

Assembly Bill No. 2729

CHAPTER 834

An act to amend Sections 14087.3, 14087.4, 14087.47, 14087.55, 14088.18, 14088.6, 14089, 14089.8, 14139.13, 14204, 14499.5, and 14594 of the Welfare and Institutions Code, relating to Medi-Cal.

[Approved by Governor September 24, 1998. Filed
with Secretary of State September 25, 1998.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2729, Alquist. Medi-Cal: managed care provider payment rates.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Services, pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons.

Existing law authorizes the department to contract with various types of health care providers and entities in order to obtain Medi-Cal services through managed care arrangements. Existing law requires that various of those contracts are subject to the approval of the Department of Finance.

This bill would require that the department determine preliminary per capita payment rates for managed care plans and provide to them preliminary contract rates and source documents at least 60 days prior to the effective date of each new rate period.

The bill would require, on or before June 1, 1999, the department to enter into a memorandum of understanding with the managed care plans subject to these provisions regarding the development of capitation rates to ensure that capitation rates become effective in a timely manner and remain stable throughout the rate year. The bill would delete the requirement of approval by the Department of Finance of specified types of contracts.

The people of the State of California do enact as follows:

SECTION 1. Section 14087.3 of the Welfare and Institutions Code is amended to read:

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.

SEC. 2. Section 14087.4 of the Welfare and Institutions Code is amended to read:

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 Commissioner of Corporations 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.

SEC. 3. Section 14087.47 of the Welfare and Institutions Code is amended to read:

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.

SEC. 4. Section 14087.55 of the Welfare and Institutions Code is amended to read:

14087.55. (a) The department shall enter into contracts with counties under this article, and shall be bound by the rates, terms, and conditions negotiated by the negotiator.

(b) In implementing this article, the department may enter into contracts for the provision of essential administrative and other services.

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

SEC. 5. Section 14088.18 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

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

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

SEC. 6. Section 14088.6 of the Welfare and Institutions Code is amended to read:



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

SEC. 7. Section 14089 of the Welfare and Institutions Code is amended to read:

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

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

(1) Certification, where legally required, by the Commissioner of Corporations and the Insurance Commissioner.

(2) Compliance with all of the following:

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

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

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

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

(B) Enrollment in a Medi-Cal managed health care plan under this article shall be voluntary for beneficiaries eligible for the federal Supplemental Security Income for the Aged, Blind, and Disabled



Program (Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code).

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

(d) The department shall enter into contracts pursuant to this article, and shall be bound by the rates, terms, and conditions negotiated by the negotiator.

(e) (1) An eligible beneficiary shall be entitled to enroll in any health care plan contracted for pursuant to this article that is in effect for the geographic area in which he or she resides. Enrollment shall be for a minimum of six months. Contracts entered into pursuant to this article shall be for at least one but no more than three years. The director shall make available to recipients information summarizing the benefits and limitations of each health care plan available pursuant to this section in the geographic area in which the recipient resides.

(2) No later than 30 days following the date a Medi-Cal or AFDC recipient is informed of the health care options described in paragraph (1) of subdivision (e), the recipient shall indicate his or her choice in writing of one of the available health care plans and his or her choice of primary care provider or clinic contracting with the selected health care plan.

(3) The health care options information described in paragraph (1) of subdivision (e) shall include the following elements:

(A) Each beneficiary or eligible applicant shall be provided with the name, address, and telephone number of each primary care provider, by specialty, or clinic participating in each health care plan. The name, address, and telephone number of each specialist participating in each health care plan shall be made available by contacting the health care options contractor or the health care plan.

(B) 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 contracting with any of the health plans available and has the available capacity and agrees to continue to treat that beneficiary or eligible applicant.

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

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



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

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

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

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

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

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

(g) The negotiator and the department shall establish pilot projects to test the cost effectiveness of delivering benefits as defined in subdivisions (a) through (f).

(h) The California Medical Assistance Commission shall evaluate the cost effectiveness of these pilot projects after one year of implementation. Pursuant to this evaluation the commission may either terminate or retain the existing pilot projects.

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

(j) In implementing this article, the department may enter into contracts for the provision of essential administrative and other services. Contracts entered into under this subdivision may be on a



noncompetitive bid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

SEC. 8. Section 14089.8 of the Welfare and Institutions Code is amended to read:

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

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

SEC. 9. Section 14139.13 of the Welfare and Institutions Code is amended to read:

14139.13. (a) Any contract entered into pursuant to this article may be renewed if the long-term care services agency continues to meet the requirements of this article 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 corrections of any deficiencies.

(b) The department may terminate or decline to renew a contract in whole or in part when the director determines that the action is necessary to protect the health of the beneficiaries or the funds appropriated to the Medi-Cal program. The administrative hearing requirements of Section 14123 do not apply to the nonrenewal or termination of a contract under this article.

(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 Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(d) The Commissioner of Corporations shall, at the director's request, immediately grant an exemption from Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code for purposes of carrying out any contract entered into pursuant to this article.

SEC. 10. Section 14204 of the Welfare and Institutions Code is amended to read:

14204. (a) Pursuant to the provisions of this chapter, the department may contract with one or more prepaid health plans in order to provide the benefits authorized under this chapter and Chapter 7 (commencing with Section 14000) of this part. The department may contract with one or more children's hospitals on an exclusive basis for a specified population in a specified geographic area. Contracts entered into pursuant to this chapter may be awarded on a bid or nonbid basis.



(b) In order to achieve maximum cost savings the Legislature hereby determines that expedited contract process for contracts under this chapter is necessary. Therefore, contracts under this chapter shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

SEC. 11. Section 14499.5 of the Welfare and Institutions Code is amended to read:

14499.5. (a) (1) In carrying out the intent of this article, the director shall contract for the operation of one local pilot program. Special consideration shall be given to approving a program contracted through county government in Santa Barbara County.

(2) Notwithstanding the limitations contained in Section 14490, the director may enter into, or extend, contracts with the local pilot program in Santa Barbara County pursuant to paragraph (1) for periods that do not exceed three years.

(b) The establishment of a pilot program pursuant to this section shall be contingent upon the availability of state and federal funding. The program shall include the following components:

(1) Local authority for administration, fiscal management, and delivery of services, but not including eligibility determination.

(2) Physician case management.

(3) Cost containment through provider incentives and other means.

(c) The program for the pilot project shall include a plan and budget for delivery of services, administration, and evaluation. During the first year of the pilot program, the amount of the state contract shall equal 95 percent of total projected Medi-Cal expenditures for delivery of services and for administration based on fee-for-service conditions in the program county. During the remaining years of the pilot project Medi-Cal expenditures in the program county shall be no more than 100 percent of total projected expenditures for delivery of services and for administration based on any combination of the following paragraphs:

(1) Relevant prior fee-for-service Medi-Cal experience in the program county.

(2) The fee-for-service Medi-Cal experience in comparable counties or groups of counties.

(3) Medi-Cal experience of the pilot project in the program county if, as determined by the department, the scope, level, and duration of, and expenditures for, any services used in setting the rates under this paragraph would be comparable to fee-for-service conditions were they to exist in the program county and would be more actuarially reliable for use in ratesetting than data available for use in applying paragraph (1) or (2).

The projected total expenditure shall be determined annually according to an acceptable actuarial process. The data elements used by the department shall be shared with the proposed contractor.



(d) The director shall accept or reject the proposal within 30 days after the date of receipt. If a decision is made to reject the proposal, the director shall set forth the reasons for this decision in writing. Upon approval of the proposal, a contract shall be written within 60 days. After signature by the local contractor, the State Department of Health Services and the Department of General Services shall execute the contract within 60 days.

(e) The director shall seek the necessary state and federal waivers to enable operation of the program. If the federal waivers for delivery of services under this plan are not granted, the department is under no obligation to contract for implementation of the program.

(f) For purposes of Section 1343 of the Health and Safety Code, the Santa Barbara Regional Health Authority shall be considered to be a county-operated pilot program contracting with the State Department of Health Services pursuant to this article, and notwithstanding any other provision of law, during the period that this contract is in effect, the contractor shall be exempt from the provisions of 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, relative to the services provided to Medi-Cal beneficiaries under the terms and provisions of the pilot program.

(g) Dental services may be included within the services provided in this pilot program.

(h) Any federal demonstration funding for this pilot program shall be made available to the county within 60 days upon notification of the award without the state retaining any portion not previously specified in the grant application as submitted.

(i) (1) (A) Commencing January 1, 1996, the California Medical Assistance Commission may negotiate exclusive contracts and rates on behalf of the department with the Santa Barbara Regional Health Authority in the implementation of this section.

(B) Contracts entered into under this article may be on a noncompetitive bid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code. These contracts shall have no force or effect unless approved by the Department of Finance.

(C) The department shall enter into contracts pursuant to this article, and shall be bound by the terms and conditions related to the rates negotiated by the negotiator.

(2) The department shall implement this subdivision to the extent that the following apply:

(A) Its implementation does not revise the status of the pilot program as a federal demonstration project.

(B) Existing federal waivers apply to the pilot program as revised by this subdivision, or the federal government extends the applicability of the existing federal waivers or authorizes additional federal waivers for the implementation of the program.



(3) The implementation of this subdivision shall not affect the pilot program's having met any of the requirements of Part 3.5 (commencing with Section 1175) of Division 1 of the Health and Safety Code and this division applicable to the pilot program with respect to the negotiations of contracts and rates by the department.

(j) An independent evaluation of the program shall be conducted and a report submitted to the Legislature and the director by January 1, 1988. The independent evaluation of the program commissioned by the federal Health Care Financing Administration may fulfill the purposes of this part. This evaluation and report shall include, but is not limited to, the following:

(1) An assessment of the cost of medical services as compared to the cost of the existing Medi-Cal fee-for-service delivery mode.

(2) An assessment of utilization levels of specialist and emergency services.

(3) An assessment of the quality of care.

(4) Recommendations for future policy on delivery of services.

SEC. 12. Section 14594 of the Welfare and Institutions Code is amended to read:

14594. Contracts under this chapter may 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.

