review bodies, their individual members, and persons or entities assisting in the peer review process, including, but not limited to, those afforded by Section 1370 of the Health and Safety Code.

(r) 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 commission shall be considered for all purposes to satisfy the requirements of subdivision (p) of Section 14163.

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

(t) Notwithstanding any other provision of law, those records of the commission and of the county that reveal the rates of payment for health care services or the commission's deliberative processes, discussions, communications, or any other portion of the negotiations with providers of health care services for rates of payment, shall not be disclosed pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), or any similar local law requiring disclosure of public records. However, three years after a contract or amendment to a contract is fully executed, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(u) Notwithstanding the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), Article 3 (commencing with Section 11200) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code, Chapter 9 (commencing with Section 54960) of Part 1 of Division 2 of Title 5 of the Government Code, or any other provision of state or local law requiring disclosure of public records, those records of the commission and the county that reveal the proceedings of a peer review body, as defined in paragraph (1) of subdivision (a) of Section 805 of the Business and Professions Code, formed pursuant to the powers granted to the commission authorized by this section, shall not be required to be disclosed. The records and proceedings of the peer review body and its members shall receive to the fullest extent, all immunities, privileges,

and protections available to these records and proceedings, including, but not limited to, those afforded by Section 1157 of the Evidence Code.

(v) (1) Provisions of the Evidence Code, the Government Code, including the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), the Civil Code, the Business and Professions Code, and other applicable law pertaining to the confidentiality of peer review activities of peer review bodies shall apply to the peer review activities of the commission. Peer review proceedings shall constitute an official proceeding authorized by law within the meaning of Section 47 of the Civil Code, and those privileges set forth in that section with respect to official proceedings shall apply to peer review proceedings of the commission. If the commission is required by law or contractual obligation to submit to the state or federal government peer review information or information relevant to the credentialing of a participating provider, that submission shall not constitute a waiver of confidentiality. All laws pertaining to the confidentiality of peer review activities shall be construed together as extending, to the extent permitted by law, the maximum degree of protection of confidentiality.

(2) Notwithstanding any other provision of law, Section 1461 of the Health and Safety Code shall apply to hearings on the reports of hospital medical audit or quality assurance committees as they relate to network providers or applicants.

(w) Except as expressly provided by other provisions of this section, all exemptions and exclusions from disclosure as public records pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), including, but not limited to, those pertaining to trade secrets and information withheld in the public interest, shall be fully applicable for all state agencies and local agencies with respect to all writings that the commission is required to prepare, produce, or submit pursuant to this section.

(x) (1) The commission may use a computerized management information system in connection with the administration of its health delivery system, including the administration of the state-mandated two-plan Medi-Cal managed care model.

(2) Information maintained in the management information system that pertains to persons who are Medi-Cal applicants or recipients shall be confidential pursuant to Section 14100.2, and shall not be open to examination other than for purposes directly connected with the administration of the Medi-Cal program, including, but not limited to, those set forth in subdivision (c) of Section 14100.2. This safeguarded information includes, but is not limited to, the names and addresses of recipients, the medical services provided, the social and economic conditions or circumstances of the recipients, an evaluation by the commission of personal information, and medical data, including the diagnosis and past history of disease or disability.

(3) Information maintained in the management information system that pertains to peer review-related activities shall be confidential and subject to the full protections of the law with respect to the confidentiality of activities related to peer review generally.

(y) (1) The records of the commission, whether paper records, records maintained in the management information system, or records in any other form, that relate to rates of payment, including records relating to rates of payment determination, allocation or distribution methodologies, formulas or calculations, and records of the health authority that relate to contract negotiations with providers of health care for alternative rates, shall not be subject to disclosure pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(2) The transmission of the records of the commission, or the information contained therein in an alternative form, to the board of supervisors shall not constitute a waiver of exemption from disclosure, and the records and information, once transmitted to the county board of supervisors, shall be subject to this same exemption. The information, if compelled pursuant to an order of a court of competent jurisdiction or administrative body in a manner permitted by law, shall be limited to in camera review, and shall not be shared with the parties to the proceeding.

(3) The submission, to the Department of Managed Health Care, of information described in this section for the purpose of obtaining licensure under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, or to the State Department of Health Services, shall not constitute a waiver of exemption from disclosure.

(z) (1) (A) Notwithstanding the Ralph M. Brown Act (Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code), the commission may meet in closed session for the purpose of discussion of, or taking action on matters involving, commission trade secrets.

(B) The requirement that the commission make a public report of actions taken in closed session and the vote or abstention of every member present may be limited to a brief general description of the action taken and the vote so as to prevent the disclosure of a trade secret.

(C) For purposes of this subdivision, “commission trade secret” means a trade secret, as defined in subdivision (d) of Section 3426.1 of the Civil Code, that also meets both of the following criteria:

(i) The secrecy of the information is necessary for the commission to initiate a new service, program, marketing strategy, business plan, or technology, or to add a benefit or product.

(ii) Premature disclosure of the trade secret would create a substantial probability of depriving the commission of a substantial economic benefit or opportunity.

(2) Those records of the commission that reveal the commission's trade secrets are exempt from disclosure pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records. This exemption shall apply for a period of two years after the service, program, marketing strategy, business plan, technology, benefit, or product that is the subject of the trade secret is formally adopted by the governing body of the commission, provided that the service, program, marketing strategy, business plan, technology, benefit, or product continues to be a trade secret. The commission may delete the portion or portions containing trade secrets from any documents that were finally approved in the closed session held pursuant to paragraph (1) that are provided to persons who have made the timely or standing request.

(3) Nothing in this section shall be construed as preventing the commission from meeting in closed session as otherwise provided by law.

(Amended by Stats. 2004, Ch. 228, Sec. 12.1. Effective August 16, 2004.)

14087.316. (a) In lieu of establishing the special commission authorized by Section 14087.31, the county may, itself, negotiate with the department the contract specified in Section 14087.3 and arrange for the provision of health care services provided pursuant to this chapter. If the county elects to exercise this option, subdivisions (p), (q), (t), (u), (v), (w), (x), and (z), of Section 14087.31 shall apply with equal force and effect to the County of Tulare, its board of supervisors and its members, and any advisory commission and its members appointed by the board of supervisors to assist with the provision of health care services provided pursuant to this section.

(b) The Tulare County Board of Supervisors shall establish and maintain an advisory commission. The advisory commission shall have a membership that includes beneficiaries, representatives of the community clinics, representatives of hospitals, and physicians. Physician membership shall be nominated by the Tulare County Medical Society.

(Added by Stats. 1996, Ch. 1017, Sec. 2. Effective January 1, 1997.)

14087.32. Commencing on the date the authority first receives Medi-Cal capitated payments for the provision of health care services to Medi-Cal beneficiaries and until a commission established pursuant to Section 14087.31 is in compliance with all the requirements regarding tangible net equity applicable to a health care service plan licensed under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, all of the following shall apply:

(a) The commission may select and design its automated management information system. The department, in cooperation with the commission, prior to making capitated payments, 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 health care service plans.

(b) In addition to the reports required by the Department of Managed Health Care under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, and the rules of the Director of the Department of Managed Health Care promulgated thereunder, a commission established pursuant to Section 14087.31 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 or 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, which has contracted with the authority to provide health care services.

(c) In addition to the reporting and notification obligations the commission has under Chapter 2.2 (commencing with Section 1340) of Division 2 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 to health care providers or to other parties. The written notice shall describe the fact or facts, the anticipated fiscal consequences, and the actions which will be taken to address the anticipated consequences.

(d) The Department of Managed Health Care shall not, in any way, 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 2 of the Health and Safety Code, after three years from the date of 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 2 of the Health and Safety Code, and the rules of the Director of the Department of Managed Health Care adopted thereunder, the commission shall develop a stop-loss program appropriate to the risks of the commission, which program shall be satisfactory to both the department and the Department of Managed Health Care.

(e) (1) If the commission votes to file a petition of bankruptcy, or the county board of supervisors notifies the department of its intent to terminate the commission, the department shall immediately transfer the authority's Medi-Cal beneficiaries as follows:

(A) To other managed care contractors, when available, provided those 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.

(B) To the extent that other managed care contractors are unavailable or the department determines that it is otherwise in the best interest of any particular beneficiary, to a fee-for-service reimbursement system pending the availability of managed care contractors provided those 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, or 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.

(2) Beneficiary eligibility for Medi-Cal shall not be affected by actions taken pursuant to paragraph (1).

(3) 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 the federal freedom-of-choice requirements.

(f) (1) A commission established pursuant to Section 14087.31 shall submit to a review of financial records when the department determines, based on data reported by the commission or otherwise, that the commission will not be able to meet its financial obligations to health care providers contracting with the commission. Where the review of financial records determines that the commission will not be able to meet its financial obligations 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 state, and immediately transfer the commission's Medi-Cal beneficiaries in accordance with subdivision (e) in order to ensure uninterrupted provision of health care services to the beneficiaries and to minimize financial disruption to providers.

(2) The action of the Director of Health Services pursuant to paragraph (1) shall be the final administrative determination. Beneficiary eligibility for Medi-Cal shall not be affected by this action.

(3) Beneficiaries who have been or who are scheduled to be transferred under subdivision (e) 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.

(g) 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 and permit the department to administer the number of covered Medi-Cal enrollments in such a manner that the commission's provider network and administrative structure are able to provide appropriate and timely services to beneficiaries and to participating providers.

(h) In the event a commission is terminated, files for bankruptcy, or otherwise no longer functions for the purpose 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.

(i) 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 2 of the Health and Safety Code, nor shall anything in the section be construed to reduce or otherwise limit the obligation of a commission licensed as a health care service plan to comply with the requirements of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code and the rules of the Director of the Department of Managed Health Care adopted thereunder.

(j) Except as expressly provided by other provisions of this section, all exemptions and exclusions from disclosure as public records pursuant to the Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), including, but not limited to, those pertaining to trade secrets and information withheld in the public interest, shall be fully applicable for all state agencies and local agencies with respect to all writings that the commission is required to prepare, produce, or submit pursuant to this section.

(Amended by Stats. 2001, Ch. 159, Sec. 197. Effective January 1, 2002.)

14087.325. (a) The department shall require, as a condition of obtaining a contract with the department, that a local initiative, as defined in subdivision (w) of Section 53810 of Title 22 of the California Code of Regulations, offer a subcontract to an entity defined in Section 1396d(l)(2)(B) of Title 42 of the United States Code providing services as defined in Section 1396d(a)(2)(C) of Title 42 of the United States Code and operating in the service area covered by the local initiative's contract with the department. These entities are also known as federally qualified health centers.

(b) Except as otherwise provided in this section, managed care subcontracts offered to a federally qualified health center or a rural health clinic, as defined in Section 1396d(l)(1) of Title 42 of the United States Code, by a local initiative, county organized health

system, as defined in Section 12693.05 of the Insurance Code, commercial plan, as defined in subdivision (i) of Section 53810 of Title 22 of the California Code of Regulations, or a health plan contracting with a geographic managed care program, as defined in subdivision (g) of Section 53902 of Title 22 of the California Code of Regulations, shall be on the same terms and conditions offered to other subcontractors providing a similar scope of service. A beneficiary, subscriber, or enrollee of a program or plan who affirmatively selects, or is assigned by default to, a federally qualified health center or rural health clinic under the terms of a contract between a plan, government program, or a subcontractor of a plan or program, and a federally qualified health center or rural health clinic, shall be assigned directly to the federally qualified health center or rural health clinic, and not to an individual provider performing services on behalf of the federally qualified health center or rural health clinic.

(c) The department shall provide incentives in the competitive application process described in paragraph (1) of subdivision (b) of Section 53800 of Title 22 of the California Code of Regulations, to encourage potential commercial plans as defined in subdivision (i) of Section 53810 of Title 22 of the California Code of Regulations to offer subcontracts to these federally qualified health centers.

(d) Reimbursement to federally qualified health centers and rural health centers for services provided pursuant to a subcontract with a local initiative, a commercial plan, geographic managed care program health plan, or a county organized health system, shall be paid in a manner that is not less than the level and amount of payment that the plan would make for the same scope of services if the services were furnished by a provider that is not a federally qualified health center or rural health clinic.

(e) (1) The department shall administer a program to ensure that total payments to federally qualified health centers and rural health clinics operating as managed care subcontractors pursuant to subdivision (d) comply with applicable federal law pursuant to Sections 1902(aa) and 1903(m)(2)(A)(ix) of the Social Security Act (42 U.S.C. Secs. 1396a(aa) and 1396b(m)(2)(A)(ix)). Under the department's program, federally qualified health centers and rural health clinics subcontracting with local initiatives, commercial plans, county organized health systems, and geographic managed care program health plans shall seek supplemental reimbursement from the department through a per visit fee-for-service billing system utilizing the state's Medi-Cal fee-for-service claims processing system contractor. To carry out this per visit payment process, each federally qualified health system and rural health clinic shall submit to the department for approval a rate differential calculated to reflect the amount necessary to reimburse the federally qualified health center or rural health clinic for the difference between the payment the center or clinic received from the managed care health plan and either the interim rate established by the department based on the center's or clinic's reasonable cost or the center's or clinic's prospective payment rate. The department shall adjust the computed rate differential as it deems necessary to minimize the difference between the center's or clinic's revenue from the plan and the center's or clinic's cost-based reimbursement or the center's or clinic's prospective payment rate.

(2) In addition, to the extent feasible, within six months of the end of the center's or clinic's fiscal year, the department shall perform an annual reconciliation to reasonable cost, and make payments to, or obtain a recovery from, the center or clinic.

(f) In calculating the capitation rates to be paid to local initiatives, commercial plans, geographic managed care program health plans, and county organized health systems, the department shall not include the additional dollar amount applicable to cost-based reimbursement that would otherwise be paid, absent cost-based reimbursement, to federally qualified health centers and rural health clinics in the Medi-Cal fee-for-service program.

(g) On or before September 30, 2002, the director shall conduct a study of the actual and projected impact of the transition from a cost-based reimbursement system to a prospective payment system for federally qualified health centers and rural health clinics. In conducting the study, the director shall evaluate the extent to which the prospective payment system stimulates expansion of services, including new facilities to expand capacity of the centers, and the extent to which actual and estimated prospective payment rates of federally qualified health centers and rural health clinics for the first five years of the prospective payment system are reflective of the cost of providing services to Medi-Cal beneficiaries. Clinics may submit cost reporting information to the department to provide data for the study.

(h) The department shall approve all contracts between federally qualified health centers or rural health clinics and a local initiative, commercial plan, geographic managed care program health plan, or county organized health system in order to ensure compliance with this section.

(i) This section shall not preclude the department from establishing pilot programs pursuant to Section 14087.329.

(Amended by Stats. 2017, Ch. 561, Sec. 281. (AB 1516) Effective January 1, 2018.)

14087.329. (a) The department may establish, for local initiative and for commercial plans, that are providing services to Medi-Cal beneficiaries under a two-plan model contract with the department, not more than two pilot programs for the establishment of reimbursement methodologies. The reimbursement methodologies shall not be limited to those provided in Section 14087.325. The pilot programs may be implemented by amendment to the contract between the department and the local initiative or commercial plan. The department may select the pilot program county or counties on a nonbid basis. The selected counties shall include one county with a sizable number of entities defined in Section 1396d(l)(2)(B) of Title 42 of the United States Code. The department shall review each pilot program annually. Following the review, and notwithstanding any determination made pursuant to subdivision (d), the department shall terminate a pilot program established under this section and shall delete amendments made to the contract implementing the pilot program if the department determines that the pilot program creates any additional cost to the General Fund.

The department may also terminate a pilot program based upon criteria specified in the department's contract establishing the pilot program. The department shall provide the local initiative and commercial plan with notice of the department's decision to terminate the pilot program for this reason at least 90 days prior to the termination date of the pilot program and deletion of the contract amendments.

(b) Each local initiative and commercial plan participating in a pilot program under this section shall make available to the department any and all financial, membership, utilization, and other information reasonably required by the department to conduct the annual review described in subdivision (a). The information may include, but is not limited to, the financial or other records of participating providers. The amendment to the contract between the local initiative or commercial plan and the department establishing the pilot program shall specify a reasonable timeframe in which the commercial plan or local initiative shall furnish records to the department pursuant to the request of the department.

(c) In assessing whether the pilot program creates any additional cost to the General Fund, as described in subdivision (a), the department shall specifically consider all of the following factors, and may consider additional factors:

(1) Increases in the number of Medi-Cal beneficiaries assigned by the plan to cost-based primary care providers. To enable the department to evaluate these factors, the department may include in the contract amendments establishing the pilot program a requirement that contractors shall periodically report data regarding the number of plan members assigned to each cost-based primary care provider in the plan's network.

(2) Expansions in the services provided by providers entitled to cost-based reimbursement under the Medi-Cal program.

(3) Medi-Cal caseload or plan membership growth.

(4) Inflation or other reasonable costs of provider operations.

(5) The necessity for a plan to assign plan members to specific primary care providers to meet all of the following requirements:

(A) Medi-Cal contract requirements for access to care.

(B) Unique Medi-Cal member cultural and linguistic needs.

(C) Unique member needs for age-appropriate, gender-appropriate, or pregnancy care requirements.

(d) The pilot program shall be deemed to be successful if the alternative reimbursement methodologies tested result in no additional cost to the General Fund as described in subdivision (c), and the local initiatives, commercial plans, and federally qualified health centers participating in the pilot program agree to accept full financial risk for the scope of services provided by the federally qualified health centers during the final year of the pilot program.

(Added by Stats. 1997, Ch. 649, Sec. 1. Effective January 1, 1998.)

14087.35. (a) Because of the unique circumstances that exist in the County of Alameda, it is necessary that the Board of Supervisors of the County of Alameda be given authority to create a health authority separate and apart from the County of Alameda as a means of establishing the local initiative component of the state-mandated two-plan managed care model for the delivery of medical care and services to the Medi-Cal populations. It is further necessary to enable the board of supervisors to expand publicly assisted medical and health care delivery by the newly created health authority to other populations should the board of supervisors elect to do so. Thus, the adoption of a special act is required.

(b) The Board of Supervisors of the County of Alameda may, by ordinance, establish a health authority separate and apart from the County of Alameda, whose governing board shall reflect the diversity of local stakeholders such as provider groups, beneficiary groups, and officials of government, and that is appointed by the board of supervisors. Notwithstanding any other provision of this chapter, the governing board may include, but need not be limited to, the following: a member of the board of supervisors, individuals that represent and further the interests of the perspectives of Medi-Cal beneficiaries, and individuals that represent and further the interests of the perspectives of Medi-Cal provider physicians and other health practitioners, hospitals, and nonprofit community health centers. Other perspectives may be represented at the discretion of the board of supervisors. The enabling ordinance shall more specifically set forth the membership of the health authority governing board, the qualifications for individual members, the manner of appointment, selection, or removal of governing board members, their terms of office, and all other matters that the board of supervisors deems necessary or convenient for the conduct of the health authority's activities.

(c) The governing board of the health authority and the appropriate state departments, to the extent permitted by federal law, may negotiate and 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 and for other targeted populations. The contracts may be on an exclusive or nonexclusive basis, and shall include payment provisions on any basis negotiated between the state and health authority. Prior to the commencement of operations, the health authority shall be licensed as a health care service plan pursuant to the Knox-Keene Health Care Services Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(d) The board of supervisors may transfer responsibility for administration of county-provided health care services to the health authority for the purpose of service of populations including uninsured and indigent persons subject to the provisions of any ordinances or resolutions passed by the board of supervisors. The transfer of administrative responsibility for those health care services shall not relieve the county of its responsibility for indigent care pursuant to Section 17000. In addition, the services and programs of the health authority may include, but are not limited to, individuals covered under Title XVIII of the Social Security Act, contained in Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, and individuals and groups employed by public agencies and private businesses.

(e) As a legal entity separate and apart from the County of Alameda, the health authority shall file the statement required by Section 53051 of the Government Code. The health authority shall have the power to acquire, possess, and dispose of real or personal property as may be necessary for the performance of its functions, to sue or be sued, to employ personnel and contract for services required to meet its obligations, and to enter into agreements under Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code.

(f) (1) The health authority shall be deemed to be a legal entity separate and apart from the County of Alameda, and shall not be considered to be an agency, division, department, or instrumentality of the County of Alameda.

(2) The health authority shall not be governed by, nor be subject to, the Charter of the County of Alameda and shall not be subject to county policies or operational rules, including, but not limited to, those relating to personnel and procurement.

(g) The health authority shall be considered a public entity, and employees of the health authority shall be considered public employees, for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, relating to claims and actions against public entities and public employees. Members of the governing board of the health authority shall not be vicariously liable for injuries caused by the act or omission of the health authority or advisory body to the extent that protection applies to members of governing boards of local public entities generally under Section 820.9 of the Government Code.

(h) Upon the enactment of the ordinance, all rights, powers, duties, privileges, and immunities vested in the County of Alameda with respect to the subject matter of this section shall be vested in the health authority. Any obligation of the health authority, statutory, contractual, or otherwise, shall be the obligation solely of the health authority and shall not be the obligation of the County of Alameda or the state.

(i) The health authority shall not be a “person” subject to suit under the Cartwright Act, Chapter 2 (commencing with Section 16700) of Part 2 of Division 7 of the Business and Professions Code.

(j) The health authority created pursuant to this section may borrow from the county and the county may lend the health authority funds, or issue revenue anticipation notes to obtain those funds necessary to commence operations.

(k) The health authority or the county, or both, may engage in marketing, advertising, and promotion of the medical and health care services made available to the target populations by the health authority.

(l) Provisions for the termination of the health authority’s activities with respect to the delivery of services to Medi-Cal populations shall be contained in the appropriate contracts executed by and between the health authority and the appropriate state departments.

(m) If the board of supervisors expands publicly assisted medical and health care delivery by the health authority to other populations, and the board of supervisors subsequently determines that the health authority may no longer function for the purpose of the expanded delivery, at the time as the health authority’s existing obligations with respect thereto have been satisfied, the board of supervisors may, by ordinance, terminate the expanded delivery activities of the health authority.

(n) All assets of the health authority that are related to Medi-Cal services shall be disposed of pursuant to the Medi-Cal related contract entered into between the state and the health authority.

(o) All liabilities or obligations of the health authority with respect to its activities pursuant to the state-mandated two-plan managed care model for the delivery of medical care and services to the Medi-Cal population shall be the liabilities or obligations of the health authority, and shall not become the liabilities or obligations of the county upon the termination of the health authority or at any other time. Any liabilities or obligations of the health authority with respect to the liquidation or disposition of the health authority’s assets upon termination of the health authority shall not become the liabilities or obligations of the county, except that the county shall manage any remaining Medi-Cal related assets of the health authority until superseded by a plan approved by the department.

(p) The Legislature finds and declares that Section 14105 provides that the Director of Health Services prescribe the policies for the administration of Medi-Cal managed care contracts. The state-mandated two-plan managed care model distributed by the director sets forth that policy, expressly providing that local stakeholders, including government officials, providers, and community-based organizations, are afforded maximum flexibility and control in designing a delivery system that reflects the needs and priorities of the community that it serves. The mandated model requires that the governing board of the local initiative reflect an effort to include representation of the perspectives of provider and beneficiary groups. To effectuate this policy, all of the following shall apply:

(1) Notwithstanding any provision of law to the contrary, a member of the governing board of the health authority shall be deemed not to be interested in a contract entered into by the health authority 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 the following apply:

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

(B) The contract authorizes the member or the organization the member represents to provide services to beneficiaries or administrative services under the health authority's programs.

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

(D) The member does not influence or attempt to influence the health authority or another member of the health authority to enter into the contract in which the member is interested.

(E) The member discloses the interest to the health authority and abstains from voting on the contract.

(F) The health authority notes the member's disclosure and abstention in its official records and authorizes the contract in good faith by a vote of its membership sufficient for the purpose without counting the vote of the interested member.

(2) Notwithstanding Article 4.7 (commencing with Section 1125) of Chapter 1 of Division 4 of Title 1 of the Government Code related to incompatible activities, no member of the governing board, no officer, and no member of the alliance staff shall be considered to be engaged in activities inconsistent and incompatible with his or her duties as a governing board member, officer, or staff person solely as a result of employment or affiliation with the county, private hospital, clinic, pharmacy, other provider group, employee organization, or citizen's group.

(q) (1) The health authority may use a computerized management information system in connection with the administration of its health delivery system, including the administration of the state-mandated two-plan Medi-Cal managed care model.

(2) Information maintained in the management information system that pertains to persons who are Medi-Cal applicants or recipients shall be confidential pursuant to Section 14100.2, and shall not be open to examination other than for purposes directly connected with the administration of the Medi-Cal program, including, but not limited to, those set forth in subdivision (c) of Section 14100.2. This safeguarded information includes, but is not limited to, names and addresses, medical services provided, social and economic conditions or circumstances, health authority evaluation of personal information, and medical data, including diagnosis and past history of disease or disability.

(3) Information maintained in the management information system that pertains to peer review-related activities shall be confidential and subject to the full protections of the law with respect to the confidentiality of activities related to peer review generally.

(r) The records of the health authority, whether paper records, records maintained in the management information system, or records in any other form, that relate to rates of payment, including records relating to rates of payment determination, allocation or distribution methodologies, formulas or calculations, and records of the health authority that relate to contract negotiations with providers of health care for alternative rates, shall not be subject to disclosure pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). The transmission of the records, or the information contained therein in an alternative form, to the board of supervisors shall not constitute a waiver of exemption from disclosure, and the records and information once transmitted to the board of supervisors shall be subject to this same exemption.

(s) (1) (A) Notwithstanding the Ralph M. Brown Act (Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code), the governing board of the health authority may meet in closed session for the purpose of discussion of, or taking action on matters involving, health authority trade secrets.

(B) The requirement that the authority make a public report of actions taken in closed session and the vote or abstention of every member present may be limited to a brief general description of the action taken and the vote so as to prevent the disclosure of a trade secret.

(C) For purposes of this subdivision, "health authority trade secret" means a trade secret, as defined in subdivision (d) of Section 3426.1 of the Civil Code, that also meets both of the following criteria:

(i) The secrecy of the information is necessary for the health authority to initiate a new service, program, marketing strategy, business plan, or technology, or to add a benefit or product.

(ii) Premature disclosure of the trade secret would create a substantial probability of depriving the health authority of a substantial economic benefit or opportunity.

(2) Those records of the health authority that reveal the health authority's trade secrets are exempt from disclosure pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records. This exemption shall apply for a period of two years after the

service, program, marketing strategy, business plan, technology, benefit, or product that is the subject of the trade secret is formally adopted by the governing body of the health authority, provided that the service, program, marketing strategy, business plan, technology, benefit, or product continues to be a trade secret. The governing board may delete the portion or portions containing trade secrets from any documents that were finally approved in the closed session held pursuant to paragraph (1) that are provided to persons who have made the timely or standing request.

(3) Nothing in this section shall be construed as preventing the governing board from meeting in closed session as otherwise provided by law.

(t) Open sessions of the health authority shall constitute official proceedings authorized by law within the meaning of Section 47 of the Civil Code, and those privileges set forth in that section with respect to official proceedings shall apply to open sessions of the health authority.

(u) The health authority shall be considered a public agency for purposes of eligibility with respect to grants and other funding and loan guarantee programs. Contributions to the health authority shall be tax deductible to the extent permitted by state and federal law.

(v) Contracts by and between the health authority and the state, and contracts by and between the health authority and providers of health care, goods, or services may be let 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.

(w) (1) Provisions of the Evidence Code, the Government Code, including the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), the Civil Code, the Business and Professions Code, and other applicable law pertaining to the confidentiality of peer review activities of peer review bodies shall apply to the peer review activities of the health authority. Peer review proceedings shall constitute an official proceeding authorized by law within the meaning of Section 47 of the Civil Code, and those privileges set forth in that section with respect to official proceedings shall apply to peer review proceedings of the health authority. If the health authority is required by law or contractual obligation to submit to the state or federal government peer review information or information relevant to the credentialing of a participating provider, that submission shall not constitute a waiver of confidentiality. The laws pertaining to the confidentiality of peer review activities shall be together construed as extending, to the extent permitted by law, the maximum degree of protection of confidentiality.

(2) Notwithstanding any other provision of law, Section 1461 of the Health and Safety Code shall apply to hearings on the reports of hospital medical audit or quality assurance committees as they relate to network providers or applicants.

(x) The health authority shall carry general liability insurance to the extent sufficient to cover its activities.

(y) The establishment of a health authority under Article 2.8 (commencing with Section 14087.5) shall be valid as if established pursuant to this section and this section shall apply to that health authority.

(Amended by Stats. 2004, Ch. 228, Sec. 12.2. Effective August 16, 2004.)

14087.36. (a) The following definitions shall apply for purposes of this section:

(1) “County” means the City and County of San Francisco.

(2) “Board” means the Board of Supervisors of the City and County of San Francisco.

(3) “Department” means the State Department of Health Care Services.

(4) “Governing body” means the governing body of the health authority.

(5) “Health authority” means the separate public agency established by the board of supervisors to operate a health care system in the county and to engage in the other activities authorized by this section.

(b) The Legislature finds and declares that it is necessary that a health authority be established in the county to arrange for the provision of health care services in order to meet the problems of the delivery of publicly assisted medical care in the county, to enter into a contract with the department under Article 2.97 (commencing with Section 14093), or to contract with a health care service plan on terms and conditions acceptable to the department, and to demonstrate ways of promoting quality care and cost efficiency.

(c) The county may, by resolution or ordinance, establish a health authority to act as and be the local initiative component of the Medi-Cal state plan pursuant to regulations adopted by the department. If the board elects to establish a health authority, all rights, powers, duties, privileges, and immunities vested in a county under Article 2.8 (commencing with Section 14087.5) and Article 2.97 (commencing with Section 14093) shall be vested in the health authority. The health authority shall have all power necessary and appropriate to operate programs involving health care services, including, but not limited to, the power to acquire, possess, and dispose of real or personal property, to employ personnel and contract for services required to meet its obligations, to sue or be sued, to take all actions and engage in all public and private business activities, subject to any applicable licensure, as permitted a

health care service plan pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, and to enter into agreements under Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code.

(d) (1) (A) The health authority shall be considered a public entity for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, separate and distinct from the county, and shall file the statement required by Section 53051 of the Government Code. The health authority shall have primary responsibility to provide the defense and indemnification required under Division 3.6 (commencing with Section 810) of Title 1 of the Government Code for employees of the health authority who are employees of the county. The health authority shall provide insurance under terms and conditions required by the county in order to satisfy its obligations under this section.

(B) For purposes of this paragraph, “employee” shall have the same meaning as set forth in Section 810.2 of the Government Code.

(2) The health authority shall not be considered to be an agency, division, department, or instrumentality of the county and shall not be subject to the personnel, procurement, or other operational rules of the county.

(3) Notwithstanding any other provision of law, any obligations of the health authority, statutory, contractual, or otherwise, shall be the obligations solely of the health authority and shall not be the obligations of the county, unless expressly provided for in a contract between the authority and the county, nor of the state.

(4) Except as agreed to by contract with the county, no liability of the health authority shall become an obligation of the county upon either termination of the health authority or the liquidation or disposition of the health authority’s remaining assets.

(e) (1) To the full extent permitted by federal law, the department and the health authority 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 health authority. The health authority may also enter into contracts for the provision of health care services to individuals including, but not limited to, those covered under Subchapter XVIII (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 individuals.

(2) Notwithstanding paragraph (1), or subdivision (f), the health authority may not operate health plans or programs for individuals covered under Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, or for private businesses, until the health authority is in full compliance with all of the requirements of the Knox-Keene Health Care Service Plan Act of 1975 under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, including tangible net equity requirements applicable to a licensed health care service plan. This limitation shall not preclude the health authority from enrolling persons pursuant to the county’s obligations under Section 17000, or from enrolling county employees.

(f) The board of supervisors may transfer responsibility for administration of county-provided health care services to the health authority for the purpose of service of populations including uninsured and indigent persons, subject to the provisions of any ordinances or resolutions passed by the county board of supervisors. The transfer of administrative responsibility for those health care services shall not relieve the county of its responsibility for indigent care pursuant to Section 17000. The health authority may also enter into contracts for the provision of health care services to individuals including, but not limited to, those covered under Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, and individuals employed by public agencies and private businesses.

(g) Upon creation, the health authority may borrow from the county and the county may lend the authority funds, or issue revenue anticipation notes to obtain those funds necessary to commence operations or perform the activities of the health authority. Notwithstanding any other provision of law, both the county and the health authority shall be eligible to receive funding under subdivision (p) of Section 14163.

(h) The county may terminate the health authority, but only by an ordinance approved by a two-thirds affirmative vote of the full board.

(i) Prior to the termination of the health authority, the county shall notify the department of its intent to terminate the health authority. The department shall conduct an audit of the health authority’s records within 30 days of notification to determine the liabilities and assets of the health authority. The department shall report its findings to the county and to the Department of Managed Health Care within 10 days of completion of the audit. The county shall prepare a plan to liquidate or otherwise dispose of the assets of the health authority and to pay the liabilities of the health authority to the extent of the health authority’s assets, and present the plan to the department and the Department of Managed Health Care within 30 days upon receipt of these findings.

(j) Any assets of the health authority derived from the contract entered into between the state and the authority pursuant to Article 2.97 (commencing with Section 14093), after payment of the liabilities of the health authority, shall be disposed of pursuant to the contract.

(k) (1) The governing body shall consist of 18 voting members, 14 of whom shall be appointed by resolution or ordinance of the board as follows:

(A) One member shall be a member of the board or any other person designated by the board.

(B) One member shall be a person who is employed in the senior management of a hospital not operated by the county or the University of California and who is nominated by the San Francisco Section of the West Bay Hospital Conference or any successor organization, or, if there is no successor organization, a person who shall be nominated by the Hospital Council of Northern and Central California.

(C) Two members, one of whom shall be a person employed in the senior management of San Francisco General Hospital and one of whom shall be a person employed in the senior management of St. Luke's Hospital (San Francisco). If San Francisco General Hospital or St. Luke's Hospital, at the end of the term of the person appointed from its senior management, is not designated as a disproportionate share hospital, and if the governing body, after providing an opportunity for comment by the West Bay Hospital Conference, or any successor organization, determines that the hospital no longer serves an equivalent patient population, the governing body may, by a two-thirds vote of the full governing body, select an alternative hospital to nominate a person employed in its senior management to serve on the governing body. Alternatively, the governing body may approve a reduction in the number of positions on the governing body as set forth in subdivision (p).

(D) Two members shall be employees in the senior management of either private nonprofit community clinics or a community clinic consortium, nominated by the San Francisco Community Clinic Consortium, or any successor organization.

(E) Two members shall be physicians, nominated by the San Francisco Medical Society, or any successor organization.

(F) One member shall be nominated by the San Francisco Labor Council, or any successor organization.

(G) Two members shall be persons nominated by the member advisory committee of the health authority. Nominees of the member advisory committee shall be enrolled in any of the health insurance or health care coverage programs operated by the health authority or be the parent or legal guardian of an enrollee in any of the health insurance or health care coverage programs operated by the health authority.

(H) Two members shall be persons knowledgeable in matters relating to either traditional safety net providers, health care organizations, the Medi-Cal program, or the activities of the health authority, nominated by the program committee of the health authority.

(I) One member shall be a person nominated by the San Francisco Pharmacy Leadership Group, or any successor organization.

(2) One member, selected to fulfill the appointments specified in subparagraph (A), (G), or (H) shall, in addition to representing the member's specified organization or employer, represent the discipline of nursing, and shall possess or be qualified to possess a registered nursing license.

(3) The initial members appointed by the board under the subdivision shall be, to the extent those individuals meet the qualifications set forth in this subdivision and are willing to serve, those persons who are members of the steering committee created by the county to develop the local initiative component of the Medi-Cal state plan in San Francisco. Following the initial staggering of terms, each of those members shall be appointed to a term of three years, except the member appointed pursuant to subparagraph (A) of paragraph (1), who shall serve at the pleasure of the board. At the first meeting of the governing body, the members appointed pursuant to this subdivision shall draw lots to determine seven members whose initial terms shall be for two years. Each member shall remain in office at the conclusion of that member's term until a successor member has been nominated and appointed.

(l) In addition to the requirements of subdivision (k), one member of the governing body shall be appointed by the Mayor of the City of San Francisco to serve at the pleasure of the mayor, one member shall be the county's director of public health or designee, who shall serve at the pleasure of that director, one member shall be the Chancellor of the University of California at San Francisco or the chancellor's designee, who shall serve at the pleasure of the chancellor, and one member shall be the county director of mental health or the director's designee, who shall serve at the pleasure of that director.

(m) There shall be one nonvoting member of the governing body who shall be appointed by, and serve at the pleasure of, the health commission of the county.

(n) Each person appointed to the governing body shall, throughout the member's term, either be a resident of the county or be employed within the geographic boundaries of the county.

(o) (1) The composition of the governing body and nomination process for appointment of its members shall be subject to alteration upon a two-thirds vote of the full membership of the governing body. This action shall be concurred in by a resolution or ordinance of

the county.

(2) Notwithstanding paragraph (1), no alteration described in that paragraph shall cause the removal of a member prior to the expiration of that member's term.

(p) 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. However, no official shall be approved with less than the affirmative vote of six members of the governing body, unless the number of members prohibited from voting because of conflicts of interest precludes adequate participation in the vote. The governing body may, by a two-thirds vote, adopt, amend, or repeal rules and procedures for the governing body. Those rules and procedures may require that certain decisions be made by a vote that is greater than a majority vote.

(q) For purposes of Section 87103 of the Government Code, members appointed pursuant to subparagraphs (B) to (E), inclusive, of paragraph (1) of subdivision (k) represent, and are appointed to represent, respectively, the hospitals, private nonprofit community clinics, and physicians that contract with the health authority, or the health care service plan with which the health authority contracts, to provide health care services to the enrollees of the health authority or the health care service plan. Members appointed pursuant to subparagraphs (F) and (G) of paragraph (1) of subdivision (k) represent, and are appointed to represent, respectively, the health care workers and enrollees served by the health authority or its contracted health care service plan, and traditional safety net and ancillary providers and other organizations concerned with the activities of the health authority.

(r) A member of the governing body may be removed from office by the board by resolution or ordinance, only upon the recommendation of the health authority, and for any of the following reasons:

(1) Failure to retain the qualifications for appointment specified in subdivisions (k) and (n).

(2) Death or a disability that substantially interferes with the member's ability to carry out the duties of office.

(3) Conviction of any felony or a crime involving corruption.

(4) Failure of the member to discharge legal obligations as a member of a public agency.

(5) Substantial failure to perform the duties of office, including, but not limited to, unreasonable absence from meetings. The failure to attend three meetings in a row of the governing body, or a majority of the meetings in the most recent calendar year, may be deemed to be unreasonable absence.

(s) Any vacancy on the governing body, however created, shall be filled for the unexpired term by the board by resolution or ordinance. Each vacancy shall be filled by an individual having the qualifications of the individual's predecessor, nominated as set forth in subdivision (k).

(t) The chair of the authority shall be selected by, and serve at the pleasure of, the governing body.

(u) The health authority shall establish all of the following:

(1) A member advisory committee to advise the health authority on issues of concern to the recipients of services.

(2) A program committee to advise the health authority on matters relating to traditional safety net providers, ancillary providers, and other organizations concerned with the activities of the health authority.

(3) Any other committees determined to be advisable by the health authority.

(v) (1) Notwithstanding any provision of state or local law, including, but not limited to, the county charter, a member of the health authority shall not be deemed to be interested in a contract entered into by the authority within the meaning of Article 4 (commencing with Section 1090) of Chapter 1 of Division 4 of Title 1 of the Government Code, or within the meaning of conflict-of-interest restrictions in the county charter, if all of the following apply:

(A) The member does not influence or attempt to influence the health authority or another member of the health authority to enter into the contract in which the member is interested.

(B) The member discloses the interest to the health authority and abstains from voting on the contract.

(C) The health authority notes the member's disclosure and abstention in its official records and authorizes the contract in good faith by a vote of its membership sufficient for the purpose without counting the vote of the interested member.

(D) The member has an interest in or was appointed to represent the interests of physicians, health care practitioners, hospitals, pharmacies, or other health care organizations.

(E) The contract authorizes the member or the organization the member has an interest in or represents to provide services to beneficiaries under the authority's program or administrative services to the authority.

(2) In addition, no person serving as a member of the governing body shall, by virtue of that membership, be deemed to be engaged in activities that are inconsistent, incompatible, or in conflict with their duties as an officer or employee of the county or the University of California, or as an officer or an employee of any private hospital, clinic, or other health care organization. The membership shall not be deemed to be in violation of Section 1126 of the Government Code.

(w) Notwithstanding any other provision of law, those records of the health authority and of the county that reveal the authority's rates of payment for health care services or the health authority's deliberative processes, discussions, communications, or any other portion of the negotiations with providers of health care services for rates of payment, or the health authority's peer review proceedings shall not be required to be disclosed pursuant to the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records. However, three years after a contract or amendment to a contract is fully executed, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(x) Notwithstanding any other provision of law, the health authority may meet in closed session to consider and take action on peer review proceedings and on matters pertaining to contracts and contract negotiations by the health authority's staff with providers of health care services concerning all matters relating to rates of payment. However, a decision as to whether to enter into, amend the services provisions of, or terminate, other than for reasons based upon peer review, a contract with a provider of health care services, shall be made in open session.

(y) (1) (A) Notwithstanding the Ralph M. Brown Act (Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code), the governing board of the health authority may meet in closed session for the purpose of discussion of, or taking action on matters involving, health authority trade secrets.

(B) The requirement that the authority make a public report of actions taken in closed session and the vote or abstention of every member present may be limited to a brief general description of the action taken and the vote so as to prevent the disclosure of a trade secret.

(C) For purposes of this subdivision, "health authority trade secret" means a trade secret, as defined in subdivision (d) of Section 3426.1 of the Civil Code, that also meets both of the following criteria:

(i) The secrecy of the information is necessary for the health authority to initiate a new service, program, marketing strategy, business plan, or technology, or to add a benefit or product.

(ii) Premature disclosure of the trade secret would create a substantial probability of depriving the health authority of a substantial economic benefit or opportunity.

(2) Those records of the health authority that reveal the health authority's trade secrets are exempt from disclosure pursuant to the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records. This exemption shall apply for a period of two years after the service, program, marketing strategy, business plan, technology, benefit, or product that is the subject of the trade secret is formally adopted by the governing body of the health authority, provided that the service, program, marketing strategy, business plan, technology, benefit, or product continues to be a trade secret. The governing board may delete the portion or portions containing trade secrets from any documents that were finally approved in the closed session held pursuant to this subdivision that are provided to persons who have made the timely or standing request.

(z) The health authority shall be deemed to be a public agency for purposes of all grant programs and other funding and loan guarantee programs.

(aa) Contracts under this article between the State Department of Health Services and the health authority 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.

(ab) (1) The county controller or the controller's designee, at intervals the county controller deems appropriate, shall conduct a review of the fiscal condition of the health authority, shall report the findings to the health authority and the board, and shall provide a copy of the findings to any public agency upon request.

(2) Upon the written request of the county controller, the health authority shall provide full access to the county controller all health authority records and documents as necessary to allow the county controller or the controller's designee to perform the activities authorized by this subdivision.

(ac) A Medi-Cal recipient receiving services through the health authority shall be deemed to be a subscriber or enrollee for purposes of Section 1379 of the Health and Safety Code.

(Amended by Stats. 2021, Ch. 615, Sec. 442. (AB 474) Effective January 1, 2022. Operative January 1, 2023, pursuant to Sec. 463 of Stats. 2021, Ch. 615.)

14087.37. Commencing on the date that a health authority established pursuant to Section 14087.35 or 14087.36 first receives Medi-Cal capitated payments for the provision of health care services to Medi-Cal beneficiaries and until the time that the health authority is in compliance with all the requirements regarding tangible net equity applicable to a health care service plan licensed under the Knox-Keene Health Care Service Plan Act of 1975, the following provisions shall apply:

(a) The health authority may select and design its automated management information system, but the department, in cooperation with the health authority, prior to making capitated payments 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 health authority and any other information generally required by the department in its contracts with health care service plans.

(b) In addition to the reports required by the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the Director of the Department of Managed Health Care promulgated thereunder, the health authority shall provide on a monthly basis to the department, the Department of Managed Health Care, and the members of the health authority, 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 or 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 health authority to provide health care services.

(c) In addition to the reporting and notification obligations the health authority has under the Knox-Keene Health Care Service Plan Act of 1975, the chief executive officer or director of the health authority shall immediately notify the department, the Department of Managed Health Care, and the members of the health authority in writing of any fact or facts that, in the chief executive officers' or director's reasonable and prudent judgment, is likely to result in the health authority being unable to meet its financial obligations to health care providers or to other parties. Written notice shall describe the fact or facts, the anticipated fiscal consequences, and the actions that will be taken to address the anticipated consequences.

(d) The Department of Managed Health Care shall not 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 health authority under the Knox-Keene Health Care Service Plan Act of 1975 after three years from the date of commencement of capitated payments to the health authority. Until the time the health authority is in compliance with all of the tangible net equity requirements under the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the Director of the Department of Managed Health Care promulgated thereunder, the health authority shall develop a stop-loss program appropriate to the risks of the health authority. The program shall be satisfactory to both the department and the Department of Managed Health Care.

(e) In the event that the health authority votes to file a petition of bankruptcy, or the board of supervisors notifies the department of its intent to terminate the health authority, the department shall immediately convert the health authority's Medi-Cal beneficiaries to either of the following:

(1) To other managed care contractors when available, provided those 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.

(2) To the extent that other managed care contractors are unavailable or the department determines that the action is otherwise in the best interest of any particular beneficiary, to a fee-for-service reimbursement system pending the availability of managed care contractors, provided those 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, or if 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. Beneficiary eligibility for Medi-Cal shall not be affected by this action. Beneficiaries who have been or who are scheduled to be converted 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 the federal freedom-of-choice requirements.

(f) The health authority shall submit to a review of financial records when the department determines, based on data reported by the health authority or otherwise, that the health authority will not be able to meet its financial obligations to health care providers contracting with the health authority. Where the review of financial records determines that the health authority will not be able to meet its financial obligations to contracting health care providers for the provision of health care services, the director shall immediately terminate the contract between the health authority and the state, and immediately convert the health authority Medi-Cal beneficiaries in accordance with subdivision (e) in order to ensure uninterrupted provision of health care services to the beneficiaries and to minimize financial disruption to providers. The action of the director shall be the final administrative determination. Beneficiary eligibility for Medi-Cal shall not be affected by this action. Beneficiaries who have been or who are scheduled to be converted under subdivision (e) 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.

(g) 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 health authority shall authorize and permit the department to administer the number of covered Medi-Cal enrollments in such a manner that the health authority's provider network and administrative structure are able to provide appropriate and timely services to beneficiaries and to participating providers.

(h) In the event a health authority is terminated, files for bankruptcy, or otherwise no longer functions for the purpose 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 health authority.

(i) Nothing in this subdivision shall be construed to impair or diminish the authority of the Director of the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975, nor shall anything in the section be construed to reduce or otherwise limit the obligation of a health authority licensed as a health care service plan to comply with the requirements of the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the Director of the Department of Managed Health Care promulgated thereunder.

(Amended by Stats. 2000, Ch. 857, Sec. 83. Effective January 1, 2001.)

14087.38. (a) (1) In counties selected by the director with the concurrence of the county, a special county health authority may be established in order to meet the problems of delivery of publicly assisted medical care in each county, and to demonstrate ways of promoting quality care and cost efficiency. Nothing in this section shall be construed to preclude the department from expanding Medi-Cal managed care in ways other than those provided for in this section, including, but not limited to, the establishment of a public benefit corporation as set forth in Section 5110 of the Corporations Code.

(2) For purposes of this section, "health authority" means an entity separate from the county that meets the requirements of state and federal law and the quality, cost, and access criteria established by the department.

(b) The board of supervisors of a county described in subdivision (a) may, by ordinance, establish a health authority to negotiate and enter into contracts authorized by Section 14087.3, and to arrange for the provision of health care services provided pursuant to this chapter. If the board of supervisors elects to enact this ordinance, all rights, powers, duties, privileges, and immunities vested in a county contracting with the department under this article shall be vested in the health authority. The health authority may also enter into contracts for the provision of health care services to individuals including, but not limited to, those covered under Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, those entitled to coverage under other publicly supported programs, those employed by public agencies or private businesses, and uninsured or indigent individuals.

(c) The enabling ordinance shall specify the membership of the governing board of the health authority, the qualifications for individual members, the manner of appointment, selection, or removal of board members, and how long they shall serve, and any other matters the board of supervisors deems necessary or convenient for the conduct of the health authority's activities. Members of the governing board shall be appointed by the board of supervisors to represent the interests of the county, the general public, beneficiaries, physicians, hospitals, clinics, and other nonphysician health care providers. The health authority so established shall be considered an entity separate from the county and shall file a statement required by Section 53051 of the Government Code. The health authority shall have the power to acquire, possess, and dispose of real or personal property, as necessary for the performance of its functions, to employ personnel and contract for services required to meet its obligations, to sue or be sued, and to enter into agreements under Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code. Any obligations of a health authority, statutory, contractual, or otherwise, shall be obligations solely of the health authority and shall not be the obligations of the county or of the state.

(d) Upon creation, the health authority may borrow from the county, and the county may lend the health authority funds or issue revenue anticipation notes to obtain those funds necessary to commence operations.

(e) Notwithstanding any other provision of law, both the county and the health authority shall be eligible to receive funding under subdivision (p) of Section 14163, and the health authority shall be considered to have satisfied the requirements of that subdivision.

(f) The health authority shall be deemed to be a public agency that is a unit of local government for purposes of all grant programs and other funding and loan guarantee programs.

(g) It is the intent of the Legislature that if a health authority is formed pursuant to this section, 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 health authority for contracts to provide health care services. Nothing in this subdivision shall be construed to interfere with or limit the health authority in giving preference in negotiating to disproportionate share hospitals or other providers of health care to medically indigent or uninsured individuals.

(h) Notwithstanding any other provision of law, a member of the governing board of the health authority shall not be deemed to be interested in a contract entered into by the health authority 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 the following apply:

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

(2) The contract authorizes the member or the organization the member represents to provide services to beneficiaries under the health authority's programs.

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

(4) The member does not influence or attempt to influence the health authority or another member of the health authority to enter into the contract in which the member is interested.

(5) The member discloses the interest to the health authority and abstains from voting on the contract.

(6) The governing board notes the member's disclosure and abstention in its official records and authorizes the contract in good faith by a vote of its membership sufficient for the purpose without counting the vote of the interested member.

(i) All claims for money or damages against the health authority 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 provided by other statutes or regulations that expressly apply to the health authority.

(j) (1) The health authority shall be considered a public entity for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code.

(2) The health authority, members of its governing board, and its employees, are protected by the immunities applicable to public entities and public employees governed by Part 1 (commencing with Section 810) and 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 health authority.

(k) Notwithstanding any other provision of law, except as otherwise provided in this section, a county shall not be liable for any act or omission of the health authority.

(l) The transfer of responsibility for health care services to the health authority shall not relieve the county of its responsibility for indigent care pursuant to Section 17000.

(m) Notwithstanding any other provision of law, the governing board of the health authority may meet in closed session to consider and take action on matters pertaining to contracts, and to contract negotiations by health authority staff with providers of health care services concerning all matters related to rates of payment.

(n) (1) (A) Notwithstanding the Ralph M. Brown Act (Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code), the governing board of the health authority may meet in closed session for the purpose of discussion of, or taking action on matters involving, health authority trade secrets.

(B) The requirement that the authority make a public report of actions taken in closed session and the vote or abstention of every member present may be limited to a brief general description of the action taken and the vote so as to prevent the disclosure of a trade secret.

(C) For purposes of this section, "health authority trade secret" means a trade secret, as defined in subdivision (d) of Section 3426.1 of the Civil Code, that also meets both of the following criteria:

(i) The secrecy of the information is necessary for the health authority to initiate a new service, program, marketing strategy, business plan, or technology, or to add a benefit or product.

(ii) Premature disclosure of the trade secret would create a substantial probability of depriving the health authority of a substantial economic benefit or opportunity.

(2) Those records of the health authority that reveal the health authority's trade secrets are exempt from disclosure pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records. This exemption shall apply for a period of two years after the service, program, marketing strategy, business plan, technology, benefit, or product that is the subject of the trade secret is formally adopted by the governing body of the health authority, provided that the service, program, marketing strategy, business plan, technology, benefit, or product continues to be a trade secret. The governing board may delete the portion or portions containing trade secrets from any documents that were finally approved in closed session held pursuant to this subdivision that are provided to persons who have made the timely or standing request.

(o) Notwithstanding Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of, and Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of, the Government Code, or any other provision of law, any peer review body, as defined in paragraph (1) of subdivision (a) of Section 805 of the Business and Professions Code, formed pursuant to the powers granted to the health authority authorized by this section, may, at its discretion and without notice to the public, meet in closed session, so long as the purpose of the meeting is the peer review body's discharge of its responsibility to evaluate and

improve the quality of care rendered by health facilities and health practitioners, pursuant to the powers granted to the health authority. The peer review body and its members shall receive, to the fullest extent, all immunities, privileges, and protections available to those peer review bodies, their individual members, and persons or entities assisting in the peer review process, including those afforded by Section 1157 of the Evidence Code and Section 1370 of the Health and Safety Code.

(p) Notwithstanding any other provision of law, those records of the health authority and of the county that reveal the health authority's rates of payment for health care services or the health authority's deliberative processes, discussions, communications, or any other portion of the negotiations with providers of health care services for rates of payment, shall not be required to be disclosed pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records. However, three years after a contract or amendment to a contract is fully executed, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(q) Notwithstanding the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), or Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of, and Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of, the Government Code, or any other provision of state or local law requiring disclosure of public records, those records of a peer review body, as defined in paragraph (1) of subdivision (a) of Section 805 of the Business and Professions Code, formed pursuant to the powers granted to the health authority authorized by this section, shall not be required to be disclosed. The records and proceedings of the peer review body and its individual members shall receive, to the fullest extent, all immunities, privileges, and protections available to those records and proceedings, including those afforded by Section 1157 of the Evidence Code and Section 1370 of the Health and Safety Code.

(r) Except as expressly provided by other provisions of this section, all exemptions and exclusions from disclosure as public records pursuant to the California Public Records Act, including, but not limited to, those pertaining to trade secrets and information withheld in the public interest, shall be fully applicable for all state agencies and local agencies with respect to all writings that the health authority is required to prepare, produce, or submit pursuant to this section.

(s) (1) Any health authority formed pursuant to this section shall obtain licensure as a health care service plan under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code).

(2) Notwithstanding subdivisions (b) and (t), a health authority may not operate health plans or programs for individuals covered under Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, or for private businesses, until the health authority is in full compliance with all of the requirements of the Knox-Keene Health Care Service Plan Act of 1975, including tangible net equity requirements applicable to a licensed health care service plan.

(t) Commencing on the date that the health authority first receives Medi-Cal capitated payments for the provision of health care services to Medi-Cal beneficiaries and until the time that the health authority is in compliance with all the requirements regarding tangible net equity applicable to a health care service plan licensed under the Knox-Keene Health Care Service Plan Act of 1975, the following provisions shall apply:

(1) The health authority may select and design its automated management information system, but the department, in cooperation with the health authority, prior to making capitated payments, 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 health authority and any other information generally required by the department in its contracts with health care service plans.

(2) In addition to the reports required by the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the Director of the Department of Managed Health Care promulgated thereunder, the health authority shall provide on a monthly basis to the department, the Department of Managed Health Care, and the members of the health authority, a copy of the automated report described in paragraph (1) 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 or 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 health authority to provide health care services.

(3) In addition to the reporting and notification obligations the health authority has under the Knox-Keene Health Care Service Plan Act of 1975, the chief executive officer or director of the health authority shall immediately notify the department, the Department of Managed Health Care, and the members of the governing board of the health authority 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 health authority being unable to meet its financial obligations to health care providers or to other parties. Written notice shall describe the fact or facts, the anticipated fiscal consequences, and the actions that will be taken to address the anticipated consequences.

(4) The Department of Managed Health Care shall not 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 health authority under the Knox-Keene Health Care Service Plan Act of 1975 after three years from the date of commencement of capitated payments to the health authority. Until the

time the health authority is in compliance with all of the tangible net equity requirements under the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the Director of the Department of Managed Health Care promulgated thereunder, the health authority shall develop a stop-loss program appropriate to the risks of the health authority. The program shall be satisfactory to both the department and the Department of Managed Health Care.

(5) In the event that the health authority votes to file a petition of bankruptcy, or the board of supervisors notifies the department of its intent to terminate the health authority, the department shall immediately convert the authority's Medi-Cal beneficiaries to either of the following:

(A) To other managed care contractors when available, provided those 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.

(B) To the extent that other managed care contractors are unavailable or the department determines that the action is otherwise in the best interest of any particular beneficiary, to a fee-for-service reimbursement system pending the availability of managed care contractors, provided those 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, or if 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. Beneficiary eligibility for Medi-Cal shall not be affected by this action. Beneficiaries who have been or who are scheduled to be converted 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 the federal freedom-of-choice requirements.

(6) The health authority shall submit to a review of financial records when the department determines, based on data reported by the health authority or otherwise, that the health authority will not be able to meet its financial obligations to health care providers contracting with the health authority. Where the review of financial records determines that the health authority will not be able to meet its financial obligations to contracting health care providers for the provision of health care services, the director shall immediately terminate the contract between the health authority and the state, and immediately convert the health authority Medi-Cal beneficiaries in accordance with paragraph (5) in order to ensure uninterrupted provision of health care services to the beneficiaries and to minimize financial disruption to providers. The action of the director shall be the final administrative determination. Beneficiary eligibility for Medi-Cal shall not be affected by this action. Beneficiaries who have been or who are scheduled to be converted 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 health authority shall authorize and permit the department to administer the number of covered Medi-Cal enrollments in such a manner that the health authority'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 health authority is terminated, files for bankruptcy, or otherwise no longer functions for the purpose 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 health authority.

(9) Nothing in this subdivision shall be construed to impair or diminish the authority of the Director of the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975, nor shall anything in this section be construed to reduce or otherwise limit the obligation of a health authority licensed as a health care service plan to comply with the requirements of the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the Director of the Department of Managed Health Care promulgated thereunder.

(u) In the event a health authority may no longer function for the purposes for which it is established, at the time the health authority's then-existing obligations have been satisfied or the health authority's assets have been exhausted, the board of supervisors may, by ordinance, terminate the health authority.

(v) (1) Prior to the termination of the health authority, the board of supervisors shall notify the department of its intent to terminate the health authority. The department shall conduct an audit of the health authority's records within 30 days of the notification to determine the liabilities and assets of the health authority.

(2) The department shall report its findings to the board within 10 days of completion of the audit. The board shall prepare a plan to liquidate or otherwise dispose of the assets of the health authority and to pay the liabilities of the health authority to the extent of the health authority's assets, and present the plan to the department within 30 days upon receipt of these findings.

(w) Any assets of the health authority shall be disposed of pursuant to provisions contained in the contract entered into between the state and the health authority pursuant to this section.

(x) Upon termination of a health authority by the board, the county shall manage any remaining assets of the health authority until superseded by a department-approved plan. Any liabilities of the health authority shall not become obligations of the county upon either the termination of the health authority or the liquidation or disposition of the health authority's remaining assets.

(y) This section shall apply to any county health authority or any county special commission operating under this article or Article 2.81 (commencing with Section 14087.96), except to the extent that this section conflicts with Sections 14087.31, 14087.35, and 14087.36 or Article 2.81 (commencing with Section 14087.96).

(Amended by Stats. 2004, Ch. 228, Sec. 12.4. Effective August 16, 2004.)

14087.385. (a) The following definitions apply for purposes of this section:

(1) "Board" means the Board of Supervisors of the County of Sacramento.

(2) "County" means the County of Sacramento.

(3) "Department" means the State Department of Health Care Services.

(4) "Health authority" means a separate public entity established by the board that meets the requirements of state and federal law and criteria established by the department and engages in activities authorized by this section.

(b) The Legislature finds and declares that it is necessary that a health authority be established in the county to meet the problems of delivery of publicly assisted medical care in the county and to demonstrate ways of promoting timely access, quality care, and cost efficiency.

(c) A health authority established by the board, consistent with Section 14087.38, may do all of the following:

(1) Designate a number of Knox-Keene licensed health plans for purposes of the department's Medi-Cal managed care plan procurement under Section 14089 for the County of Sacramento as specified under subdivision (d), until the health authority implements a county-sponsored local initiative health plan as authorized by Section 14087.38 as described in paragraph (3).

(2) Meet with health plans that operate as Medi-Cal managed care plans in the county pursuant to Section 14089 to review and discuss strategies for improving quality, cost, and access of Medi-Cal services in the county, until the health authority implements any activity described in paragraph (3).

(3) (A) Consistent with Section 14087.38, and upon approval of the health authority and the board, pursue either of the following activities:

(i) Seek and obtain Knox-Keene health plan licensure in order to serve as the county-sponsored local initiative to contract with the department to arrange for the provision of health care services to qualifying individuals, as authorized by Section 14087.3.

(ii) Negotiate and enter into a contract with a Knox-Keene licensed health plan to be the designated county-sponsored local initiative health plan for the purpose of contracting with the department for the provision of health care services to qualifying individuals as authorized by Section 14087.3.

(B) Upon the implementation of any activity described in subparagraph (A), the county may continue to administer its stakeholder advisory committee, as described under Section 14089.07.

(d) (1) For purposes of the designation of health plans pursuant to paragraph (1) of subdivision (c), prior to procurement under Section 14089, the health authority shall meet with any health plans intending to contract with the department as Medi-Cal managed care plans in the county. Any health plan intending to contract with the department as a Medi-Cal managed care plan in the county, and intending to submit a proposal to the department in a procurement process, shall first be required to meet with the health authority.

(2) Subsequent to meeting with all interested health plans, the health authority shall designate to the department at least two Knox-Keene licensed health plans for the department's approval based on the criteria described in paragraph (3).

(3) Any criteria used by the health authority to determine the designation of health plans pursuant to paragraph (1) of subdivision (c) shall not conflict with requirements for Medi-Cal managed care plans established by the department, the Department of Managed Health Care, the federal Medicaid program, or state law, and shall conform with any guidance issued by the department

pursuant to paragraph (7). Designation requirements imposed by the health authority shall further the department's goals and requirements for procurement under Section 14089 including, but not limited to, increased quality, access, network adequacy, reduction of health disparities, and integration of behavioral and oral health within the delivery of health care services in the Medi-Cal program.

(4) Notwithstanding any designation by the health authority, only health plans approved by the department as meeting plan procurement requirements determined by the department shall be eligible to contract with the department as Medi-Cal managed care plans in the county. Designation by the health authority provides the health plan only with the opportunity to compete in the procurement process under Section 14089 and does not guarantee the award of a Medi-Cal managed care plan contract with the department.

(5) If the health authority does not designate at least two health plans that receive approval from the department, the department shall determine other health plans to contract with as Medi-Cal managed care plans to ensure there are at least two Medi-Cal managed care plans in Sacramento County.

(6) Designation of health plans by the health authority shall continue for the term of the Medi-Cal contract, unless the department determines that the criteria for designation specified in paragraph (3) is no longer met.

(7) 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 subdivision by means of letters or other similar instructions, without taking any further regulatory action. This may include, but need not be limited to, guidance to the health authority with respect to the requisite criteria and timing for the designation of health plans pursuant to this subdivision.

(Added by Stats. 2021, Ch. 446, Sec. 1. (SB 226) Effective January 1, 2022.)

14087.39. (a) In any transfer of functions from county employees to a health authority established pursuant to Section 14087.35, 14087.36, or 14087.38, the health authority shall continue to recognize the employee organization that represented the employees performing those functions at the time of the transfer of duties.

(b) Any health authority to which this section applies shall 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 of the transfer of functions, or until replaced by a subsequent memorandum of understanding between the health authority and the employee organization.

(c) Subdivision (b) shall not apply to administrative functions performed by the authority that are directly related to the operation of a health care service plan licensed under Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code, unless the functions were transferred from county employees to the authority.

(d) In order to further the statewide interest in the development of an effective managed care delivery system to Medi-Cal beneficiaries in the county, it is necessary to ensure that the public health and hospital facilities of the county are financially viable so that the county may participate in that delivery system through the use of those facilities. Accordingly, notwithstanding any provision of the county charter to the contrary, the county shall be fully authorized to offer and provide medical care to members of the health service system of the county at the public health and hospital facilities of the county.

(Added by Stats. 1994, Ch. 642, Sec. 7. Effective September 20, 1994.)

14087.4. (a) Any contract made pursuant to this article may be renewed if the provider continues to meet the requirements of this chapter, regulations promulgated pursuant thereto, and the contract. Failure to meet these requirements shall be cause for nonrenewal of the contract. The department may condition renewal on timely completion of a mutually agreed upon plan of correction of any deficiencies.

(b) The department may terminate or decline to renew a contract, in whole or in part, when the director determines that such action is necessary to protect the health of the beneficiaries or the funds appropriated to carry out the Medi-Cal program. Nonrenewal or termination under this article shall not qualify the applicant for an administrative hearing including a hearing pursuant to Section 14123.

(c) 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 shall be exempt from the provisions of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(d) For any contract entered into pursuant to this article, the Director of the Department of Managed Health Care shall, at the director's request and with all due haste, grant an exemption 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 contract.

(Amended by Stats. 2000, Ch. 857, Sec. 85. Effective January 1, 2001.)

14087.41. The department shall develop a simple form, consistent with the notice requirements of Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations, for Medi-Cal managed care plans to use to notify a Medi-Cal enrollee of a denial, termination, delay, or modification in benefits. The department shall require all Medi-Cal managed care plans to use the form as a condition of participation in Medi-Cal managed care pursuant to any contract negotiated after the effective date of this section.

(Added by Stats. 1999, Ch. 539, Sec. 6. Effective January 1, 2000.)

14087.45. The provisions of this article shall not become operative until July 1, 1983, the date upon which the California Medical Assistance Commission, created pursuant to Assembly Bill 3480, assumes its full responsibilities.

(Added by Stats. 1982, Ch. 328, Sec. 18. Effective June 30, 1982. Section operative July 1, 1983, by its own provisions.)

14087.46. (a) The department shall implement a dental managed care program for Medi-Cal beneficiaries to achieve major cost savings, while ensuring access and quality of care, pursuant to this section.

(b) The department shall issue a request for proposals and award contracts on a competitive basis to one or more dental health care service contractors licensed 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) in each county or region that the department determines to be feasible. The department may contract with county organized health systems.

(c) To ensure access and continuity of care, the department shall award contracts to plans that agree to negotiate in good faith and subcontract with any provider who agrees to provide dental services to Medi-Cal beneficiaries at a reimbursement rate comparable to that paid by the plan to other participating providers. A plan shall contract whenever feasible with traditional and safety net providers of dental services to Medi-Cal beneficiaries. In evaluating the plans, the department shall assign favorable weighting to contractors that include traditional and safety net providers.

(d) The department shall implement a process to inform each Medi-Cal beneficiary of their choice of participating dentists and to allow a beneficiary to choose or change their participating dentist.

(e) The department shall make every effort to achieve operational contracts to place Medi-Cal beneficiaries in dental managed care by October 1, 1995. The department may determine which counties or categories of Medi-Cal beneficiaries are to be included in the dental managed care program. If the department has achieved one or more operational managed care contracts in a county or region, fee-for-service dental services shall not be an option for selection by a beneficiary, except that the department may provide for fee-for-service dental care if needed to ensure adequate access in rural or underserved areas, or for unique populations.

(f) The department shall require a participating plan to provide, at a minimum, the full scope of dental benefits pursuant to state and federal law.

(g) In order to achieve maximum cost savings, the Legislature hereby determines that an expedited contract process for contracts under this section is necessary. Therefore, contracts under this section shall be exempt from the Public Contract Code.

(h) A Medi-Cal beneficiary shall be able to receive their dental care from federally qualified health centers and rural health clinics certified pursuant to Public Law 95-210 that provide dental care in their service area. At the time of informing the Medi-Cal beneficiary of their choice of participating dentists, the beneficiary shall be informed of this option. Federally qualified health centers and rural health clinics shall continue to be reimbursed for dental services through the medical payment system in accordance with federal regulations.

(i) The department shall monitor the implementation of dental managed care, and for each of the first three years of implementation, shall annually evaluate the program on a county-by-county basis in terms of access, quality of care, and cost savings. The evaluation shall be provided to the Legislature within 120 days of the close of each of the three fiscal years.

(j) The department shall seek federal waivers necessary to allow for federal financial participation in the program implemented pursuant to this section. This article shall not be implemented unless and until the director has executed a declaration, to be retained by the director, that approval of all necessary federal waivers have been obtained by the department.

(k) Notwithstanding any other law, to the extent any necessary federal approvals are obtained, the department shall extend the dental managed care contracts, which are in effect on the effective date of the act that added this subdivision, for the provision of covered dental services authorized under this section pursuant to all of the following:

(1) These existing contracts shall be extended through December 31, 2023, or through the calendar day immediately preceding the effective date for the new dental managed care contracts described in paragraph (3), to the extent that effective date is later than January 1, 2024.

(2) Contract extensions shall be secured on a sole source basis.

(3) The department shall conduct a competitive bid and procurement process to award new dental managed care contracts, commencing on an effective date of January 1, 2024, subject to the department obtaining all necessary federal approvals for the contracts.

(4) If new dental managed care contracts have not taken effect on or before July 1, 2024, the department shall provide an update to the Legislature detailing the specific circumstances that contributed to the delay and an expected commencement date for the new contracts.

(5) Contracts entered into or amended pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

(l) 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, in whole or in part, by means of information notices, plan letters, or other similar instructions, without taking any further regulatory action.

(Amended by Stats. 2022, Ch. 47, Sec. 88. (SB 184) Effective June 30, 2022.)

14087.47. (a) The department may contract under this article with the Counties of Sonoma, Placer, and San Luis Obispo, which have been selected by the department through a request for proposal process, for the operation of a fee-for-service managed care program administered by the county through which primary care, specialty care, and case management are provided to residents of the county who are Medi-Cal eligible persons designated by the director.

(b) (1) Upon receipt of the necessary federal medicaid freedom of choice waivers, the department may, consistent with the federal waivers, assign to a fee-for-service managed care program residents of the county who are Medi-Cal eligible persons with Medi-Cal aid codes designated by the director. The department may require that assigned beneficiaries receive their Medi-Cal services and case management through the program.

(2) Medi-Cal eligible county residents who are dually eligible for Medi-Cal and Medicare benefits shall not, however, be assigned to a fee-for-service managed care program.

(3) Medi-Cal beneficiaries eligible for benefits through age, blindness, or disability, as defined in Title XVI of the Social Security Act (42 U.S.C. Sec. 1381 et. seq.) shall be assigned to a fee-for-service managed care program. However, each county participating in the program authorized by this section shall allow these beneficiaries to select a provider or providers of their choice and shall ensure that existing provider-patient relationships are permitted to continue.

(4) Services covered by the California Children's Services program shall not be incorporated into a fee-for-service managed care program in a manner that is inconsistent with Article 2.98 (commencing with Section 14094).

(5) A foster child may be enrolled voluntarily in a fee-for-service managed care program if the county director of social services, or his or her delegated representative, makes an individual determination that enrollment in a fee-for-service managed care program is in the best interest of the child. In determining what is in the best interest of the foster child, the county director of social services, or his or her delegated representative, shall consult with the child's caretaker, and shall include the decision of whether or not to enroll the child in a fee-for-service managed care program in the child's case plan provided for pursuant to subdivision (b) of Section 11400.

(c) Each contract entered into by the department under this section may have an initial term of up to three years. Contracts may be renewed for periods of up to three years upon a determination by the department that a contract is successful.

(d) The department shall periodically evaluate each fee-for-service managed care program through an independent assessment as required under the department's approved federal waiver request to determine if the program is successfully providing quality health care while not placing the Medi-Cal program or counties at additional financial risk. The assessment shall evaluate quality of care, access, the provision of preventive health care, and costs. The department shall terminate a contract when the department finds that the fee-for-service managed care program is unsuccessful.

(e) In order to ensure maximum cost effectiveness, the Legislature hereby determines that an expedited contract process for contracts entered into under this section between the department and the counties is necessary. Therefore, contracts under this article shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(f) Fee-for-service managed care program contractors shall ensure broad participation of primary care and other providers, including specialists, safety net and traditional Medi-Cal providers, in the program and shall contract with any primary care provider that agrees to provide services in accord with the same terms and conditions that the fee-for-service managed care program contractor requires of other primary care providers. To the extent possible, the fee-for-service managed care program contractor shall contract with primary care providers in a manner that minimizes the disruption of existing relationships between Medi-Cal eligible residents and their primary care providers.

(g) Medi-Cal eligible county residents in the aid codes designated by the director shall be informed about the fee-for-service managed care program through the health care options process established by the department in each county in which the program

is operated consistent with the health care options process authorized in other Medi-Cal managed care counties designated by the director.

(h) Designated Medi-Cal residents shall have the right to select a primary care provider from among the primary care providers contracting with the fee-for-service managed care program contractor and to change primary care providers. Covered Medi-Cal residents shall be informed of this right and the selection and change processes through the health care options process established in the county by the department consistent with the health care options process authorized in other Medi-Cal managed care counties designated by the director. The fee-for-service managed care program contractor shall also include this information in its membership materials.

(i) The board of supervisors of each county participating in the project authorized by this section shall establish or cause to be established an advisory committee comprised of county, physician, hospital, clinic, and beneficiary representatives to advise the county on the implementation and operation of the project provided for under this section.

(j) The department may adopt regulations to implement this section in accordance with the Administrative Procedure Act, Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The initial adoption of any emergency regulations implementing this section shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Initial emergency regulations adopted pursuant to this subdivision shall remain in effect for no more than 120 days.

(Amended by Stats. 1998, Ch. 834, Sec. 3. Effective January 1, 1999.)

14087.48. (a) For purposes of this section, “Medi-Cal managed care plan” means any individual, organization, or entity that enters into a contract with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), Article 2.9 (commencing with Section 14088), or Article 2.91 (commencing with Section 14089), or pursuant to Article 1 (commencing with Section 14200), or Article 7 (commencing with Section 14490) of Chapter 8.

(b) Before a Medi-Cal managed care plan commences operations based upon an action of the director that expands the geographic area of Medi-Cal managed care, the department shall perform an evaluation to determine the readiness of any affected Medi-Cal managed care plan to commence operations. The evaluation shall include, at a minimum, all of the following:

(1) The extent to which the Medi-Cal managed care plan demonstrates the ability to provide reliable service utilization and cost data, including, but not limited to, quarterly financial reports, audited annual reports, utilization reports of medical services, and encounter data.

(2) The extent to which the Medi-Cal managed care plan has an adequate provider network, including, but not limited to, the location, office hours, and language capabilities of primary care physicians and, if applicable, nonphysician medical practitioners, specialists, pharmacies, and hospitals, that the types of specialists in the provider network are based on the population makeup and particular geographic needs, and that whether requirements will be met for availability of services and travel distance standards, as set forth in Sections 53852 and 53885, respectively, of Title 22 of the California Code of Regulations.

(3) The extent to which the Medi-Cal managed care plan has developed procedures for the monitoring and improvement of quality of care, including, but not limited to, procedures for retrospective reviews which include patterns of practice reviews and drug prescribing practice reviews, utilization management mechanisms to detect both under- and over-utilization of health care services, and procedures that specify timeframes for medical authorization.

(4) The extent to which the Medi-Cal managed care plan has demonstrated the ability to meet accessibility standards in accordance with Section 1300.67.2 of Title 28 of the California Code of Regulations, including, but not limited to, procedures for appointments, waiting times, telephone procedures, after hours calls, urgent care, and arrangement for the provision of unusual specialty services.

(5) The extent to which the Medi-Cal managed care plan has met all standards and guidelines established by the department that demonstrate readiness to provide services to enrollees.

(6) The extent to which the Medi-Cal managed care plan has submitted all required contract deliverables to the department, including, but not limited to, quality improvement systems, utilization management, access and availability, member services, member grievance systems, and enrollments and disenrollments.

(7) The extent to which the Medi-Cal managed care plan’s Evidence of Coverage, Member Services Guide, or both, conforms to federal and state statutes and regulations, is accurate, and is easily understood.

(8) The extent to which the Medi-Cal managed care plan’s primary care and facility sites have been reviewed and evaluated by the department.

(Amended by Stats. 2013, Ch. 684, Sec. 3. (SB 494) Effective January 1, 2014.)