

AMENDED IN ASSEMBLY JUNE 27, 2007

AMENDED IN SENATE APRIL 30, 2007

**SENATE BILL**

**No. 840**

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**Introduced by Senator Kuehl**

**(Principal coauthors: Senators Alquist, Corbett, Migden, and Yee)**

(Principal coauthors: Assembly Members Bass and Hancock, *Hancock, and Leno*)

**(Coauthors: Senators Cedillo, Florez, Lowenthal, Oropeza, Padilla, Perata, Ridley-Thomas, Romero, Steinberg, and Wiggins)**

(Coauthors: Assembly Members Alarcon, Beall, Berg, Brownley, Coto, ~~Dymally~~, *Caballero, Coto, De Leon, DeSaulnier, Dymally, Eng, Evans, Feuer, Hayashi, Huffman, Jones, Krekorian, Laird, Levine, Lieber, Lieu, Ma, Mullin, Nava, Nunez, Swanson, and Torrico*)

February 23, 2007

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An act to add Division 113 (commencing with Section 140000) to the Health and Safety Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 840, as amended, Kuehl. Single-payer health care coverage.

Existing law does not provide a system of universal health care coverage for California residents. Existing law provides for the creation of various programs to provide health care services to persons who have limited incomes and meet various eligibility requirements. These programs include the Healthy Families Program administered by the Managed Risk Medical Insurance Board, and the Medi-Cal program administered by the State Department of Health Care Services. Existing law provides for the regulation of health care service plans by the Department of Managed Health Care and health insurers by the Department of Insurance.

This bill would establish the California ~~Universal~~ Healthcare System to be administered by the newly created California ~~Universal~~ Healthcare Agency under the control of a ~~Universal~~ Healthcare Commissioner appointed by the Governor and subject to confirmation by the Senate. The bill would make all California residents eligible for specified health care benefits under the California ~~Universal~~ Healthcare System, which would, on a single-payer basis, negotiate for or set fees for health care services provided through the system and pay claims for those services. *The bill would provide that a resident of the state with a household income, as specified, at or below 200% of the federal poverty level would be eligible for the type of benefits provided under the Medi-Cal program.* The bill would require the commissioner to seek all necessary waivers, exemptions, agreements, or legislation to allow various existing federal, state, and local health care payments to be paid to the California ~~Universal~~ Healthcare System, which would then assume responsibility for all benefits and services previously paid for with those funds.

The bill would create the ~~Universal~~ Healthcare Policy Board to establish policy on medical issues and various other matters relating to the system. The bill would create the Office of Patient Advocacy within the agency to represent the interests of health care consumers relative to the system. The bill would create within the agency the Office of Health Planning to plan for the health care needs of the population, and the Office of Health Care Quality, headed by a chief medical officer, to support the delivery of high quality care and promote provider and patient satisfaction. The bill would create the Office of Inspector General for the California ~~Universal~~ Healthcare System within the Attorney General's office, which would have various oversight powers. The bill would prohibit health care service plan contracts or health insurance policies from being issued for services covered by the California ~~Universal~~ Healthcare System. The bill would create the ~~Universal~~ Healthcare Fund and the Payments Board to administer the finances of the California ~~Universal~~ Healthcare System. The bill would create the California ~~Universal~~ Healthcare Premium Commission (Premium Commission) to determine the cost of the California ~~Universal~~ Healthcare System and to develop a premium structure for the system that complies with specified standards. The bill would require the Premium Commission to recommend a premium structure to the Governor and Legislature on or before January 1, 2010, and to make a draft recommendation to the Governor, the Legislature, and the public 90 days before submitting its final premium structure recommendation.

The bill would specify that only its provisions relating to the Premium Commission would become operative on January 1, 2008, with its remaining provisions becoming operative on the date the Secretary of California Health and Human Services notifies the Legislature, as specified, that sufficient funding exists to implement the California Universal Healthcare System. The bill would require that system to be operative within 2 years of that date and would provide for various transition processes for that period.

The bill would extend the application of certain insurance fraud laws to providers of services and products under the system, thereby imposing a state-mandated local program by revising the definition of a crime. The bill would enact other related provisions relative to budgeting, regional entities, federal preemption, subrogation, collective bargaining agreements, compensation of health care providers, conflict of interest, patient grievances, independent medical review, and associated matters.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: yes.

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

1 SECTION 1. Division 113 (commencing with Section 140000)  
2 is added to the Health and Safety Code, to read:

3  
4 DIVISION 113. CALIFORNIA UNIVERSAL HEALTHCARE  
5 ACT

6  
7 CHAPTER 1. GENERAL PROVISIONS

8  
9 140000. There is hereby established in state government the  
10 California—Universal Healthcare System, which shall be  
11 administered by the California—Universal Healthcare Agency, an  
12 independent agency under the control of the—Universal Healthcare  
13 Commissioner.

14 140000.6. No health care service plan contract or health  
15 insurance policy, except for the California—Universal Healthcare

1 System plan, may be sold in California for services provided by  
2 the system.

3 140001. This division shall be known and may be cited as the  
4 California Universal Healthcare Act.

5 140002. This division shall be liberally construed to accomplish  
6 its purposes.

7 140003. The California-Universal Healthcare Agency is hereby  
8 created and designated as the single state agency with full power  
9 to supervise every phase of the administration of the California  
10 Universal Healthcare System and to receive grants-in-aid made  
11 by the United States government, by the state, or by other sources  
12 in order to secure full compliance with the applicable provisions  
13 of state and federal law.

14 140004. The California-Universal Healthcare Agency shall be  
15 comprised of the following entities:

16 (a) The-Universal Healthcare Policy Board.

17 (b) The Office of Patient Advocacy.

18 (c) The Office of Health Planning.

19 (d) The Office of Health Care Quality.

20 (e) The-Universal Healthcare Fund.

21 (f) The Public Advisory Committee.

22 (g) The Payments Board.

23 (h) Partnerships for Health.

24 140005. The Legislature finds and declares all of the following:

25 (a) An estimated 6.5 million Californians lacked health care  
26 coverage at some time in 2004, including one in every five  
27 nonelderly Californians.

28 (b) Health care spending continues to grow much faster than  
29 the economy, and efforts to control health care costs and the growth  
30 of health care spending have been unsuccessful.

31 (c) On average, the United States spends more than twice as  
32 much as all other industrial nations on health care, both per person  
33 and as a percentage of its gross domestic product.

34 (d) A majority of California residents and businesses support a  
35 system of universal publicly financed health care.

36 (e) Consumers can no longer rely on traditional health care  
37 coverage due to a continuous decline of employer-offered coverage,  
38 unstable employment trends, uncontrolled increases in the amount  
39 of premiums and cost sharing, and increases in benefit gaps.

1 (f) As a result, one-half of all bankruptcies in the United States  
2 now relate to medical costs, though three-fourths of bankrupt  
3 families had health care coverage at the time of sustaining the  
4 injury or illness.

5 (g) Health insurance companies have ~~no~~ *insufficient* business  
6 motive to provide comprehensive and affordable health care  
7 coverage to residents who are likely to require health care services,  
8 including seniors, disabled residents, residents with or at risk of  
9 developing a chronic illness, and women of child-bearing age.

10 (h) Health care quality is rapidly declining, and the United States  
11 Institute of Medicine has declared an epidemic of substandard  
12 health care throughout the nation.

13 (i) The World Health Organization ranks the United States below  
14 all other industrial nations and 37th overall in population-based  
15 health outcomes.

16 (j) Recent emergencies in the South and growing fears of disease  
17 pandemics, underscore the critical importance of a regular source  
18 of health care for all residents and systemwide health care planning  
19 to ensure disaster and emergency preparedness.

20 (k) Growing epidemics of chronic diseases such as diabetes,  
21 obesity, and asthma require a system of universal health care and  
22 a continuous source of health care for all residents in order to  
23 adequately address the health care needs of all residents.

24 (l) Severe health access disparities exist by region, ethnicity,  
25 income, and gender. These disparities destabilize the overall health  
26 care system throughout the state and reflect a lack of effective  
27 health care planning.

28 (m) Inadequate access to a regular source of care has caused  
29 uninsured and underinsured patients to seek treatment in emergency  
30 facilities for conditions that could have been treated more  
31 appropriately in a nonemergency setting.

32 (n) Emergency departments and trauma centers face growing  
33 financial losses, and uncompensated hospital care totaled over one  
34 billion dollars (\$1,000,000,000) in 2000. The burden for providing  
35 uncompensated care falls disproportionately on a minority of  
36 hospitals in California and leads to significant financial instability  
37 for the overall health care system.

38 (o) Multiple quantitative analyses indicate that under a single  
39 payer health care coverage system, the amount currently spent for  
40 health care is more than adequate to finance comprehensive high

1 quality health care coverage for every resident of the state while  
2 guaranteeing the right of every resident to choose his or her own  
3 physician.

4 (p) According to these reports and numerous other studies, by  
5 simplifying administration, achieving bulk purchase discounts on  
6 pharmaceuticals, reducing the use of emergency facilities for  
7 primary care, and carefully managing health care capital  
8 investment, California could divert billions of dollars toward  
9 providing direct health care and improve the quality of, and access  
10 to, that care.

11 140005.1 (a) It is the intent of the Legislature to establish a  
12 system of universal health care coverage in this state that provides  
13 all residents with comprehensive health care benefits, guarantees  
14 a single standard of care for all residents, stabilizes the growth in  
15 health care spending, and improves the quality of health care for  
16 all residents.

17 (b) It is the intent of the Legislature that, in order to ensure an  
18 adequate supply and distribution of direct care providers in the  
19 state, a just and fair return for providers electing to be compensated  
20 by the health care system, and a uniform system of payments, the  
21 state shall actively supervise and regulate a system of payments  
22 whereby groups of fee-for-service physicians are authorized to  
23 select representatives of their specialties to negotiate with the  
24 health care system, pursuant to Section 140209. Nothing in this  
25 division shall be construed to allow collective action against the  
26 health care system.

27 140006. This division shall have all of the following purposes:

28 (a) To provide affordable and comprehensive health care  
29 coverage with a single standard of care for all California residents.

30 (b) To control health care costs and the growth of health care  
31 spending, subject to the obligation described in subdivision (a).

32 (c) To achieve measurable improvement in the quality of care  
33 and the efficiency of care delivery.

34 (d) To prevent disease and disability and to improve or maintain  
35 health and functionality.

36 (e) To increase health care provider, consumer, employee, and  
37 employer satisfaction with the health care system.

38 (f) To implement policies that strengthen and improve culturally  
39 and linguistically sensitive care and sensitive care provided to  
40 disabled persons.

1 (g) To develop an integrated population-based health care  
2 database to support health care planning.

3 (h) To provide information and care in an appropriate and  
4 accessible format.

5 140007. As used in this division, the following terms have the  
6 following meanings:

7 (a) “Agency” means the California—~~Universal~~ Healthcare  
8 Agency.

9 (b) “Clinic” means an organized outpatient health facility that  
10 provides direct medical, surgical, dental, optometric, or podiatric  
11 advice, services, or treatment to patients who remain less than 24  
12 hours, and that may also provide diagnostic or therapeutic services  
13 to patients in the home as an alternative to care provided at the  
14 clinic facility, and includes those facilities defined under Sections  
15 1200 and 1200.1.

16 (c) “Commissioner” means the—~~Universal~~ Healthcare  
17 Commissioner.

18 (d) “Direct care provider” means any licensed health care  
19 professional that provides health care services through direct  
20 contact with the patient, either in person or using approved  
21 telemedicine modalities as identified in Section 2290.5 of the  
22 Business and Professions Code.

23 (e) “Essential community provider” means a health facility that  
24 has served as part of the state’s health care safety net for low  
25 income and traditionally underserved populations in California  
26 and that is one of the following:

27 (1) A “community clinic” as defined under subparagraph (A)  
28 of paragraph (1) of subdivision (a) of Section 1204.

29 (2) A “free clinic” as defined under subparagraph (B) of  
30 paragraph (1) of subdivision (a) of Section 1204.

31 (3) A “federally qualified health center” as defined under Section  
32 1395x (aa)(4) or 1396d (l)(2) of Title 42 of the United States Code.

33 (4) A “rural health clinic” as defined under Section 1395x (aa)(2)  
34 or 1396d (l)(1) of Title 42 of the United States Code.

35 (5) Any clinic conducted, maintained, or operated by a federally  
36 recognized Indian tribe or tribal organization, as defined in Section  
37 1603 of Title 25 of the United States Code.

38 (6) Any clinic exempt from licensure under subdivision (h) of  
39 Section 1206.

1 (f) “Health care provider” means any professional person,  
2 medical group, independent practice association, organization,  
3 health facility, or other person or institution licensed or authorized  
4 by the state to deliver or furnish health care services.

5 (g) “Health facility” means any facility, place, or building that  
6 is organized, maintained, and operated for the diagnosis, care,  
7 prevention, and treatment of human illness, physical or mental,  
8 including convalescence and rehabilitation and including care  
9 during and after pregnancy, or for any one or more of these  
10 purposes, for one or more persons, and includes those facilities  
11 defined under subdivision (b) of Section 15432 of the Government  
12 Code.

13 (h) “Hospital” means all health facilities to which persons may  
14 be admitted for a 24-hour stay or longer, as defined in Section  
15 1250, with the exception of nursing, skilled nursing, intermediate  
16 care, and congregate living health facilities.

17 (i) “Integrated health care delivery system” means a provider  
18 organization that meets ~~at~~ *both* of the following criteria:

19 (1) Is fully integrated operationally and clinically to provide a  
20 broad range of health care services, including preventative care,  
21 prenatal and well-baby care, immunizations, screening diagnostics,  
22 emergency services, hospital and medical services, surgical  
23 services, and ancillary services.

24 (2) Is compensated using capitation or facility budgets, except  
25 for copayments, for the provision of health care services.

26 ~~(3) Provides health care services primarily through direct care  
27 providers who are either employees or partners of the organization,  
28 or through arrangements with direct care providers or one or more  
29 groups of physicians, organized on a group practice or individual  
30 practice basis.~~

31 (j) “Large employer” means a person, firm, proprietary or  
32 nonprofit corporation, partnership, public agency, or association  
33 that is actively engaged in business or service, that, on at least 50  
34 percent of its working days during the preceding calendar year  
35 employed at least 50 employees, or, if the employer was not in  
36 business during any part of the preceding calendar year, employed  
37 at least 50 employees on at least 50 percent of its working days  
38 during the preceding calendar quarter.

39 (k) “Premium Commission” means the California ~~Universal~~  
40 Healthcare Premium Commission.



1 (l) “Primary care provider” means a direct care provider that is  
2 a family physician, internist, general practitioner, pediatrician, an  
3 ~~obstetrician/gynecologist~~ *obstetrician-gynecologist*, or a family  
4 nurse practitioner or physician assistant practicing under  
5 supervision as defined in California codes or essential community  
6 providers who employ primary care providers.

7 (m) “Small employer” means a person, firm, proprietary or  
8 nonprofit corporation, partnership, public agency, or association  
9 that is actively engaged in business or service and that, on at least  
10 50 percent of its working days during the preceding calendar year  
11 employed at least two but no more than 49 employees, or, if the  
12 employer was not in business during any part of the preceding  
13 calendar year, employed at least two but no more than 49 eligible  
14 employees on at least 50 percent of its working days during the  
15 preceding calendar quarter.

16 (n) “System” means the California ~~Universal~~ Healthcare System.  
17 140008. The definitions contained in Section 140007 shall  
18 govern the construction of this division, unless the context requires  
19 otherwise.

20  
21 CHAPTER 2. GOVERNANCE  
22

23 140100. (a) (1) The commissioner shall be appointed by the  
24 Governor on or before March 1, 2008, subject to confirmation by  
25 the Senate. If in session, the Senate shall act on the appointment  
26 within 30 days of the appointment date. If the Senate does not act  
27 on the appointment within that period, the nominee shall be deemed  
28 confirmed and may take office. If the Senate is not in session at  
29 the time of the appointment, the Senate shall act on the appointment  
30 within 30 days of the commencement of the next legislative  
31 session. If the Senate does not act on the appointment within that  
32 period, the appointee shall be deemed confirmed and may take  
33 office.

34 (2) If the Senate by a vote fails to confirm the nominee for  
35 commissioner, the Governor shall make a new appointment within  
36 30 days of the Senate’s vote. The appointment is subject to  
37 confirmation by the Senate, and the procedures described in  
38 paragraph (1) shall apply to the confirmation process.

1 (b) The commissioner is exempt from the State Civil Service  
2 Act (Part 2 (commencing with Section 18500) of Division 5 of  
3 Title 2 of the Government Code).

4 (c) The commissioner may not be a state legislator or a Member  
5 of the United States Congress while holding the position of  
6 commissioner.

7 (d) The commissioner shall not have been employed in any  
8 capacity by a for-profit insurance, pharmaceutical, or medical  
9 equipment company that sells products to the system for a period  
10 of two years prior to appointment as commissioner.

11 (e) For two years after completing service in the system, the  
12 commissioner may not receive payments of any kind from, or be  
13 employed in any capacity or act as a paid consultant to, a for-profit  
14 insurance, pharmaceutical, or medical equipment company that  
15 sells products to the system.

16 (f) The compensation and benefits of the commissioner shall  
17 be established by the California Citizens Compensation  
18 Commission in accordance with Section 8 of Article III of the  
19 California Constitution.

20 (g) The commissioner shall be subject to Title 9 (commencing  
21 with Section 81000) of the Government Code.

22 140101. (a) The commissioner shall be the chief officer of the  
23 agency and shall administer all aspects of the agency.

24 (b) The commissioner shall be responsible for the performance  
25 of all duties, the exercise of all power and jurisdiction, and the  
26 assumption and discharge of all responsibilities vested by law in  
27 the agency. The commissioner shall perform all duties imposed  
28 upon him or her by this division and other laws related to health  
29 care, and shall enforce the execution of those related to the system,  
30 and shall enforce the execution of those provisions and laws to  
31 promote their underlying aims and purposes. These broad powers  
32 shall include, but are not limited to, the power to establish the  
33 system's budget and to set rates, to establish the system's goals,  
34 standards, and priorities, to hire, fire, and fix the compensation of  
35 agency personnel, to make allocations and reallocations to the  
36 health planning regions, and to promulgate generally binding  
37 regulations concerning any and all matters related to the  
38 implementation of this division and its purposes.

39 (c) The commissioner shall appoint a deputy commissioner, the  
40 Director of the ~~Universal~~ Healthcare Fund, the patient advocate

1 of the Office of Patient Advocacy, the chief medical officer, the  
2 Director of the Payments Board, the Director of the Office of  
3 Health Planning, the Director of the Partnerships for Health, the  
4 regional health planning directors, the chief enforcement counsel,  
5 and legal counsel in any action brought by or against the  
6 commissioner under or pursuant to any provision of any law under  
7 the commissioner’s jurisdiction, or in which the commissioner  
8 joins or intervenes as to a matter within the commissioner’s  
9 jurisdiction, as a friend of the court or otherwise, and stenographic  
10 reporters to take and transcribe the testimony in any formal hearing  
11 or investigation before the commissioner or before a person  
12 authorized by the commissioner.

13 (d) The commissioner, in accordance with the State Civil Service  
14 Act (Part 2 (commencing with Section 18500) of Division 5 of  
15 Title 2 of the Government Code), may appoint and fix the  
16 compensation of clerical, inspection, investigation, evaluation, and  
17 auditing personnel as may be necessary to implement this division.

18 (e) The personnel of the agency shall perform duties as assigned  
19 to them by the commissioner. The commissioner shall designate  
20 certain employees by the rule or order that are to take and subscribe  
21 to the constitutional oath within 15 days after their appointments,  
22 and to file that oath with the Secretary of State. The commissioner  
23 shall also designate those employees that are to be subject to Title  
24 9 (commencing with Section 81000) of the Government Code.

25 (f) The commissioner shall adopt a seal bearing the inscription:  
26 “Commissioner, California ~~Universal~~ Healthcare Agency, State  
27 of California.” The seal shall be affixed to or imprinted on all  
28 orders and certificates issued by him or her and other instruments  
29 as he or she directs. All courts shall take notice of this seal.

30 (g) The administration of the agency shall be supported from  
31 the ~~Universal~~ Healthcare Fund created pursuant to Section 140200.

32 (h) The commissioner, as a general rule, shall publish or make  
33 available for public inspection any information filed with or  
34 obtained by the agency, unless the commissioner finds that this  
35 availability or publication is contrary to law. No provision of this  
36 division authorizes the commissioner or any of the commissioner’s  
37 assistants, clerks, or deputies to disclose any information withheld  
38 from public inspection except among themselves or when necessary  
39 or appropriate in a proceeding or investigation under this division  
40 or to other federal or state regulatory agencies. No provision of

1 this division either creates or derogates from any privilege that  
2 exists at common law or otherwise when documentary or other  
3 evidence is sought under a subpoena directed to the commissioner  
4 or any of his or her assistants, clerks, and deputies.

5 (i) It is unlawful for the commissioner or any of his or her  
6 assistants, clerks, or deputies to use for personal benefit any  
7 information that is filed with, or obtained by, the commissioner  
8 and that is not then generally available to the public.

9 (j) The commissioner shall avoid political activity that may  
10 create the appearance of political bias or impropriety. Prohibited  
11 activities shall include, but not be limited to, leadership of, or  
12 employment by, a political party or a political organization; public  
13 endorsement of a political candidate; contribution of more than  
14 five hundred dollars (\$500) to any one candidate in a calendar year  
15 or a contribution in excess of an aggregate of one thousand dollars  
16 (\$1,000) in a calendar year for all political parties or organizations;  
17 and attempting to avoid compliance with this prohibition by making  
18 contributions through a spouse or other family member.

19 (k) The commissioner shall not participate in making or in any  
20 way attempt to use his or her official position to influence a  
21 governmental decision in which he or she knows or has reason to  
22 know that he or she or a family or a business partner or colleague  
23 has a financial interest.

24 (l) The commissioner, in pursuit of his or her duties, shall have  
25 unlimited access to all nonconfidential and all nonprivileged  
26 documents in the custody and control of the agency.

27 (m) The Attorney General shall render to the commissioner  
28 opinions upon all questions of law, relating to the construction or  
29 interpretation of any law under the commissioner's jurisdiction or  
30 arising in the administration thereof, that may be submitted to the  
31 Attorney General by the commissioner and upon the  
32 commissioner's request shall act as the attorney for the  
33 commissioner in actions and proceedings brought by or against  
34 the commissioner or under or pursuant to any provision of any law  
35 under the commissioner's jurisdiction.

36 140102. The commissioner shall do all of the following:

37 (a) Oversee the establishment, as part of the administration of  
38 the agency, of all of the following:

39 (1) The ~~Universal~~ Healthcare Policy Board, pursuant to Section  
40 140103.

- 1 (2) The Office of Patient Advocacy, pursuant to Section 140105.
- 2 (3) The Office of Health Planning, pursuant to Section 140602.
- 3 (4) The Office of ~~Health Care~~ *Healthcare* Quality, pursuant to
- 4 Section 140605.
- 5 (5) The ~~Universal~~ Healthcare Fund, pursuant to Section 140200.
- 6 (6) The Public Advisory Committee, pursuant to Section 140104.
- 7 (7) The Payments Board, pursuant to Section 140208.
- 8 (8) Partnerships for Health.
- 9 (b) Determine goals, standards, guidelines, and priorities for
- 10 the system.
- 11 (c) Establish health planning regions, pursuant to Section
- 12 140112.
- 13 (d) Oversee the establishment of locally based integrated service
- 14 networks, including those that provide services through medical
- 15 technologies such as telemedicine, that include physicians in
- 16 fee-for-service, solo and group practice, essential community, and
- 17 ancillary care providers and facilities in order to pool and align
- 18 resources and form interdisciplinary teams that share responsibility
- 19 and accountability for patient care and provide a continuum of
- 20 coordinated high quality primary to tertiary care to all California
- 21 residents while preserving patient choice. This shall be
- 22 accomplished in collaboration with the chief medical officer, the
- 23 Director of the Office of Health Planning, the regional medical
- 24 officers, the regional planning boards, and the patient advocate.
- 25 (e) Annually assess projected revenues and expenditures to
- 26 assure financial solvency of the system.
- 27 (f) Develop the system's budget pursuant to Section 140206 to
- 28 ensure adequate funding to meet the health care needs of the
- 29 population. Review all budgets and allocations annually to ensure
- 30 they address disparities in service availability and health care
- 31 outcomes and for sufficiency of rates, fees, and prices.
- 32 (g) Establish a capital management framework for the system
- 33 pursuant to Section 140216, including, but not limited to, a
- 34 standardized process and format for the development and
- 35 submission of regional operating and regional capital budget
- 36 requests and ensure a smooth transition to system oversight.
- 37 (h) Establish standards and criteria for the development and
- 38 submission of provider operating and capital budget requests.

1 (i) Establish standards and criteria for the allocation of funds  
2 from the ~~Universal~~ Healthcare Fund as described in Chapter 3  
3 (commencing with Section 140200).

4 (j) During transition and annually thereafter, determine the  
5 appropriate level for a reserve fund for the system and implement  
6 policies needed to establish the appropriate reserve.

7 (k) Establish an enrollment system that ensures all eligible  
8 California residents, including those who travel out-of-state; those  
9 who have disabilities that limit their mobility, hearing, or vision  
10 or their mental or cognitive capacity; those who cannot read; and  
11 those who do not speak or write English are aware of their right  
12 to health care and are formally enrolled in the system. The  
13 commissioner may contract with a third party for eligibility and  
14 enrollment services if the commissioner finds that doing so would  
15 meet the system's goals and standards, and result in greater  
16 efficiency and cost savings to the system.

17 (l) Establish an electronic claims and payments system for the  
18 system where all claims under the system shall be filed and paid,  
19 and implement, to the extent permitted by federal law, standardized  
20 claims and reporting methods. The commissioner may contract  
21 with a third party for claims and payment services if the  
22 commissioner finds that doing so would meet the system's goals  
23 and standards, and result in greater efficiency and cost savings to  
24 the system.

25 (m) Establish a system of secure electronic medical records that  
26 comply with state and federal privacy laws and that are compatible  
27 across the system.

28 (n) Establish an electronic referral system that is accessible to  
29 providers and to patients.

30 (o) Establish standards based on clinical efficacy to guide  
31 delivery of care and a process to identify areas where no such  
32 standards exist, set priorities and a timetable for their development,  
33 and ensure a smooth transition to clinical ~~decisionmaking~~ *decision*  
34 *making* under statewide standards.

35 (p) Implement policies to ensure that all Californians receive  
36 culturally and linguistically sensitive care, pursuant to Section  
37 140604, and that all disabled Californians receive care in  
38 accordance with the federal Americans with Disabilities Act (42  
39 U.S.C. Sec. 12101 et seq.) and Section 504 of the Rehabilitation  
40 Act of 1973 (29 U.S.C. Sec. 794) and develop mechanisms and

1 incentives to achieve these purposes and a means to monitor the  
2 effectiveness of efforts to achieve these purposes.

3 (q) Create a systematic approach to the measurement,  
4 management, and accountability for care quality that assures the  
5 delivery of high quality care to all California residents, including  
6 a system of performance contracts that contain measurable goals  
7 and outcomes.

8 (r) Establish and maintain appropriate statewide and regional  
9 health care databases.

10 (s) Establish standards for mandatory reporting by health care  
11 providers and penalties for failure to report.

12 (t) Develop methods and a framework to measure the  
13 performance of health care coverage and health delivery system  
14 upper level managers, including a system of performance contracts  
15 that contain measurable goals and outcomes.

16 (u) Implement policies to ensure that all residents of this state  
17 have access to medically appropriate, coordinated mental health  
18 services.

19 (v) Ensure the establishment of policies that support the public  
20 health.

21 (w) Ensure that the system's policies and providers support all  
22 Californians in achieving and maintaining maximum physical and  
23 mental functionality.

24 (x) Institute necessary cost controls pursuant to Section 140203  
25 to assure financial solvency of the system.

26 (y) Meet regularly with the chief medical officer, the patient  
27 advocate for the Office of Patient Advocacy, the Public Advisory  
28 Committee, the Director of the Office of Health Planning, the  
29 Director of the Payments Board, the Director of the Partnerships  
30 for Health, ~~the Technology Advisory Committee~~, regional planning  
31 directors, and regional medical officers to review the impact of  
32 the agency and its policies on the health of the population and on  
33 satisfaction with the system.

34 (z) Negotiate for or set rates, fees, and prices involving any  
35 aspect of the system and establish procedures thereto.

36 (aa) Establish a formulary based on clinical efficacy for all  
37 prescription drugs and durable and nondurable medical equipment  
38 for use by the system.

- 1 (bb) Establish guidelines for prescribing medications, nutritional  
2 supplements, and durable medical equipment that are not included  
3 in the system's formularies.
- 4 (cc) Utilize the purchasing power of the state to negotiate price  
5 discounts for prescription drugs and durable and nondurable  
6 medical equipment for use by the system.
- 7 (dd) Ensure that use of state purchasing power achieves the  
8 lowest possible prices for the system without adversely affecting  
9 needed pharmaceutical research.
- 10 (ee) Create incentives and guidelines for research needed to  
11 meet the goals of the system and disincentives for research that  
12 does not achieve the system goals.
- 13 (ff) Implement eligibility standards for the system, including  
14 guidelines to prevent an influx of persons to the state for the  
15 purpose of obtaining medical care.
- 16 (gg) Determine an appropriate level of, and provide support  
17 during the transition for, training and job placement for persons  
18 who are displaced from employment as a result of the initiation of  
19 the system.
- 20 (hh) Oversee the establishment of a system for resolution of  
21 disputes pursuant to Sections 140608 and 140610.
- 22 ~~(ii) Establish a Technology Advisory Committee to evaluate  
23 the cost and effectiveness of new medical technology, including  
24 electronic medical technology, and to make recommendations  
25 about the financial and health impact of its inclusion in the benefit  
26 package.~~
- 27 (ii) *[Reserved.]*
- 28 (jj) Investigate the costs and benefits to the health of the  
29 population of advances in information technology, including those  
30 that support data collection, analysis, and distribution.
- 31 (kk) Ensure that consumers of health care have access to  
32 information needed to support their choice of a physician.
- 33 (ll) Collaborate with the boards that license health facilities to  
34 ensure that facility performance is monitored and that deficient  
35 practices are recognized and corrected in a timely fashion and that  
36 consumers and providers of health care have access to information  
37 needed to support their choice of facility.
- 38 (mm) Establish an Internet Web site that provides information  
39 to the public about the system that includes, but is not limited to,  
40 information that supports choice of providers and facilities, informs



1 the public about meetings of state and regional health planning  
2 boards and activities of the Partnerships for Health.

3 (nn) Procure funds, including loans, for the system, enter into  
4 leases, and obtain insurance for the system and its employees and  
5 agents.

6 (oo) Collaborate with state and local authorities, including  
7 regional planning directors, to plan for needed earthquake retrofits  
8 in a manner that does not disrupt patient care.

9 (pp) Establish a process that is accessible to all Californians for  
10 the system to receive the concerns, opinions, ideas, and  
11 recommendation of the public regarding all aspects of the system.

12 (qq) Annually report to the Legislature and the Governor, on  
13 or before October of each year and at other times pursuant to this  
14 division, on the performance of the system, its fiscal condition and  
15 need for rate adjustments, consumer copayments or consumer  
16 deductible payments, recommendations for statutory changes,  
17 receipt of payments from the federal government and other sources,  
18 whether current year goals and priorities are met, future goals, and  
19 priorities, and major new technology or prescription drugs or other  
20 circumstances that may affect the cost of health care.

21 140103. (a) The commissioner shall establish a ~~Universal~~  
22 Healthcare Policy Board and shall serve as the president of the  
23 board.

24 (b) The board shall do all of the following:

25 (1) Establish goals and priorities for the system, including  
26 research and capital investment priorities.

27 (2) Establish the scope of services to be provided to the  
28 population *in accordance with Chapter 5 (commencing with Section*  
29 *140500)*.

30 (3) Establish guidelines for evaluating the performance of the  
31 system, its officers, health planning regions, and health care  
32 providers.

33 (4) Establish guidelines for ensuring public input on the system's  
34 policy, standards, and goals.

35 (c) The board shall consist of the following members:

36 (1) The commissioner.

37 (2) The deputy commissioner.

38 (3) The Director of the ~~Universal~~ Healthcare Fund.

39 (4) The patient advocate of the Office of Patient Advocacy.

40 (5) The chief medical officer.

- 1 (6) The Director of the Office of Health Planning.
- 2 (7) The Director of the Partnerships for Health.
- 3 (8) The Director of the Payments Board.
- 4 (9) The State Public Health Officer.
- 5 (10) One member of the Public Advisory Committee who shall
- 6 serve on a rotating basis to be determined by the Public Advisory
- 7 Committee.
- 8 (11) Two representatives from regional planning boards.
- 9 (A) A regional representative shall serve a term of one year and
- 10 terms shall be rotated in order to allow every region to be
- 11 represented within a five-year period.
- 12 (B) A regional planning director shall appoint the regional
- 13 representative to serve on the board.
- 14 (d) It is unlawful for the board members or any of their
- 15 assistants, clerks, or deputies to use for personal benefit any
- 16 information that is filed with or obtained by the board and that is
- 17 not then generally available to the public.
- 18 140104. (a) The commissioner shall establish the Public
- 19 Advisory Committee to advise the ~~Universal~~ Healthcare Policy
- 20 Board on all matters of policy for the system.
- 21 (b) Members of the Public Advisory Committee shall include
- 22 all of the following:
- 23 (1) Four physicians all of whom shall be board certified in their
- 24 field and at least one of whom shall be a psychiatrist. The Senate
- 25 Committee on Rules and the Governor shall each appoint one
- 26 member. The Speaker of the Assembly shall appoint two of these
- 27 members, both of whom shall be primary care providers.
- 28 (2) One registered nurse, to be appointed by the Senate
- 29 Committee on Rules.
- 30 (3) One licensed vocational nurse, to be appointed by the Senate
- 31 Committee on Rules.
- 32 (4) One licensed allied health practitioner, to be appointed by
- 33 the Speaker of the Assembly.
- 34 (5) One mental health care provider, to be appointed by the
- 35 Senate Committee on Rules.
- 36 (6) One dentist, to be appointed by the Governor.
- 37 (7) One representative of private hospitals, to be appointed by
- 38 the Governor.
- 39 (8) One representative of public hospitals, to be appointed by
- 40 the Governor.

1 (9) One representative of an integrated health care delivery  
2 system, to be appointed by the Governor.

3 (10) Four consumers of health care. The Governor shall appoint  
4 two of these members, one of whom shall be a member of the  
5 disability community. The Senate Committee on Rules shall  
6 appoint a member who is 65 years of age or older. The Speaker  
7 of the Assembly shall appoint the fourth member.

8 (11) One representative of organized labor, to be appointed by  
9 the Speaker of the Assembly.

10 (12) One representative of essential community providers, to  
11 be appointed by the Senate Committee on Rules.

12 (13) One union member, to be appointed by the Senate  
13 Committee on Rules.

14 (14) One representative of small business, to be appointed by  
15 the Governor.

16 (15) One representative of large business, to be appointed by  
17 the Speaker of the Assembly.

18 (16) One pharmacist, to be appointed by the Speaker of the  
19 Assembly.

20 (c) In making appointments pursuant to this section, the  
21 Governor, the Senate Committee on Rules, and the Speaker of the  
22 Assembly shall make good faith efforts to assure that their  
23 appointments, as a whole, reflect, to the greatest extent feasible,  
24 the social and geographic diversity of the state.

25 (d) Any member appointed by the Governor, the Senate  
26 Committee on Rules, or the Speaker of the Assembly shall serve  
27 a four-year term. These members may be reappointed for  
28 succeeding four-year terms.

29 (e) Vacancies that occur shall be filled within 30 days after the  
30 occurrence of the vacancy, and shall be filled in the same manner  
31 in which the vacating member was initially selected or appointed.  
32 The commissioner shall notify the appropriate appointing authority  
33 of any expected vacancies on the board.

34 (f) Members of the Public Advisory Committee shall serve  
35 without compensation, but shall be reimbursed for actual and  
36 necessary expenses incurred in the performance of their duties to  
37 the extent that reimbursement for those expenses is not otherwise  
38 provided or payable by another public agency or agencies, and  
39 shall receive one hundred dollars (\$100) for each full day of  
40 attending meetings of the committee. For purposes of this section,

1 “full day of attending a meeting” means presence at, and  
2 participation in, not less than 75 percent of the total meeting time  
3 of the committee during any particular 24-hour period.

4 (g) The Public Advisory Committee shall meet at least six times  
5 a year in a place convenient to the public. All meetings of the board  
6 shall be open to the public, pursuant to the Bagley-Keene Open  
7 Meeting Act (Article 9 (commencing with Section 11120) of  
8 Chapter 1 of Part 1 of Division 3 of Title 2 of the Government  
9 Code).

10 (h) The Public Advisory Committee shall elect a chair who shall  
11 serve for two years and who may be reelected for an additional  
12 two years.

13 (i) Appointed committee members shall have worked in the  
14 field they represent on the committee for a period of at least two  
15 years prior to being appointed to the committee.

16 (j) The Public Advisory Committee shall elect a member to  
17 serve on the ~~Universal~~ Healthcare Policy Board. The elected  
18 member shall serve for one year, and may be recalled by the Public  
19 Advisory Committee for cause. In that case, a new member shall  
20 be elected to serve on that board. The Public Advisory Committee  
21 representative shall represent to the board the views of the  
22 committee members.

23 (k) It is unlawful for the committee members or any of their  
24 assistants, clerks, or deputies to use for personal benefit any  
25 information that is filed with or obtained by the committee and  
26 that is not generally available to the public.

27 140105. (a) (1) There is within the agency an Office of Patient  
28 Advocacy to represent the interests of the consumers of health  
29 care. The goal of the office shall be to help residents of the state  
30 secure the health care services and benefits to which they are  
31 entitled under the laws administered by the agency and to advocate  
32 on behalf of and represent the interests of consumers in governance  
33 bodies created by this division and in other forums.

34 (2) The office shall be headed by a patient advocate appointed  
35 by the commissioner.

36 (3) The patient advocate shall establish an office in the City of  
37 Sacramento and other offices throughout the state that shall provide  
38 convenient access to residents.

39 (b) The patient advocate shall do all the following:

40 (1) Administer all aspects of the Office of Patient Advocacy.

- 1 (2) Assure that services of the Office of Patient Advocacy are  
2 available to all California residents.
- 3 (3) Serve on the ~~Universal~~ Healthcare Policy Board and  
4 participate in the regional Partnerships for Health.
- 5 (4) Oversee the establishment and maintenance of the grievance  
6 process pursuant to Sections 140608 and 140610.
- 7 (5) Participate in the grievance process and independent medical  
8 review system on behalf of consumers pursuant to Section 140610.
- 9 (6) Receive, evaluate, and respond to consumer complaints  
10 about the system.
- 11 (7) Provide a means to receive recommendations from the public  
12 about ways to improve the system and hold public hearings at least  
13 once annually to discuss problems and receive recommendations  
14 from the public.
- 15 (8) Develop educational and informational guides for consumers  
16 describing their rights and responsibilities and informing them  
17 about effective ways to exercise their rights to secure health care  
18 services and to participate in the system. The guides shall be easy  
19 to read and understand, available in English and other languages,  
20 including Braille and formats suitable for those with hearing  
21 limitations, and shall be made available to the public by the agency,  
22 including access on the agency's Internet Web site and through  
23 public outreach and educational programs, and displayed in  
24 provider offices and health care facilities.
- 25 (9) Establish a toll-free telephone number, including a TDD  
26 number, to receive complaints regarding the agency and its  
27 services. Those with hearing and speech limitations may use the  
28 California Relay Service's toll-free telephone numbers to contact  
29 the Office of Patient Advocacy. The agency's Internet Web site  
30 shall have complaint forms and instructions on their use.
- 31 (10) Report annually to the public, the commissioner, and the  
32 Legislature about the consumer perspective on the performance  
33 of the system, including recommendations for needed  
34 improvements.
- 35 (c) Nothing in this division shall prohibit a consumer or class  
36 of consumers or the patient advocate from seeking relief through  
37 the judicial system.
- 38 (d) The patient advocate in pursuit of his or her duties shall have  
39 unlimited access to all nonconfidential and all nonprivileged  
40 documents in the custody and control of the agency.

1 (e) It is unlawful for the patient advocate or any of his or her  
2 assistants, clerks, or deputies to use for personal benefit any  
3 information that is filed with, or obtained by, the agency and that  
4 is not then generally available to the public.

5 140106. (a) There is within the Office of the Attorney General  
6 an Office of the Inspector General for the California-Universal  
7 Healthcare System. The Inspector General shall be appointed by  
8 the Governor and subject to Senate confirmation.

9 (b) The Inspector General shall have broad powers to investigate,  
10 audit, and review the financial and business records of individuals,  
11 public and private agencies and institutions, and private  
12 corporations that provide services or products to the system, the  
13 costs of which are reimbursed by the system.

14 (c) The Inspector General shall investigate allegations of  
15 misconduct on the part of an employee or appointee of the agency  
16 and on the part of any health care provider of services that are  
17 reimbursed by the system and shall report any findings of  
18 misconduct to the Attorney General.

19 (d) The Inspector General shall investigate patterns of medical  
20 practice that may indicate fraud and abuse related to over or under  
21 utilization or other inappropriate utilization of medical products  
22 and services.

23 (e) The Inspector General shall arrange for the collection and  
24 analysis of data needed to investigate the inappropriate utilization  
25 of these products and services.

26 (f) The Inspector General shall conduct additional reviews or  
27 investigations of financial and business records when requested  
28 by the Governor or by any Member of the Legislature and shall  
29 report findings of the review or investigation to the Governor and  
30 the Legislature.

31 (g) The Inspector General shall establish a telephone hotline  
32 for anonymous reporting of allegations of failure to make health  
33 insurance premium payments established by this division. The  
34 Inspector General shall investigate information provided to the  
35 hotline and shall report any findings of misconduct to the Attorney  
36 General.

37 (h) The Inspector General shall annually report  
38 recommendations for improvements to the system or the agency  
39 to the Governor, the Legislature, and the commissioner.

1 140107. The provisions of the Insurance Frauds Prevention  
2 Act (Chapter 12 (commencing with Section 1871) of Part 2 of  
3 Division 1 of the Insurance Code), and the provisions of Article  
4 6 (commencing with Section 650) of Chapter 1 of Division 2 of  
5 the Business and Professions Code shall be applicable to health  
6 care providers who receive payments for services through the  
7 system under this division.

8 140108. (a) Nothing contained in this division is intended to  
9 repeal any legislation or regulation governing the professional  
10 conduct of any person licensed by the State of California or any  
11 legislation governing the licensure of any facility licensed by the  
12 State of California.

13 (b) All federal legislation and regulations governing referral  
14 fees and fee-splitting, including, but not limited to, Sections  
15 1320a-7b and 1395nn of Title 42 of the United States Code, shall  
16 be applicable to all health care providers of services reimbursed  
17 under this division, whether or not the health care provider is paid  
18 with funds coming from the federal government.

19 140110. (a) The system shall be operational no later than two  
20 years after the date this division, other than Article 2 (commencing  
21 with Section 140230) of Chapter 3, becomes operative, as described  
22 in Section 140700.

23 (b) The transition shall be funded from a loan from the General  
24 Fund and from other sources, including private sources identified  
25 by the commissioner.

26 (c) The commissioner shall assess health plans and insurers for  
27 care provided by the system in those cases in which a person's  
28 health care coverage extends into the time period in which the new  
29 system is operative.

30 (d) The commissioner shall implement means to assist persons  
31 who are displaced from employment as a result of the initiation of  
32 the system, including determination of the period of time during  
33 which assistance shall be provided and possible sources of funds,  
34 including funds from the system, to support retraining and job  
35 placement. That support shall be provided for a period of five years  
36 from the date that this division becomes operative.

37 140111. (a) The commissioner shall appoint a transition  
38 advisory group to assist with the transition to the system. The  
39 transition advisory group shall include, but not be limited to, the  
40 following members:

- 1 (1) The commissioner.
- 2 (2) The patient advocate of the Office of Patient Advocacy.
- 3 (3) The chief medical officer.
- 4 (4) The Director of the Office of Health Planning.
- 5 (5) The Director of the ~~Universal~~ Healthcare Fund.
- 6 (6) The State Public Health Officer.
- 7 (7) Experts in health care financing and health care
- 8 administration.
- 9 (8) Direct care providers.
- 10 (9) Representatives of retirement boards.
- 11 (10) Employer and employee representatives.
- 12 (11) Hospital, integrated health care delivery system, essential
- 13 community provider, and long-term care facility representatives.
- 14 (12) Representatives from state departments and regulatory
- 15 bodies that shall or may relinquish some or all parts of their
- 16 delivery of health care services to the system.
- 17 (13) Representatives of counties.
- 18 (14) Consumers of health care services.
- 19 (b) The transition advisory group shall advise the commissioner
- 20 on all aspects of the implementation of this division.
- 21 (c) The transition advisory group shall make recommendations
- 22 to the commissioner, the Governor, and the Legislature on how to
- 23 integrate health care delivery services and responsibilities relating
- 24 to the delivery of the services of the following departments and
- 25 agencies into the system:
- 26 (1) The State Department of Health Care Services.
- 27 (2) The Department of Managed Health Care.
- 28 (3) The Department of Aging.
- 29 (4) The Department of Developmental Services.
- 30 (5) The Health and Welfare Data Center.
- 31 (6) The State Department of Mental Health.
- 32 (7) The State Department of Alcohol and Drug Programs.
- 33 (8) The Department of Rehabilitation.
- 34 (9) The Emergency Medical Services Authority.
- 35 (10) The Managed Risk Medical Insurance Board.
- 36 (11) The Office of Statewide Health Planning and Development.
- 37 (12) The Department of Insurance.
- 38 (13) The State Department of Public Health.



1 (d) The transition advisory group shall make recommendations  
2 to the Governor, the Legislature, and the commissioner regarding  
3 research needed to support transition to the system.

4 140112. (a) The transition advisory group shall make  
5 recommendations to the commissioner relative to how the system  
6 shall be regionalized for the purposes of local and  
7 community-based planning for the delivery of high quality  
8 cost-effective care and efficient service delivery.

9 (b) The commissioner, in consultation with the Director of the  
10 Office of Health Planning, shall establish up to 10 health planning  
11 regions composed of geographically contiguous counties grouped  
12 on the basis of the following considerations:

13 (1) Patterns of utilization of health care services.

14 (2) Health care resources, including workforce resources.

15 (3) Health needs of the population, including public health  
16 needs.

17 (4) Geography.

18 (5) Population and demographic characteristics.

19 (6) Other considerations as determined by the commissioner,  
20 the Director of the Office of Health Planning, or the chief medical  
21 officer.

22 (c) The commissioner shall appoint a director for each region.  
23 Regional planning directors shall serve at the will of the  
24 commissioner and may serve up to two eight-year terms to coincide  
25 with the terms of the commissioner.

26 (d) Each regional planning director shall appoint a regional  
27 medical officer.

28 (e) Compensation for officers of the system and appointees who  
29 are exempt from the civil service shall be established by the  
30 California Citizens Commission in accordance with Section 8 of  
31 Article III of the California Constitution, and shall take into  
32 consideration regional differences in the cost of living.

33 (f) The regional planning director and the regional medical  
34 officer shall be subject to Title 9 (commencing with Section 81000)  
35 of the Government Code and shall comply with the qualifications  
36 for office described in subdivisions (c), (d), and (e) of Section  
37 140100 and subdivisions (j) and (k) of Section 140101.

38 140113. (a) Regional planning directors shall administer the  
39 health planning region. The regional planning director shall be  
40 responsible for all duties, the exercise of all powers and

1 jurisdiction, and the assumptions and discharge of all  
2 responsibilities vested by law in the regional agency. The regional  
3 planning director shall perform all duties imposed upon him or  
4 her by this division and by other laws related to health care, and  
5 shall enforce execution of those provisions and laws to promote  
6 their underlying aims and purposes.

7 (b) The regional planning director shall reside in the region in  
8 which he or she serves.

9 (c) The regional planning director shall do all of the following:

10 (1) Establish and administer a regional office of the state agency.  
11 Each regional office shall include, at minimum, an office of each  
12 of the following: Patient Advocacy, Health Care Quality, Health  
13 Planning, and Partnerships for Health.

14 (2) Appoint regional planning board members and serve as  
15 president of the board.

16 (3) Identify and prioritize regional health care needs and goals,  
17 in collaboration with the regional medical officer, regional health  
18 care providers, the regional planning board, and regional director  
19 of Partnerships for Health pursuant to the priorities and goals of  
20 the system established by the commissioner.

21 (4) Regularly assess projected revenues and expenditures to  
22 ensure fiscal solvency of the regional planning system and advise  
23 the commissioner of potential revenue shortfalls and the possible  
24 need for cost controls.

25 (5) Assure that regional administrative costs meet standards  
26 established by the division and seek innovative means to lower  
27 the costs of administration of the regional planning office and those  
28 of regional providers.

29 (6) Plan for the delivery of, and equal access to, high quality  
30 and culturally and linguistically sensitive care and such care for  
31 disabled persons that meets the needs of all regional residents  
32 pursuant to standards established by the commissioner.

33 (7) Seek innovative and systemic means to improve care quality  
34 and efficiency of care delivery and to achieve access to programs  
35 for all state residents.

36 (8) Recommend means to and implement policies established  
37 by the commissioner to provide support to persons displaced from  
38 employment as a result of the initiation of the new system.

39 (9) Make needed revenue sharing arrangements so that  
40 regionalization does not limit a patient's choice of provider.

- 1 (10) Implement procedures established by the commissioner  
2 for the resolution of disputes.
- 3 (11) Implement processes established by the commissioner and  
4 recommend needed changes to permit the public to share concerns,  
5 provide ideas, opinions, and recommendations regarding all aspects  
6 of the system's policies.
- 7 (12) Report regularly to the public and, at intervals determined  
8 by the commissioner and pursuant to this division, to the  
9 commissioner on the status of the regional planning system,  
10 including evaluating access to care, quality of care delivered, and  
11 provider performance, and other issues related to regional health  
12 care needs, and recommending needed improvements.
- 13 (13) Identify or establish guidelines for providers to identify,  
14 maintain, and provide to the regional *planning* director inventories  
15 of regional health care assets.
- 16 (14) Establish and maintain regional health care databases that  
17 are coordinated with other regional and statewide databases.
- 18 (15) In collaboration with the regional medical officer, enforce  
19 reporting requirements established by the system and make  
20 recommendations to the commissioner, the Director of the Office  
21 of Health Planning, and the chief medical officer for needed  
22 changes in reporting requirements.
- 23 (16) Establish and implement a regional capital management  
24 plan pursuant to the capital management plan established by the  
25 commissioner for the system.
- 26 (17) Implement standards and formats established by the  
27 commissioner for the development and submission of operating  
28 and capital budget requests and make recommendations to the  
29 commissioner and the Director of the Office of Health Planning  
30 for needed changes.
- 31 (18) Support regional providers in developing operating and  
32 capital budget requests.
- 33 (19) Receive, evaluate, and prioritize provider operating and  
34 capital budget requests pursuant to standards and criteria  
35 established by the commissioner.
- 36 (20) Prepare a three-year regional operating and capital budget  
37 request that meets the health care needs of the region pursuant to  
38 this division, for submission to the commissioner.
- 39 (21) Establish a comprehensive three-year regional planning  
40 budget using funds allocated to the region by the commissioner.

1 140114. ~~(a)~~—The regional medical officers shall do all of the  
2 following:  
3 ~~(1)~~  
4 (a) Administer all aspects of the regional office of health care  
5 quality.  
6 ~~(2)~~  
7 (b) Serve as a member of the regional planning board.  
8 ~~(3)~~  
9 (c) In collaboration with the commissioner, the chief medical  
10 officer, the regional medical officer, regional planning boards, the  
11 patient advocate of the Office of Patient Advocacy, regional  
12 providers, and patients, oversee the establishment of integrated  
13 service networks, including those that provide services through  
14 medical technologies such as telemedicine, that include physicians  
15 in fee-for-service, solo and group practice, essential community,  
16 and ancillary care providers and facilities that pool and align  
17 resources and form interdisciplinary teams that share responsibility  
18 and accountability for patient care and provide a continuum of  
19 coordinated high quality primary to tertiary care to all residents  
20 of the region.  
21 ~~(4)~~  
22 (d) Assure the evaluation and measurement of the quality of  
23 care delivered in the region, including assessment of the  
24 performance of individual providers, pursuant to standards and  
25 methods established by the chief medical officer to ensure a single  
26 standard of high quality care is delivered to all state residents.  
27 ~~(5)~~  
28 (e) In collaboration with the chief medical officer and regional  
29 providers, evaluate standards of care in use at the time the system  
30 becomes operative.  
31 ~~(6)~~  
32 (f) Ensure a smooth transition toward use of standards based on  
33 clinical efficacy that guide clinical decisionmaking. Identify areas  
34 of medical practice where standards have not been established and  
35 collaborated with the chief medical officer and health care  
36 providers, to establish priorities in developing needed standards.  
37 ~~(7)~~  
38 (g) Support the development and distribution of user-friendly  
39 software for use by providers in order to support the delivery of  
40 high quality care.

- 1     ~~(8)~~  
2     (h) Provide feedback to, and support and supervision of, health  
3 care providers to ensure the delivery of high quality care pursuant  
4 to standards established by the system.  
5     ~~(9)~~  
6     (i) Collaborate with the regional Partnerships for Health to  
7 develop patient education to assist consumers in evaluating and  
8 appropriately utilizing health care providers and facilities.  
9     ~~(10)~~  
10    (j) Collaborate with regional public health officers to establish  
11 regional health policies that support the public health.  
12    ~~(11)~~  
13    (k) Establish a regional program to monitor and decrease medical  
14 errors and their causes pursuant to standards and methods  
15 established by the chief medical officer.  
16    ~~(12)~~  
17    (l) Support the development and implementation of innovative  
18 means to provide high quality care and assist providers in securing  
19 funds for innovative demonstration-~~project~~ *projects* that seek to  
20 improve care quality.  
21    ~~(13)~~  
22    (m) Establish means to assess the impact of the system’s policies  
23 intended to assure the delivery of high quality care.  
24    ~~(14)~~  
25    (n) Collaborate with the chief medical officer, the Director of  
26 the Office of Health Planning, the regional planning director, and  
27 health care providers in the development and maintenance of  
28 regional health care databases.  
29    ~~(15)~~  
30    (o) Ensure the enforcement of, and recommend needed changes  
31 in, the system’s reporting requirements.  
32    ~~(16)~~  
33    (p) Support providers in developing regional budget requests.  
34    ~~(17)~~  
35    (q) Annually report to the commissioner, the public, the regional  
36 planning board, and the chief medical officer on the status of  
37 regional health care programs, needed improvements, and plans  
38 to implement and evaluate delivery of care improvements.  
39    140115. (a) Each region shall have a regional planning board  
40 consisting of 13 members who shall be appointed by the regional

1 planning director. Members shall serve eight-year terms that  
2 coincide with the term of the regional planning director and may  
3 be reappointed for a second term.

4 (b) Regional planning board members shall have resided for a  
5 minimum of two years in the region in which they serve prior to  
6 appointment to the board.

7 (c) Regional planning board members shall reside in the region  
8 they serve while on the board.

9 (d) The board shall consist of the following members:

10 (1) The regional planning director, the regional medical officer,  
11 the regional director of the Partnerships for Health, and a public  
12 health officer from one of the counties in the region.

13 (2) When there is more than one county in a region, the public  
14 health officer board position shall rotate among the public health  
15 county officers on a timetable to be established by each regional  
16 planning board.

17 (3) A representative from the Office of Patient Advocacy.

18 (4) One expert in health care financing.

19 (5) One expert in health care planning.

20 (6) Two members who are direct care providers in the region,  
21 one of whom shall be a registered nurse.

22 (7) One member who represents ancillary health care workers  
23 in the region.

24 (8) One member representing hospitals in the region.

25 (9) One member representing essential community providers  
26 in the region.

27 (10) One member representing the public.

28 (e) The regional planning director shall serve as chair of the  
29 board.

30 (f) The purpose of the regional planning boards is to advise and  
31 make recommendations to the regional planning director on all  
32 aspects of regional health policy.

33 (g) Meetings of the board shall be open to the public pursuant  
34 to the Bagley-Keene Open Meeting Act (Article 9 (commencing  
35 with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title  
36 2 of the Government Code).

37 140116. The following conflict of interest prohibitions shall  
38 apply to all appointees of the commissioner or transition advisory  
39 group, including, but not limited to, the patient advocate, the  
40 Director of the Universal Healthcare Fund, the purchasing director,

1 the Director of the Office of Health Planning, the Director of the  
2 Payments Board, the chief medical officer, the Director of  
3 Partnerships for Health, regional planning directors, and the  
4 Inspector General:

5 (a) The appointee shall not have been employed in any capacity  
6 by a for-profit insurance, pharmaceutical, or medical equipment  
7 company that sells products to the system for a period of two years  
8 prior to appointment.

9 (b) For two years after completing service in the system, the  
10 appointee may not receive payments of any kind from, or be  
11 employed in any capacity or act as a paid consultant to, a for-profit  
12 insurance, pharmaceutical, or medical equipment company that  
13 sells products to the system.

14 (c) The appointee shall avoid political activity that may create  
15 the appearance of political bias or impropriety. Prohibited activities  
16 shall include, but not be limited to, leadership of, or employment  
17 by, a political party or a political organization; public endorsement  
18 of a political candidate; contribution of more than five hundred  
19 dollars (\$500) to any one candidate in a calendar year or a  
20 contribution in excess of an aggregate of one thousand dollars  
21 (\$1,000) in a calendar year for all political parties or organizations;  
22 and attempting to avoid compliance with this prohibition by making  
23 contributions through a spouse or other family member.

24 (d) The appointee shall not participate in making or in any way  
25 attempt to use his or her official position to influence a  
26 governmental decision in which he or she or a family or a business  
27 partner or colleague has a financial interest.

28

29

### CHAPTER 3. FUNDING

30

31

#### Article 1. General Provisions

32

33

140200. (a) In order to support the agency effectively in the  
34 administration of this division, there is hereby established in the  
35 State Treasury the ~~Universal~~ Healthcare Fund. The fund shall be  
36 administered by a director appointed by the commissioner.

37

38

(b) All moneys collected, received, and transferred pursuant to  
38 this division shall be transmitted to the State Treasury to be  
39 deposited to the credit of the ~~Universal~~ Healthcare Fund for the  
40 purpose of financing the California ~~Universal~~ Healthcare System.

40

1 (c) Moneys deposited in the ~~Universal~~ Healthcare Fund shall  
2 be used exclusively to support this division.

3 (d) All claims for health care services rendered pursuant to the  
4 system shall be made to the ~~Universal~~ Healthcare Fund through  
5 an electronic claims and payment system. The commissioner shall  
6 investigate the costs, benefits, and means of supporting health care  
7 providers in obtaining electronic systems for claims and payments  
8 transactions; however, alternative provisions shall be made for  
9 health care providers without electronic systems.

10 (e) All payments made for health care services shall be disbursed  
11 from the ~~Universal~~ Healthcare Fund through an electronic claims  
12 and payments system; however, alternative provisions shall be  
13 made for health care providers without electronic systems.

14 (f) The ~~Director~~ *director* of the fund shall serve on the ~~Universal~~  
15 Healthcare Policy Board.

16 140201. (a) The Director of the ~~Universal~~ Healthcare Fund  
17 shall establish the following accounts within the ~~Universal~~  
18 Healthcare Fund:

19 (1) A system account to provide for all annual state expenditures  
20 for health care.

21 (2) A reserve account.

22 (b) Premiums collected each year shall be roughly sufficient to  
23 cover that year's projected costs.

24 (c) The system shall at all times hold in reserve an amount  
25 estimated in the aggregate to provide for the payment of all losses  
26 and claims for which the system may be liable, and to provide for  
27 the expense of adjustment or settlement of losses and claims.

28 (d) During the transition, the commissioner shall work with the  
29 Department of Insurance and other experts to determine an  
30 appropriate level of reserves for the system for the first year and  
31 for future years of its operation.

32 (e) Moneys currently held in reserve by state, city, and county  
33 health programs and federal moneys for health care held in reserve  
34 in federal trust accounts shall be transferred to the reserve account  
35 when the state assumes financial responsibility for health care  
36 under this division that is currently provided by those programs.

37 (f) The commissioner may implement arrangements to  
38 self-insure the system against unforeseen expenditures or revenue  
39 shortfalls not covered by reserves and may borrow funds to cover  
40 temporary revenue shortfalls not covered by system reserves,



1 including the issuance of bonds for this purpose, whichever is the  
2 more cost effective.

3 (g) Funds held in the reserve account and other ~~Universal~~  
4 Healthcare Fund accounts may be prudently invested to increase  
5 their value according to the Department of Insurance's standards  
6 for liquidity and asset management.

7 140203. (a) The Director of the ~~Universal~~ Healthcare Fund  
8 shall immediately notify the commissioner when regional or  
9 statewide revenue and expenditure trends indicate that expenditures  
10 may exceed revenues.

11 (b) If the commissioner determines that statewide revenue trends  
12 indicate the need for statewide cost control measures, the  
13 commissioner shall convene the ~~Universal~~ Healthcare Policy Board  
14 to discuss the need for cost control measures and shall immediately  
15 report to the Legislature and the public regarding the possible need  
16 for cost control measures.

17 (c) Cost control measures include any or all of the following:

18 (1) Changes in the system or health facility administration that  
19 improve efficiency.

20 (2) Changes in the delivery of health care services that improve  
21 efficiency and care quality.

22 (3) Postponement of introduction of new benefits or benefit  
23 improvements.

24 (4) Seeking statutory authority for a temporary decrease in  
25 benefits.

26 (5) Postponement of planned capital expenditures.

27 (6) Adjustments of health care provider payments to correct for  
28 deficiencies in care quality and failure to meet compensation  
29 contract performance goals, pursuant to subdivisions (a) to (f),  
30 inclusive, of Section 140106, paragraph (4) of subdivision (a) of  
31 Section 140204, subdivision (a) of Section 140213, and  
32 subdivisions (c) and (d) of Section 140606.

33 (7) Adjustments to the compensation of managerial employees  
34 and upper level managers under contract with the system to correct  
35 for deficiencies in management and failure to meet contract  
36 performance goals.

37 (8) Limitations on the reimbursement budgets of the system's  
38 providers and upper level managers whose compensation is  
39 determined by the Payments Board.

- 1 (9) Limitations on aggregate reimbursements to manufacturers
- 2 of pharmaceutical and durable and nondurable medical equipment.
- 3 (10) Deferred funding of the reserve account.
- 4 (11) Imposition of copayments or deductible payments. Any
- 5 copayment or deductible payments imposed under this section
- 6 shall be subject to all of the following requirements:
- 7 (A) No copayment or deductible may be established when
- 8 prohibited by federal law.
- 9 (B) All copayments and deductibles shall meet federal guidelines
- 10 for copayments and deductible payments that may lawfully be
- 11 imposed on persons with low income.
- 12 (C) The commissioner shall establish standards and procedures
- 13 for waiving copayments or deductible payments and a waiver card
- 14 that shall be issued to a patient or to a family to indicate the waiver.
- 15 Procedures for copayment waiver may include a determination by
- 16 a patient’s primary care provider that imposition of a copayment
- 17 would be a financial hardship. Copayment and deductible waivers
- 18 shall be reviewed annually by the regional planning director.
- 19 (D) Waivers shall not affect the reimbursement of health care
- 20 providers.
- 21 (E) Any copayments or deductible payments established
- 22 pursuant to this section shall be transmitted to the Treasurer to be
- 23 deposited to the credit of the ~~Universal~~ Healthcare Fund.
- 24 (12) Imposition of an eligibility waiting period and other means
- 25 if the commissioner determines that large numbers of people are
- 26 emigrating to the state for the purpose of obtaining health care
- 27 through the system.
- 28 (d) Nothing in this division shall be construed to diminish the
- 29 benefits that an individual has under a collective bargaining
- 30 agreement or statute.
- 31 (e) Nothing in this division shall preclude employees from
- 32 receiving benefits available to them under a collective bargaining
- 33 agreement or other employee-employer agreement or a statute that
- 34 are superior to benefits under this division.
- 35 (f) Cost control measures implemented by the commissioner
- 36 and the ~~Universal~~ Healthcare Policy Board shall remain in place
- 37 in the state until the commissioner and the ~~Universal~~ Healthcare
- 38 Policy Board determine that the cause of a revenue shortfall has
- 39 been corrected.

1 (g) If the ~~Universal~~ Healthcare Policy Board determines that  
2 cost control measures described in subdivision (c) will not be  
3 sufficient to meet a revenue shortfall, the commissioner shall report  
4 to the Legislature and to the public on the causes of the shortfall  
5 and the reasons for the failure of cost controls and shall recommend  
6 measures to correct the shortfall, including an increase in premium  
7 payments to the system.

8 140204. (a) If the commissioner or a regional planning director  
9 determines that regional revenue and expenditure trends indicate  
10 a need for regional cost control measures, the regional planning  
11 director shall convene the regional planning board to discuss the  
12 possible need for cost control measures and to make a  
13 recommendation about appropriate measures to control costs.  
14 These may include any of the following:

15 (1) Changes in the administration of the system or in health  
16 facility administration that improve efficiency.

17 (2) Changes in the delivery of health care services and health  
18 system management that improve efficiency or care quality.

19 (3) Postponement of planned regional capital expenditures.

20 (4) Adjustment of payments to health care providers to reflect  
21 deficiencies in care quality and failure to meet compensation  
22 contract performance goals and payments to upper level managers  
23 to reflect deficiencies in management and failure to meet  
24 compensation contract performance goals.

25 (5) Adjustment of payments to health care providers and upper  
26 level managers above a specified amount of aggregate billing.

27 (6) Adjustment of payments to pharmaceutical and medical  
28 equipment manufacturers and others selling goods and services to  
29 the system above a specified amount of aggregate billing.

30 (b) If a regional planning board is convened to implement cost  
31 control measures, the commissioner shall participate in the regional  
32 planning board meeting.

33 (c) The regional planning director, in consultation with the  
34 commissioner, shall determine if cost control measures are  
35 warranted and those measures that shall be implemented.

36 (d) Imposition of copayments or deductibles, postponement of  
37 new benefits or benefit improvements, deferred funding of the  
38 reserve account, establishment of eligibility waiting periods, and  
39 increases in premium payments under the system may occur on a

1 statewide basis only and with the concurrence of the commissioner  
2 and the ~~Universal~~ Healthcare Policy Board.

3 (e) If a regional planning director and regional planning board  
4 are considering imposition of cost control measures, the regional  
5 planning director shall immediately report to the residents of the  
6 region regarding the possible need for cost control measures.

7 (f) Cost control measures shall remain in place in a region until  
8 the regional planning director and the commissioner determine  
9 that the cause of a revenue shortfall has been corrected.

10 140205. (a) If, on June 30 of any year, the Budget Act for the  
11 fiscal year beginning on July 1 has not been enacted, all moneys  
12 in the reserve account of the ~~Universal~~ Healthcare Fund shall be  
13 used to implement this division until funds are available through  
14 the Budget Act.

15 (b) Notwithstanding any other provision of law and without  
16 regard to fiscal year, if the annual Budget Act is not enacted by  
17 June 30 of any fiscal year preceding the fiscal year to which the  
18 budget would apply and if the commissioner determines that funds  
19 in the reserve account are depleted, the following shall occur:

20 (1) The Controller shall annually transfer from the General  
21 Fund, in the form of one or more loans, an amount to the Universal  
22 Healthcare Fund for the purpose of making payments to health  
23 care providers and to persons and businesses under contract with  
24 the system or with health care providers to provide services,  
25 medical equipment, and pharmaceuticals to the system.

26 (2) Upon enactment of the Budget Act in any fiscal year to  
27 which paragraph (1) applies, the Controller shall transfer all  
28 expenditures and unexpected funds loaned to the ~~Universal~~  
29 Healthcare Fund to the appropriate Budget Act item.

30 (3) The amount of any loan made pursuant to paragraph (1) for  
31 which moneys were expended from the ~~Universal~~ Healthcare Fund  
32 shall be repaid by debiting the appropriate Budget Act item in  
33 accordance with procedures prescribed by the Department of  
34 Finance.

35 140206. (a) The commissioner annually shall prepare a budget  
36 for the system that includes all expenditures, specifies a limit on  
37 total annual state expenditures, and establishes allocations for each  
38 health care region that shall cover a three-year period and that shall  
39 be disbursed on a quarterly basis.

1 (b) The commissioner shall limit the growth of spending on a  
2 statewide and on a regional basis, by reference to average growth  
3 in state domestic product across multiple years; population growth,  
4 actuarial demographics and other demographic indicators;  
5 differences in regional costs of living; advances in technology and  
6 their anticipated adoption into the benefit plan; improvements in  
7 efficiency of administration and care delivery; improvements in  
8 the quality of care; and projected future state domestic product  
9 growth rates.

10 (c) The commissioner shall adjust the system's budget so that  
11 aggregate spending in the state on health care ~~outside of the system~~  
12 shall not exceed spending under this division by more than 5  
13 percent.

14 (d) The commissioner shall project the system's revenues and  
15 expenditures for 3, 6, 9, and 12 years pursuant to parameters  
16 prescribed in subdivision ~~(g)~~ (f).

17 ~~(e) The commissioner shall annually convene a system revenue  
18 and expenditure conference to discuss revenue and expenditure  
19 projections and future policy directions and initiatives for the  
20 system, including means to lower the cost of administration,  
21 improve management of and investment in capital assets, and  
22 improve the quality of care and health system management.  
23 Participants shall include regional planning directors and medical  
24 officers, directors of the Universal Healthcare Fund and the  
25 Payments Board, the patient advocate, state and regional directors  
26 of the Partnerships for Health, and representatives of the upper  
27 level managers of the system.~~

28 ~~(f)~~

29 (e) The budget for the system shall include all of the following:

- 30 (1) Transition budget.
- 31 (2) Providers and managers budget.
- 32 (3) Capitated operating budgets.
- 33 (4) Noncapitated operating budgets.
- 34 (5) Capital investment budget.
- 35 (6) Purchasing budget, *including prescription drugs and durable*  
36 *and nondurable medical equipment pursuant to Section 140220.*
- 37 (7) Research and innovation budget *pursuant to Section 140221.*
- 38 (8) Workforce training and development budget *pursuant to*  
39 *Section 140222.*
- 40 (9) Reserve account *pursuant to Section 140223.*

- 1 (10) System administration ~~system~~ *budget pursuant to Section*
- 2 *140224.*
- 3 (11) Regional budgets.
- 4 ~~(g)~~
- 5 (f) In establishing budgets, the commissioner shall make
- 6 adjustments based on all of the following:
- 7 (1) Costs of transition to the new system.
- 8 (2) Projections regarding the health care services anticipated to
- 9 be used by California residents.
- 10 (3) Differences in cost of living between the regions, including
- 11 the overhead costs of maintaining medical practices.
- 12 (4) Health risk of enrollees.
- 13 (5) Scope of services provided.
- 14 (6) Innovative programs that improve care quality,
- 15 administrative efficiency, and workplace safety.
- 16 (7) Unrecovered cost of providing care to persons who are not
- 17 enrollees of the system. The commissioner shall seek to recover
- 18 the costs of care provided to persons who are not enrollees of the
- 19 system.
- 20 (8) Costs of workforce training and development.
- 21 (9) Costs of correcting health outcome disparities and the unmet
- 22 needs of previously uninsured and underinsured enrollees.
- 23 (10) Relative usage of different health care providers.
- 24 (11) Needed improvements in access to care.
- 25 (12) Projected savings in administrative costs.
- 26 (13) Projected savings due to provision of primary and
- 27 preventive care to the population, including savings from decreases
- 28 in preventable emergency room visits and hospitalizations.
- 29 (14) Projected savings from improvements in care quality.
- 30 (15) Projected savings from decreases in medical errors.
- 31 (16) Projected savings from systemwide management of capital
- 32 expenditures.
- 33 (17) Cost of incentives and bonuses to support the delivery of
- 34 high quality care, including incentives and bonuses needed to
- 35 recruit and retain an adequate supply of needed providers and
- 36 managers and to attract health care providers to medically
- 37 underserved areas.
- 38 (18) Costs of treating complex illnesses, including disease
- 39 management programs.

1 (19) Cost of implementing standards of care, care coordination,  
2 electronic medical records, and other electronic initiatives.

3 (20) Costs of new technology.

4 (21) Technology research and development costs and costs  
5 related to the system's use of new technologies.

6 ~~(h)~~

7 (g) Moneys in the reserve account shall not be considered as  
8 available revenues for the purposes of preparing the system's  
9 budget, except when the annual Budget Act has not been enacted  
10 by June 30 of any fiscal year.

11 140207. The commissioner shall annually establish the total  
12 funds to be allocated for provider and manager compensation  
13 pursuant to this section. In establishing the provider and manager  
14 budgets, the commissioner shall allot sufficient funds to assure  
15 that California can attract and retain those providers and managers  
16 needed to meet the health *care* needs of the population. In  
17 establishing provider and manager budgets, the commissioner shall  
18 allocate funds for both salaries, incentives, bonuses, and benefits  
19 to be provided to officers and upper level managers of the system  
20 who are exempt from state civil service statutes.

21 140208. (a) The commissioner shall establish the Payments  
22 Board and shall appoint a director and members of the board.

23 (b) The commissioner shall retain the authority to review,  
24 approve, reject, and modify all payment contracts and  
25 compensation plans established pursuant to this section.

26 (c) The Payments Board shall be composed of experts in health  
27 care finance and insurance systems, a designated representative  
28 of the commissioner, a designated representative of the ~~Universal~~  
29 Healthcare Fund, and a representative of the regional planning  
30 directors. The position of regional representative shall rotate among  
31 the directors of the regional planning boards every two years.

32 (d) The board shall establish and supervise a uniform payments  
33 system for health care providers and managers and shall maintain  
34 a compensation plan for all of the following health care providers  
35 and managers pursuant to the provider and manager budget  
36 established by the commissioner:

37 (1) Upper level managers employed by, or under contract with,  
38 private health care facilities, including, but not limited to, hospitals,  
39 integrated health care delivery systems, group and solo medical  
40 practices, and essential community facilities.

1 (2) Managers and officers of the system who are exempt from  
2 statutes governing civil service employment.

3 (3) Health care providers including, but not limited to,  
4 physicians, osteopathic physicians, dentists, podiatrists, nurse  
5 practitioners, physician assistants, chiropractors, acupuncturists,  
6 psychologists, social workers, marriage, family and child  
7 counselors, and other professional health care providers who are  
8 required by law to be licensed to practice in California and who  
9 provide services pursuant to the system.

10 (4) Compensation for employees of the system that was  
11 determined through employer-union negotiations before  
12 implementation of this division shall be determined by negotiations  
13 between the system and the unions after implementation of this  
14 division.

15 (5) Health care providers licensed and accredited to provide  
16 services in California may choose, ~~on a case-by-case or on an~~  
17 ~~aggregate basis~~, to be compensated for their services either by the  
18 system or by a person to whom they provide services.

19 (6) Health care providers electing to be compensated by the  
20 system shall enter into a contract with the system pursuant to  
21 provisions of this section.

22 (7) Health care providers electing to be compensated by persons  
23 to whom they provide services, instead of by the system, may  
24 establish charges for their services.

25 (8) Health care providers who accept any payment from the  
26 system under this division shall not bill a patient for any covered  
27 service.

28 (e) Health care providers licensed or accredited to provide  
29 services in California, who choose to be compensated by the system  
30 instead of by patients to whom they provide services may choose  
31 how they wish to be compensated under this division, as  
32 fee-for-service providers or as salaried providers in health care  
33 systems that provide comprehensive, coordinated services.

34 (f) Notwithstanding provisions of the Business and Professions  
35 Code, nurse practitioners, physician assistants, and others who  
36 under California law must be supervised by a physician and  
37 surgeon, an osteopathic physician, a dentist, or a podiatrist, may  
38 choose fee-for-service compensation while under lawfully required  
39 supervision. However, nothing in this section shall interfere with  
40 the right of a supervising health care provider to enter into a



1 contractual arrangement that provides for salaried compensation  
2 for employees who must be supervised under the law by a  
3 physician and surgeon, an osteopathic physician, a dentist, or a  
4 podiatrist.

5 (g) The compensation plan shall include all of the following:

6 (1) Actuarially sound payments that include a just and fair return  
7 for health care providers in the fee-for-service sector and for health  
8 care providers working in health systems where comprehensive  
9 and coordinated services are provided, including the actuarial basis  
10 for the payment.

11 (2) Payment schedules that shall be in effect for three years.

12 (3) Bonus and incentive payments, including, but not limited  
13 to, all the following:

14 (A) Bonus payments for health care providers and upper level  
15 managers who, in providing services and managing facilities,  
16 practices, and integrated health systems pursuant to this division,  
17 meet performance standards and outcome goals established by the  
18 system.

19 (B) Incentive payments for health care providers and upper level  
20 managers who provide services to the system in areas identified  
21 by the Office of Health Planning as medically underserved.

22 (C) Incentive payments required to achieve the ratio of generalist  
23 to specialist health care providers needed in order to meet the  
24 standards of care and health needs of the population.

25 (D) Incentive payments required to recruit and retain nurse  
26 practitioners and physician assistants in order to provide primary  
27 and preventive care to the population.

28 (E) No bonus or incentive payment may be made in excess of  
29 the total allocation for health care provider and manager incentive  
30 and bonus reimbursement established by the commissioner in the  
31 system's budget.

32 (F) No incentive may adversely affect the care a patient receives  
33 or the care a health care provider recommends.

34 (h) Health care providers shall be paid for all services provided  
35 pursuant to this division, including care provided to persons who  
36 are subsequently determined to be ineligible for the system.

37 (i) Licensed health care providers who deliver services not  
38 covered under the system may establish rates and charge patients  
39 for those services.

- 1 (j) Reimbursement to health care providers and compensation  
2 to managers may not exceed the amount allocated by the  
3 commissioner to provider and manager annual budgets.
- 4 140209. (a) Fee-for-service health care providers shall choose  
5 representatives of their specialties to negotiate reimbursement rates  
6 with the Payments Board on their behalf.
- 7 (b) The Payments Board shall establish a uniform system of  
8 payments for all services provided pursuant to this division.
- 9 (c) Payment schedules shall be available to health care providers  
10 in printed and in electronic documents.
- 11 (d) Payment schedules shall be in effect for three years, at which  
12 time payment schedules may be renegotiated. Payment adjustments  
13 may be made at the discretion of the Payments Board to meet the  
14 goals of the system.
- 15 (e) In establishing a uniform system of payments, the Payments  
16 Board shall collaborate with regional planning directors and health  
17 care providers and shall take into consideration regional differences  
18 in the cost of living and the need to recruit and retain skilled health  
19 care providers in the region.
- 20 (f) Fee-for-service health care providers shall submit claims  
21 electronically to the ~~Universal~~ Healthcare Fund and shall be paid  
22 within 30 business days for claims filed in compliance with  
23 procedures established by the ~~Universal~~ Healthcare Fund.
- 24 140210. (a) Compensation for health care providers and upper  
25 level managers employed by, or under contract with, integrated  
26 health care delivery systems, group medical practices, and essential  
27 community providers that provide comprehensive, coordinated  
28 services shall be determined according to the following guidelines:
- 29 (b) Health care providers and upper level managers employed  
30 by, or under contract with, systems that provide comprehensive,  
31 coordinated health care services shall be represented by their  
32 respective employers or contractors for the purposes of negotiating  
33 reimbursement with the Payments Board.
- 34 (c) In negotiating reimbursement with systems providing  
35 comprehensive, coordinated services, the Payments Board shall  
36 take into consideration the need for comprehensive systems to  
37 have flexibility in establishing health care provider and upper level  
38 manager reimbursement.

1 (d) Payment schedules shall be in effect for three years.  
2 However, payment adjustments may be made at the discretion of  
3 the Payments Board to meet the goals of the system.

4 (e) The Payments Board shall take into consideration regional  
5 differences in the cost of living and the need to recruit and retain  
6 skilled health care providers and upper level managers to the  
7 regions.

8 (f) The Payments Board shall establish a timetable for  
9 reimbursement for fee-for-service health care providers  
10 negotiations. If an agreement on reimbursement is not reached  
11 according to the timetable established by the Payments Board, the  
12 Payments Board shall establish reimbursement rates, which shall  
13 be binding.

14 (g) Reimbursement negotiations shall be conducted consistent  
15 with the state action doctrine of the antitrust laws.

16 140211. (a) The Payments Board shall annually report to the  
17 commissioner on the status of health care provider and upper level  
18 manager reimbursement, including satisfaction with reimbursement  
19 levels and the sufficiency of funds allocated by the commissioner  
20 for provider and upper level manager reimbursement. The  
21 Payments Board shall recommend needed adjustments in the  
22 allocation for health care provider payments.

23 (b) The Office of Health Care Quality shall annually report to  
24 the commissioner on the impact of the bonus payments in  
25 improving quality of care, health outcomes, and management  
26 effectiveness. The Payments Board shall recommend needed  
27 adjustments in bonus allocations.

28 (c) The Office of Health Planning shall annually report to the  
29 commissioner on the impact of the incentive payments in recruiting  
30 health care providers and upper level managers to underserved  
31 areas, in establishing the needed ratio of generalist to specialist  
32 health care providers and in attracting and retaining nurse  
33 practitioners and physician assistants to the state and shall  
34 recommend needed adjustments.

35 140212. (a) The commissioner shall establish an allocation  
36 for each region to fund regional operating and capital budgets for  
37 a period of three years. Allocations shall be disbursed to the regions  
38 on a quarterly basis.

39 (b) Integrated health care delivery systems, essential community  
40 providers, and group medical practices that provide comprehensive,

1 coordinated services may choose to be reimbursed on the basis of  
2 a capitated system operating budget or a noncapitated system  
3 operating budget that covers all costs of providing health care  
4 services.

5 (c) Health care providers choosing to function on the basis of  
6 a capitated or a noncapitated system operating budget shall submit  
7 three-year operating budget requests to the regional planning  
8 director, pursuant to standards and guidelines established by the  
9 commissioner.

10 (1) Health care providers may include in their operating budget  
11 requests reimbursement for ancillary health care or social services  
12 that were previously funded by money now received and disbursed  
13 by the ~~Universal~~ Healthcare Fund.

14 (2) No payment may be made from a capitated or noncapitated  
15 budget for a capital expense except as provided in Section 140216.

16 (d) Regional planning directors shall negotiate operating budgets  
17 with regional health care entities, which shall cover a period of  
18 three years.

19 (e) Operating and capitated budgets shall include health care  
20 workforce labor costs other than those described in paragraphs  
21 (1), (2), and (3) of subdivision (d) of Section 140208. If unions  
22 represent employees working in systems functioning under  
23 capitated or noncapitated budgets, unions shall represent those  
24 employees in negotiations with the regional planning director and  
25 the Payments Board for the purpose of establishing their  
26 reimbursement.

27 140213. (a) Health systems and medical practices functioning  
28 under capitated and noncapitated operating budgets shall  
29 immediately report any projected operating deficit to the regional  
30 planning director. The regional planning director shall determine  
31 whether projected deficits reflect appropriate increases in  
32 expenditures, in which case the director shall make an adjustment  
33 to the operating budget. If the director determines that deficits are  
34 not justifiable, no adjustment shall be made.

35 (b) If a regional planning director determines that adjustments  
36 to operating budgets will cause a regional revenue shortfall and  
37 that cost control measures may be required, the regional planning  
38 director shall report the possible revenue shortfall to the  
39 commissioner and take actions required pursuant to Section  
40 140203.

1 140215. (a) Margins generated by a facility operating under  
2 a system operating budget may be retained and used to meet the  
3 health care needs of the population.

4 (b) No margin may be retained if that margin was generated  
5 through inappropriate limitations on access to health care or  
6 compromises in the quality of care or in any way that adversely  
7 affected or is likely to adversely affect the health of the persons  
8 receiving services from a facility, integrated health care delivery  
9 system, group medical practice, or essential community provider  
10 functioning under a system operating budget.

11 (1) The chief medical officer shall evaluate the source of margin  
12 generation and report violations of this section to the commissioner.

13 (2) The commissioner shall establish and enforce penalties for  
14 violations of this section.

15 (3) Penalty payments collected pursuant to violations of this  
16 section shall be remitted to the ~~Universal~~ Healthcare Fund for use  
17 in the California-~~Universal~~ Healthcare System.

18 (c) Facilities operating under system operating budgets of the  
19 California-~~Universal~~ Healthcare System may raise and expend  
20 funds from sources other than the system including, but not limited  
21 to, private or foundation donors for purposes related to the goals  
22 of this division and in accordance with provisions of this division.

23 140216. (a) During the transition, the commissioner shall  
24 develop a capital management plan that shall include  
25 conflict-of-interest standards and that shall govern all capital  
26 investments and acquisitions undertaken in the system. The plan  
27 shall include a framework, standards, and guidelines for all of the  
28 following:

29 (1) Standards whereby the Office of Health Planning shall  
30 oversee, assist in the implementation of, and ensure that the  
31 provisions of the capital management plan are enforced.

32 (2) Assessment and prioritization of short- and long-term capital  
33 needs of the system on statewide and regional bases.

34 (3) Assessment of capital health care assets and capital health  
35 care asset shortages on a regional and statewide basis at the time  
36 this division is first implemented.

37 (4) Development by the commissioner of a multiyear system  
38 capital development plan that supports the system's goals,  
39 priorities, and performance standards and meets the health *care*  
40 needs of the population.

1 (5) Development, as part of the system's capital budget, of  
2 regional capital allocations that shall cover a period of three years.

3 (6) Evaluation of, and support for, noninvestment means to  
4 meet health care needs, including, but not limited to, improvements  
5 in administrative efficiency, care quality, and innovative service  
6 delivery, use, adaptation or refurbishment of existing land and  
7 property, and identification of publicly owned land or property  
8 that may be available to the system and that may meet a capital  
9 need.

10 (7) Development and maintenance of capital inventories on a  
11 regional basis, including the condition, utilization capacity,  
12 maintenance plan and costs, deferred maintenance of existing  
13 capital inventory, and excess capital capacity.

14 (8) A process whereby those intending to make capital  
15 investments or acquisitions shall prepare a business case for making  
16 the investment or acquisition, including the full life-cycle costs of  
17 the project or acquisition, an environmental impact report that  
18 meets existing state standards, and a demonstration of how the  
19 investment or acquisition meets the health *care* needs of the  
20 population it is intended to serve. Acquisitions include, but are not  
21 limited to, the acquisition of land, operational property, or  
22 administrative office space.

23 (9) Standards and a process whereby the regional planning  
24 directors shall evaluate, accept, reject, or modify a business plan  
25 for a capital investment or acquisition. Decisions of a regional  
26 planning director may be appealed through a dispute resolution  
27 process established by the commissioner.

28 (10) Standards for binding project contracts between the system  
29 and the party developing a capital project or making a capital  
30 acquisition that shall govern all terms and conditions of capital  
31 investments and acquisitions, including terms and conditions for  
32 grants, loans, lines of credit, and lease-purchase arrangements by  
33 the system.

34 (11) A process and standards whereby the Director of the  
35 ~~Universal~~ Healthcare Fund shall negotiate terms and conditions  
36 of the liens, grants, lines of credit, and lease-purchase arrangements  
37 for capital investments and acquisitions by the system. Terms and  
38 conditions negotiated by the Director of the ~~Universal~~ Healthcare  
39 Fund shall be included in project contracts.

1 (12) A plan for the commissioner and for the regional planning  
2 directors to issue requests for proposals and to oversee a process  
3 of competitive bidding for the development of capital projects that  
4 meet the needs of the system and to fund, partially fund, or  
5 participate in seeking funding for, those capital projects.

6 (13) Responses to requests for proposals and competitive bids  
7 shall include a description of how a project meets the service needs  
8 of the region and addresses the environmental impact report and  
9 shall include the full life-cycle costs of a capital asset.

10 (14) Requests for proposals shall address how intellectual  
11 property will be handled and shall include conflict-of-interest  
12 guidelines that meet standards established by the commissioner  
13 as part of the capital management plan.

14 (15) A process and standards for periodic revisions in the capital  
15 management plan, including annual meetings in each region to  
16 discuss the plan and make recommendations for improvements in  
17 the plan.

18 (16) Standards for determining when a violation of these  
19 provisions shall be referred to the Attorney General for  
20 investigation and possible prosecution of the violation.

21 (b) No registered lobbyist shall participate in or in any way  
22 attempt to influence the request for proposals or competitive bid  
23 process.

24 (c) Development of performance standards and a process to  
25 monitor and measure performance of those making capital health  
26 care investments and acquisitions, including those making capital  
27 investments pursuant to a state competitive bidding process.

28 (d) A process for earned autonomy from state capital investment  
29 oversight for those who demonstrate the ability to manage capital  
30 investment and capital assets effectively in accordance with the  
31 system's standards, and standards for loss of earned autonomy  
32 when capital management is ineffective.

33 (e) Terms and conditions of capital project oversight by the  
34 system shall be based on the performance history of the project  
35 developer. Health care providers may earn autonomy from  
36 oversight if they demonstrate effective capital planning and project  
37 management, pursuant to the goals and guidelines established by  
38 the commissioner. Health care providers who do not demonstrate  
39 such proficiency shall remain subject to oversight by the regional  
40 planning director or shall lose autonomy from oversight.

1 (f) In general, no capital investment may be made from an  
2 operating budget. However, guidelines shall be established for the  
3 types and levels of small capital investments that may be  
4 undertaken from an operating budget without the approval of the  
5 regional planning director.

6 (g) Any capital investments required for compliance with  
7 federal, state, or local regulatory requirements or quality assurance  
8 standards shall be exempt from paragraph (2) of subdivision (c)  
9 of Section 140212.

10 140217. (a) Regional planning directors shall develop a  
11 regional capital development plan pursuant to the system's capital  
12 management plan established by the commissioner. In developing  
13 the regional capital development plan, the regional planning  
14 director shall do all of the following:

15 (1) Implement the standards and requirements of the capital  
16 management plan established by the commissioner.

17 (2) Develop a multiyear regional capital health management  
18 plan that supports regional goals and the state capital management  
19 plan.

20 (3) Assist regional health care providers to develop capital  
21 budget requests pursuant to the regional capital budget plan and  
22 the system's capital management plan established by the  
23 commissioner.

24 (4) Receive and evaluate capital budget requests from regional  
25 health care providers.

26 (5) Establish ranking criteria to assess competing demands for  
27 capital.

28 (6) Participate in planning for needed earthquake retrofits.  
29 However, the cost of mandatory earthquake retrofits of health care  
30 facilities shall not be the responsibility of the system.

31 (7) Conduct ongoing project evaluation to assure that terms and  
32 conditions of project funding are met.

33 (b) Services provided as a result of capital investments or  
34 acquisitions that do not meet the terms of the regional capital  
35 development plan and the capital management plan developed by  
36 the commissioner shall not be reimbursed by the system.

37 140218. (a) Assets financed by state grants, loans, lines of  
38 credit, and lease-purchase arrangements shall be owned, operated,  
39 and maintained by the recipient of the grant, loan, line of credit,  
40 or lease-purchase arrangement, according to terms established at



1 the time of issuance of the grant, loan, or line of credit, or  
2 lease-purchase arrangement.

3 (b) Assets financed under long-term leases with the system shall  
4 be transferred to public ownership at the end of the lease, unless  
5 the commissioner determines that an alternative disposition would  
6 be of greater benefit to the system, in which case the commissioner  
7 may authorize an alternative disposition.

8 (c) When an asset, which was in whole or in part financed by  
9 the system, is to be sold or transferred by a party that received  
10 financing from the system for purchase, lease, or construction of  
11 the asset, an impartial estimate of the fair market value of the asset  
12 shall be undertaken. The system shall receive a share of the fair  
13 market value of the asset at the time of its sale or transfer that is  
14 in proportion to the system's original investment. The system may  
15 elect to postpone receipt of its share of the value of the asset if the  
16 commissioner determines that the postponement meets the needs  
17 of the system.

18 140219. The regional planning directors shall make financial  
19 information available to the public when the system's contribution  
20 to a capital project is greater than twenty-five million dollars  
21 (\$25,000,000). Information shall include the purpose of the project  
22 or acquisition, its relation to the system's goals, the project budget  
23 and the timetable for completion, environmental impact reports,  
24 any terms-related conflicts of interest, and performance standards  
25 and benchmarks.

26 140220. (a) The commissioner shall establish a budget for the  
27 purchase of prescription drugs and durable and nondurable medical  
28 equipment for the system.

29 (b) The commissioner shall use the purchasing power of the  
30 state to obtain the lowest possible prices for prescription drugs and  
31 durable and nondurable medical equipment.

32 (c) The commissioner shall make discounted prices available  
33 to all California residents, licensed and accredited providers and  
34 facilities under the terms of their licenses and accreditation, health  
35 care providers, prescription drug and medical equipment  
36 wholesalers, and retailers of products approved for use and included  
37 in the benefit package of the system.

38 140221. (a) The commissioner shall establish a budget to  
39 support research and innovation that has been recommended by  
40 the chief medical officer, the ~~director of planning~~ *Director of the*

1 *Office of Health Planning*, the patient advocates, the Partnerships  
2 for Health, the Technology Advisory Committee, and others as  
3 required by the commissioner.

4 (b) The research and innovation budget shall support the goals  
5 and standards of the system.

6 140222. (a) The commissioner shall establish a budget to  
7 support the training, development, and continuing education of  
8 health care providers and the health care workforce needed to meet  
9 the health care needs of the population and the goals and standards  
10 of the system.

11 (b) During the transition, the commissioner shall determine an  
12 appropriate level and duration of spending to support the retraining  
13 and job placement of persons who have been displaced from  
14 employment as a result of the transition to the system.

15 (c) The commissioner shall establish guidelines for giving  
16 special consideration for employment to persons who have been  
17 displaced as a result of the transition to the system.

18 140223. (a) The commissioner shall establish a reserve ~~budget~~  
19 *account* pursuant to this section.

20 (b) The reserve budget may be used only for purposes set forth  
21 in this division.

22 140224. (a) The commissioner shall establish a budget that  
23 covers all costs of administering the system.

24 (b) Administrative costs on a systemwide basis shall be limited  
25 to 10 percent of system costs within five years of completing the  
26 transition to the system.

27 (c) Administrative costs on a systemwide basis shall be limited  
28 to 5 percent of system costs within 10 years of completing the  
29 transition to the system.

30 (d) The commissioner shall ensure that the percentage of the  
31 budget allocated to support system administration stays within the  
32 allowable limits and shall continually seek means to lower system  
33 administrative costs.

34 (e) The commissioner shall report to the public, the regional  
35 planning directors, and others attending the annual system revenue  
36 and expenditure conference pursuant to Section 140206 on the  
37 costs of administering the system and the regions and shall make  
38 recommendations for reducing administrative costs and receive  
39 recommendations for reducing administrative costs.

1 Article 2. California ~~Universal~~ Healthcare Premium  
2 Commission  
3

4 140230. (a) There is hereby created the California ~~Universal~~  
5 Healthcare Premium Commission, referred to in this division as  
6 the Premium Commission.

7 (b) The Premium Commission shall be composed of the  
8 following members:

9 (1) Three health economists with experience relevant to the  
10 functions of the Premium Commission. One shall be appointed by  
11 the Speaker of the Assembly, one shall be appointed by the Senate  
12 Committee on Rules, and one shall be appointed by the Governor.

13 (2) Two representatives of California's business community,  
14 with one representing small business. One shall be appointed by  
15 the Governor, and the representative of small business shall be  
16 appointed by the Senate Committee on Rules.

17 (3) Two representatives from organized labor. One shall be  
18 appointed by the Senate Committee on Rules, and one shall be  
19 appointed by the Speaker of the Assembly.

20 (4) Two representatives of nonprofit organizations whose  
21 principal purpose includes promoting the establishment of a system  
22 of universal health care in California. One shall be appointed by  
23 the Senate Committee on Rules and one shall be appointed by the  
24 Speaker of the Assembly.

25 (5) One representative of a nonprofit advocacy organization  
26 with expertise in taxation policy whose principal purpose includes  
27 advocating for sustainable funding for the public infrastructure.  
28 This person shall be appointed by the Speaker of the Assembly.

29 (6) Two members of the Legislature who shall be members of  
30 a policy committee having jurisdiction over health care issues.  
31 One shall be appointed by the Senate Committee on Rules and one  
32 shall be appointed by the Speaker of the Assembly.

33 (7) The Executive Officer of the Franchise Tax Board.

34 (8) The Chair of the State Board of Equalization.

35 (9) The Director of the Employment Development Department.

36 (10) The Legislative Analyst.

37 (11) The Secretary of California Health and Human Services.

38 (12) The Director of the Department of Finance.

39 (13) The Controller.

40 (14) The Treasurer.

1 (15) The Lieutenant Governor.

2 (c) Upon appointment, the Premium Commission shall meet at  
3 least once a month. The Premium Commission shall elect a chair  
4 from its membership during its first meeting. The Premium  
5 Commission shall receive public comments during a portion of  
6 each of its meetings, and all of its meetings shall be conducted  
7 pursuant to the Bagley-Keene Open Meeting Act (Article 9  
8 (commencing with Section 11120) of Chapter 1 of Part 1 of  
9 Division 3 of Title 2 of the Government Code).

10 140231. (a) The Premium Commission shall perform the  
11 following functions:

12 (1) Determine the aggregate costs of providing health care  
13 coverage pursuant to this division.

14 (2) Develop an equitable and affordable premium structure that  
15 will generate adequate revenue for the ~~Universal~~ Healthcare Fund  
16 established pursuant to Section 140200 and ensure stable and  
17 actuarially sound funding for the system.

18 (b) The Premium Commission shall perform the functions  
19 described in this section by considering existing financial  
20 simulations and analyses of universal health care proposals,  
21 including, but not limited to, the analysis completed by the Lewin  
22 Group in January 2005, of Senate Bill 921 of the 2003–04 Regular  
23 Session.

24 140232. (a) The premium structure developed by the Premium  
25 Commission shall satisfy the following criteria:

26 (1) Be means-based and generate adequate revenue to implement  
27 this division.

28 (2) To the greatest extent possible, ensure that all income earners  
29 and all employers contribute a premium amount that is affordable  
30 and that is consistent with existing funding sources for health care  
31 in California.

32 (3) Maintain the current ratio for aggregate health care  
33 contributions among the traditional health care funding sources,  
34 including employers, individuals, government, and other sources.

35 (4) Provide a fair distribution of monetary savings achieved  
36 from the establishment of a universal health care system.

37 (5) Coordinate with existing, ongoing funding sources from  
38 federal and state programs.

1 (6) Be consistent with state and federal requirements governing  
2 financial contributions for persons eligible for existing public  
3 programs.

4 (7) Comply with federal requirements.

5 (8) *Include an exemption for employers and employees who are*  
6 *subject to a collective bargaining agreement and participate in a*  
7 *Taft-Hartley Trust Fund that pays the employer and employee*  
8 *share of the premium to the Healthcare Fund.*

9 (b) The Premium Commission shall seek expert and legal advice  
10 regarding the best method to structure premium payments  
11 consistent with existing employer-employee health care financing  
12 structures.

13 140233. The Premium Commission may take all of the  
14 following actions:

15 (a) Obtain grants from, and contract with, individuals and  
16 private, local, state, and federal agencies, organizations, and  
17 institutions, including institutions of higher education.

18 (b) Receive charitable contributions or any other source of  
19 income that may be lawfully received.

20 140234. (a) The Premium Commission may consult with  
21 additional persons, advisory entities, governmental agencies,  
22 Members of the Legislature, and legislative staff as it deems  
23 necessary to perform its functions.

24 (b) The Premium Commission shall seek structured input from  
25 representatives of stakeholder organizations, policy institutes, and  
26 other persons with expertise in health care, health care financing,  
27 or universal health care models in order to ensure that it has the  
28 necessary information, expertise, and experience to perform its  
29 functions.

30 (c) The Premium Commission shall be supported by a reasonable  
31 amount of staff time, which shall be provided by the state agencies  
32 with membership on the Premium Commission. The Premium  
33 Commission may request data from, and utilize the technical  
34 expertise of, other state agencies.

35 140235. (a) On or before January 1, 2010, the Premium  
36 Commission shall submit to the Governor and the Legislature a  
37 detailed recommendation for a premium structure.

38 (b) The Premium Commission shall submit a draft  
39 recommendation to the Governor, Legislature, and the public at  
40 least 90 days prior to submission of the final recommendation

1 described in subdivision (a). The Premium Commission shall seek  
2 input from the public on the draft recommendation.  
3 140236. The Premium Commission shall be funded upon an  
4 appropriation by the Legislature in the Budget Act of 2008.

5

6

### Article 3. Governmental Payments

7

8 140240. (a) (1) The commissioner shall seek all necessary  
9 waivers, exemptions, agreements, or legislation, so that all current  
10 federal payments to the state for health care services be paid  
11 directly to the system, which shall then assume responsibility for  
12 all benefits and services previously paid for by the federal  
13 government with those funds.

14 (2) In obtaining the waivers, exemptions, agreements, or  
15 legislation, the commissioner shall seek from the federal  
16 government a contribution for health care services in California  
17 that shall not decrease in relation to the contribution to other states  
18 as a result of the waivers, exemptions, agreements, or legislation.

19 (b) (1) The commissioner shall seek all necessary waivers,  
20 exemptions, agreements, or legislation, so that all current state  
21 payments for health care services shall be paid directly to the  
22 system, which shall then assume responsibility for all benefits and  
23 services previously paid for by state government with those funds.

24 (2) In obtaining the waivers, exemptions, agreements, or  
25 legislation, the commissioner shall seek from the Legislature a  
26 contribution for health care services that shall not decrease in  
27 relation to state government expenditures for health care services  
28 in the year that this division was enacted, except that it may be  
29 corrected for change in state gross domestic product, the size and  
30 age of population, and the number of residents living below the  
31 federal poverty level.

32 (c) The commissioner shall establish formulas for equitable  
33 contributions to the system from all California counties and other  
34 local government agencies.

35 (d) The commissioner shall seek all necessary waivers,  
36 exemptions, agreements, or legislation, so that all county or other  
37 local government agency payments shall be paid directly to the  
38 system.

39 140241. The system's responsibility for providing health care  
40 services shall be secondary to existing federal, state, or local

1 governmental programs for health care services to the extent that  
2 funding for these programs is not transferred to the ~~Universal~~  
3 Healthcare Fund or that the transfer is delayed beyond the date on  
4 which initial benefits are provided under the system.

5 140242. In order to minimize the administrative burden of  
6 maintaining eligibility records for programs transferred to the  
7 system, the commissioner shall strive to reach an agreement with  
8 federal, state, and local governments in which their contributions  
9 to the ~~Universal~~ Healthcare Fund shall be fixed to the rate of  
10 change of the state gross domestic product, the size and age of  
11 population, and the number of residents living below the federal  
12 poverty level.

13 140243. If and to the extent that federal law and regulations  
14 allow the transfer of Medi-Cal program funding to the system, the  
15 commissioner shall pay from the ~~Universal~~ Healthcare Fund all  
16 premiums, deductible payments, and coinsurance for qualified  
17 Medicare beneficiaries who are receiving benefits pursuant to  
18 Chapter 3 (commencing with Section 12000) of Part 3 of Division  
19 9 of the Welfare and Institutions Code.

20 140244. If and to the extent that the commissioner obtains  
21 authorization to incorporate Medicare revenues into the ~~Universal~~  
22 Healthcare Fund, Medicare Part B payments that previously were  
23 made by individuals or the commissioner shall be paid by the  
24 system for all individuals eligible for both the system and the  
25 Medicare Program.

26

#### 27 Article 4. Federal Preemption

28

29 140300. (a) The commissioner shall pursue all reasonable  
30 means to secure a repeal or a waiver of any provision of federal  
31 law that preempts any provision of this division.

32 (b) If a repeal or a waiver of law or regulations cannot be  
33 secured, the commissioner shall exercise his or her powers to  
34 promulgate rules and regulations, or seek conforming state  
35 legislation, consistent with federal law, in an effort to best fulfill  
36 the purposes of this division.

37 140301. (a) To the extent permitted by federal law, an  
38 employee entitled to health or related benefits under a contract or  
39 plan that, under federal law, preempts provisions of this division,

1 shall first seek benefits under that contract or plan before receiving  
2 benefits from the system under this division.

3 (b) No benefits shall be denied under the system created by this  
4 division unless the employee has failed to take reasonable steps  
5 to secure like benefits from the contract or plan, if those benefits  
6 are available.

7 (c) Nothing in this section shall preclude a person from receiving  
8 benefits from the system under this division that are superior to  
9 benefits available to the person under an existing contract or plan.

10 (d) Nothing in this division is intended, nor shall this division  
11 be construed, to discourage recourse to contracts or plans that are  
12 protected by federal law.

13 (e) To the extent permitted by federal law, a health care provider  
14 shall first seek payment from the contract or plan, before submitting  
15 bills to the system.

16

17

#### Article 5. Subrogation

18

19 140302. (a) It is the intent of this division to establish a single  
20 public payer for all health care services in the State of California.  
21 However, until such time as the role of all other payers for health  
22 care services has been terminated, costs for health care services  
23 shall be collected from collateral sources whenever health care  
24 services provided to an individual are, or may be, covered services  
25 under a policy of insurance, health care service plan, or other  
26 collateral source available to that individual, or for which the  
27 individual has a right of action for compensation to the extent  
28 permitted by law.

29 (b) As used in this article, collateral source includes all of the  
30 following:

31 (1) Insurance policies written by insurers, including the medical  
32 components of automobile, homeowners, and other forms of  
33 insurance.

34 (2) Health care service plans and pension plans.

35 (3) Employers.

36 (4) Employee benefit contracts.

37 (5) Government benefit programs.

38 (6) A judgment for damages for personal injury.

39 (7) Any third party who is or may be liable to an individual for  
40 health care services or costs.



1 (c) “Collateral source” does not include either of the following:

2 (1) A contract or plan that is subject to federal preemption.

3 (2) Any governmental unit, agency, or service, to the extent that  
4 subrogation is prohibited by law. An entity described in subdivision  
5 (b) is not excluded from the obligations imposed by this article by  
6 virtue of a contract or relationship with a governmental unit,  
7 agency, or service.

8 (d) The commissioner shall attempt to negotiate waivers, seek  
9 federal legislation, or make other arrangements to incorporate  
10 collateral sources in California into the system.

11 140303. Whenever an individual receives health care services  
12 under the system and he or she is entitled to coverage,  
13 reimbursement, indemnity, or other compensation from a collateral  
14 source, he or she shall notify the health care provider and provide  
15 information identifying the collateral source, the nature and extent  
16 of coverage or entitlement, and other relevant information. The  
17 health care provider shall forward this information to the  
18 commissioner. The individual entitled to coverage, reimbursement,  
19 indemnity, or other compensation from a collateral source shall  
20 provide additional information as requested by the commissioner.

21 140304. (a) The system shall seek reimbursement from the  
22 collateral source for services provided to the individual and may  
23 institute appropriate action, including suit, to recover the  
24 reimbursement. Upon demand, the collateral source shall pay to  
25 the ~~Universal~~ Healthcare Fund the sums it would have paid or  
26 expended on behalf of the individual for the health care services  
27 provided by the system.

28 (b) In addition to any other right to recovery provided in this  
29 article, the commissioner shall have the same right to recover the  
30 reasonable value of benefits from a collateral source as provided  
31 to the Director of Health Care Services by Article 3.5 (commencing  
32 with Section 14124.70) of Chapter 7 of Part 3 of Division 9 of the  
33 Welfare and Institutions Code, in the manner so provided.

34 140305. (a) If a collateral source is exempt from subrogation  
35 or the obligation to reimburse the system as provided in this article,  
36 the commissioner may require that an individual who is entitled  
37 to health care services from the source first seek those services  
38 from that source before seeking those services from the system.

39 (b) To the extent permitted by federal law, contractual retiree  
40 health benefits provided by employers shall be subject to the same

1 subrogation as other contracts, allowing the system to recover the  
2 cost of health care services provided to individuals covered by the  
3 retiree benefits, unless and until arrangements are made to transfer  
4 the revenues of the benefits directly to the system.

5 140306. (a) Default, underpayment, or late payment of any  
6 tax or other obligation imposed by this division shall result in the  
7 remedies and penalties provided by law, except as provided in this  
8 section.

9 (b) Eligibility for benefits under Chapter 4 (commencing with  
10 Section 140400) shall not be impaired by any default,  
11 underpayment, or late payment of any tax or other obligation  
12 imposed by this chapter.

13 140307. The agency and the commissioner shall be exempt  
14 from the regulatory oversight and review of the Office of  
15 Administrative Law pursuant to Chapter 3.5 (commencing with  
16 Section 11340) of Part 1 of Division 3 of Title 2 of the Government  
17 Code. Actions taken by the agency, including, but not limited to,  
18 the negotiating or setting of rates, fees, or prices, and the  
19 promulgation of any and all regulations, shall be exempt from any  
20 review by the Office of Administrative Law, except for Sections  
21 11344.1, 11344.2, 11344.3, and 11344.6 of the Government Code,  
22 addressing the publication of regulations.

23 140308. The agency shall adopt regulations to implement the  
24 provisions of this division. The regulations may initially be adopted  
25 as emergency regulations in accordance with the Administrative  
26 Procedure Act (Chapter 3.5 (commencing with Section 11340) of  
27 Part 1 of Division 3 of Title 2 of the Government Code), but those  
28 emergency regulations shall be in effect only from the effective  
29 date of this division until the conclusion of the transition period.

30

31

#### CHAPTER 4. ELIGIBILITY

32

33 140400. All California residents shall be eligible for the system.  
34 Residency shall be based upon physical presence in the state with  
35 the intent to reside. The commissioner shall establish standards  
36 and a simplified procedure to demonstrate proof of residency.

37 140401. The commissioner shall establish a procedure to enroll  
38 eligible residents and provide each eligible individual with  
39 identification that can be used by health care providers to determine  
40 eligibility for services.

1 140402. (a) It is the intent of the Legislature for the system to  
2 provide health care coverage to California residents who are  
3 temporarily out of the state. The commissioner shall determine  
4 eligibility standards for residents temporarily out of state for longer  
5 than 90 days who intend to return and reside in California and for  
6 nonresidents temporarily employed in California. *The*  
7 *commissioner may establish financial arrangements with medical*  
8 *providers in other states and foreign countries in order to facilitate*  
9 *coverage for California residents who are temporarily out of the*  
10 *state.*

11 (b) Coverage for emergency care obtained out of state shall be  
12 at prevailing local rates. Coverage for nonemergency care obtained  
13 out of state shall be according to rates and conditions established  
14 by the commissioner. The commissioner may require that a resident  
15 be transported back to California when prolonged treatment of an  
16 emergency condition is necessary and when that transport will not  
17 adversely affect a patient's care or condition.

18 140403. Visitors to California shall be billed for all services  
19 received under the system. The commissioner may establish  
20 intergovernmental arrangements with other states and countries  
21 to provide reciprocal coverage for temporary visitors.

22 140404. All persons eligible for health care benefits from  
23 California employers but who are working in another jurisdiction  
24 shall be eligible for health care benefits under this division  
25 providing that they make payments equivalent to the payments  
26 they would be required to make if they were residing in California.

27 140404.1. ~~(a) All persons who under an employer-employee~~  
28 ~~contract or under statute are eligible for retiree health care benefits,~~  
29 ~~including retirees who elect to reside outside of California, shall~~  
30 ~~remain eligible for those benefits providing that the contractually~~  
31 ~~mandated payments for those benefits are made to the Universal~~  
32 ~~Healthcare Fund, which shall assume financial responsibility for~~  
33 ~~care provided under the terms of the contract. eligible for those~~  
34 ~~benefits in accordance with the contract or the statute.~~

35 ~~(b) The commissioner may establish financial arrangements~~  
36 ~~with states and foreign countries in order to facilitate meeting the~~  
37 ~~terms of the contracts described in subdivision (a), except that~~  
38 ~~payments for care provided by non-California health care providers~~  
39 ~~to California retirees shall be reimbursed at rates established by~~  
40 ~~the commissioner.~~

1 140405. Unmarried, unemancipated minors shall be deemed  
2 to have the residency of their parent or guardian. If a minor’s  
3 parents are deceased and a legal guardian has not been appointed,  
4 or if a minor has been emancipated by court order, the minor may  
5 establish his or her own residency.

6 140406. (a) An individual shall be presumed to be eligible if  
7 he or she arrives at a health facility and is unconscious, comatose,  
8 or otherwise unable, because of his or her physical or mental  
9 condition, to document eligibility or to act in his or her own behalf,  
10 or if the patient is a minor, the patient shall be presumed to be  
11 eligible, and the health facility shall provide care as if the patient  
12 were eligible.

13 (b) Any individual shall be presumed to be eligible when brought  
14 to a health facility pursuant to any provision of Section 5150 of  
15 the Welfare and Institutions Code.

16 (c) Any individual involuntarily committed to an acute  
17 psychiatric facility or to a hospital with psychiatric beds pursuant  
18 to any provision of Section 5150 of the Welfare and Institutions  
19 Code, providing for involuntary commitment, shall be presumed  
20 eligible.

21 (d) All health facilities subject to state and federal provisions  
22 governing emergency medical treatment shall continue to comply  
23 with those provisions.

24 (e) In the event of an influx of people into the state for the  
25 purposes of receiving medical care, the commissioner shall  
26 establish an eligibility waiting period and other criteria needed to  
27 ensure the fiscal stability of the system.

28  
29  
30

CHAPTER 5. BENEFITS

31 140500. Any eligible individual may choose to receive services  
32 under the system from any willing professional health care provider  
33 participating in the system. No health care provider may refuse to  
34 care for a patient solely on any basis that is specified in the  
35 prohibition of employment discrimination contained in the Fair  
36 Employment and Housing Act (Part 2.8 (commencing with Section  
37 12900) of Division 3 of Title 2 of the Government Code).

38 *140500.01. A resident of the state in a family with an annual*  
39 *or monthly net nonexempt household income equal to or less than*  
40 *200 percent of the federal poverty level is eligible for no-cost*

1 *Medi-Cal and shall be entitled to not less than the full scope of*  
2 *benefits available under the Medi-Cal program, pursuant to Section*  
3 *14021 of, and Article 4 (commencing with Section 14131) of*  
4 *Chapter of Division 9 of, the Welfare and Institutions Code, as*  
5 *provided on January 1, 2008.*

6 140501. Covered benefits under this chapter shall include all  
7 medical care determined to be medically appropriate by the  
8 individual's health care provider, but are subject to limitations set  
9 forth in Section 140503. Covered benefits include, but are not  
10 limited to, all of the following:

- 11 (a) Inpatient and outpatient health facility services.
- 12 (b) Inpatient and outpatient professional health care provider  
13 services by licensed health care professionals.
- 14 (c) Diagnostic imaging, laboratory services, and other diagnostic  
15 and evaluative services.
- 16 (d) Durable medical equipment, appliances, and assistive  
17 technology, including prosthetics, eyeglasses, and hearing aids  
18 and their repair.
- 19 (e) Rehabilitative care.
- 20 (f) Emergency transportation and necessary transportation for  
21 health care services for disabled and indigent persons.
- 22 (g) Language interpretation and translation for health care  
23 services, including sign language for those unable to speak, or  
24 hear, or who are language impaired, and Braille translation or other  
25 services for those with no or low vision.
- 26 (h) Child and adult immunizations and preventive care.
- 27 (i) Health education.
- 28 (j) Hospice care.
- 29 (k) Home health care.
- 30 (l) Prescription drugs that are listed on the system's formulary.  
31 Nonformulary prescription drugs may be included if standards and  
32 criteria established by the commissioner are met.
- 33 (m) Mental and behavioral health care.
- 34 (n) Dental care.
- 35 (o) Podiatric care.
- 36 (p) Chiropractic care.
- 37 (q) Acupuncture.
- 38 (r) Blood and blood products.
- 39 (s) Emergency care services.
- 40 (t) Vision care.

- 1 (u) Adult day care.
- 2 (v) Case management and coordination to ensure services
- 3 necessary to enable a person to remain safely in the least restrictive
- 4 setting.
- 5 (w) Substance abuse treatment.
- 6 (x) Care of up to 100 days in a skilled nursing facility following
- 7 hospitalization.
- 8 (y) Dialysis.
- 9 (z) Benefits offered by a bona fide church, sect, denomination,
- 10 or organization whose principles include healing entirely by prayer
- 11 or spiritual means provided by a duly authorized and accredited
- 12 practitioner or nurse of that bona fide church, sect, denomination,
- 13 or organization.
- 14 (aa) *Chronic disease management.*
- 15 (ab) *Family planning services and supplies.*
- 16 (ac) *For persons under 21 years of age, early and periodic*
- 17 *screening, diagnosis, and treatment services, as defined in 42*
- 18 *U.S.C. Sec. 1396d(r), whether or not those services are covered*
- 19 *benefits for persons who are 21 years of age or older.*
- 20 140502. The commissioner may expand benefits beyond the
- 21 minimum benefits described in this chapter when expansion meets
- 22 the intent of this division and when there are sufficient funds to
- 23 cover the expansion.
- 24 140503. The following health care services shall be excluded
- 25 from coverage by the system:
- 26 (a) Health care services determined to have no medical
- 27 indication by the commissioner and the chief medical officer.
- 28 (b) Surgery, dermatology, orthodontia, prescription drugs, and
- 29 other procedures primarily for cosmetic purposes, unless required
- 30 to correct a congenital defect, restore or correct a part of the body
- 31 that has been altered as a result of injury, disease, or surgery, or
- 32 determined to be medically necessary by a qualified, licensed
- 33 health care provider in the system.
- 34 (c) Private rooms in inpatient health facilities where appropriate
- 35 nonprivate rooms are available, unless determined to be medically
- 36 necessary by a qualified, licensed health care provider in the
- 37 system.
- 38 (d) Services of a health care provider or facility that is not
- 39 licensed or accredited by the state except for approved services

1 provided to a California resident who is temporarily out of the  
2 state.

3 140504. (a) *During the initial two years of the system's*  
4 *operation, the commissioner shall not impose a deductible payment*  
5 *or copayment other than for treatment by a specialist if no referral*  
6 *was made by the primary care provider pursuant to Section*  
7 *140601. The commissioner shall determine the amount of the*  
8 *copayment or deductible imposed pursuant to this subdivision.*  
9 *The commissioner and the Healthcare Policy Board shall review*  
10 *the deductible and copayment provisions annually, commencing*  
11 *in the third year of the system's operation, to determine whether*  
12 *they should be included in the system.*

13 (b) *Commencing in the third year of the system's operation, the*  
14 *commissioner may impose a deductible payment and copayment*  
15 *pursuant to the determination made under subdivision (a). The*  
16 *amount of the deductible payment and the copayment shall not*  
17 *exceed two hundred fifty dollars (\$250) per person each year and*  
18 *five hundred dollars (\$500) per family each year, except the*  
19 *deductible payment and copayment for treatment by a specialist*  
20 *without a referral from the primary care provider pursuant to*  
21 *Section 140601 shall not be subject to this limitation and shall be*  
22 *established by the commissioner.*

23 (c) No copayments or deductible payments may be established  
24 for preventive care as determined by a patient's primary care  
25 provider.

26 ~~(b)~~

27 (d) No copayments or deductible payments may be established  
28 when prohibited by federal law.

29 ~~(e)~~

30 (e) *No deductible payments or copayments may be imposed on*  
31 *a person who is eligible for benefits under the Medi-Cal program*  
32 *(Chapter 7 (commencing with Section 14000) of Part 3 of Division*  
33 *9 of the Welfare and Institutions Code), except for treatment by a*  
34 *specialist without a referral from the primary care provider*  
35 *pursuant to Section 140601.*

36 (f) The commissioner shall establish standards and procedures  
37 for waiving copayments or deductible payments for a person who  
38 demonstrates, to the commissioner's satisfaction, that the person  
39 lacks the financial means to pay the copayment or deductible.

1 Waivers of copayments or deductible payments shall not affect  
2 the reimbursement of health care providers.

3 ~~(d)~~

4 (g) Any copayments established pursuant to this section and  
5 collected by health care providers shall be transmitted to the  
6 Treasurer to be deposited to the credit of the Universal Healthcare  
7 Fund.

8 ~~(e)~~

9 (h) Nothing in this division shall be construed to diminish the  
10 benefits that an individual has under a collective bargaining  
11 agreement.

12 ~~(f)~~

13 (i) Nothing in this division shall preclude employees from  
14 receiving benefits available to them under a collective bargaining  
15 agreement or other employee-employer agreement that are superior  
16 to benefits under this division.

17

18 CHAPTER 6. DELIVERY OF CARE

19

20 140600. (a) All health care providers licensed or accredited  
21 to practice in California may participate in the system.

22 (b) No health care provider whose license or accreditation is  
23 suspended or revoked may participate in the system.

24 (c) If a health care provider is on probation, the licensing or the  
25 accrediting agency shall monitor the health care provider in  
26 question, pursuant to applicable California law. The licensing or  
27 accrediting agency shall report to the chief medical officer at  
28 intervals established by the chief medical officer, on the status of  
29 health care providers who are on probation and on measures  
30 undertaken to assist health care providers to return to practice and  
31 to resolve complaints made by patients.

32 (d) Health care providers may accept eligible persons for care  
33 according to the health care provider's ability to provide services  
34 needed by the patient and according to the number of patients a  
35 health care provider can treat without compromising safety and  
36 care quality. A health care provider may accept patients in the  
37 order of time of application.

38 (e) A health care provider shall not refuse to care for a patient  
39 solely on any basis that is specified in the prohibition of  
40 employment discrimination contained in the Fair Employment and



1 Housing Act (Part 2.8 (commencing with Section 12900) of  
2 Division 3 of Title 2 of the Government Code).

3 (f) Choice of health care provider:

4 (1) Persons eligible for health care services under this division  
5 may choose a primary care provider.

6 (A) Primary care providers include family practitioners, general  
7 practitioners, internists and pediatricians, nurse practitioners and  
8 physician assistants practicing under supervision as defined in  
9 California codes, and doctors of osteopathy licensed to practice  
10 as general doctors.

11 (B) Women may choose an obstetrician-gynecologist, in addition  
12 to a primary *care* provider.

13 (2) Persons who choose to enroll with integrated health care  
14 delivery systems, group medical practices, or essential community  
15 providers that offer comprehensive services, shall retain  
16 membership for at least one year after an initial three-month  
17 evaluation period during which time they may withdraw for any  
18 reason.

19 (A) The three-month period shall commence on the date when  
20 an enrollee first sees a primary care provider.

21 (B) Persons who want to withdraw after the initial three-month  
22 period shall request a withdrawal pursuant to dispute resolution  
23 procedures established by the commissioner and may request  
24 assistance from the patient advocate in the dispute process. The  
25 dispute shall be resolved in a timely fashion and shall have no  
26 adverse effect on the care a patient receives.

27 (3) Persons needing to change primary care providers because  
28 of health care needs that their primary care provider cannot meet  
29 may change primary care providers at any time.

30 140601. (a) Primary care providers shall coordinate the care  
31 a patient receives or shall ensure that a patient's care is coordinated.

32 (b) (1) Patients shall have a referral from their primary care  
33 provider, or from a health care provider rendering care to them in  
34 the emergency room or other accredited emergency setting, or  
35 from a health care provider treating a patient for an emergency  
36 condition in any setting, or from their ~~obstetrician/gynecologist~~  
37 *obstetrician-gynecologist*, to see a physician or nonphysician  
38 specialist whose services are covered by this division, unless the  
39 patient agrees to assume the ~~costs of care, in which case a referral~~  
40 ~~is not needed. A referral shall~~ *costs of care or pay a copayment,*

1 *if implemented by the commissioner pursuant to Section 140504.*

2 *A referral shall not be required to see a dentist.*

3 (2) Referrals shall be based on the medical needs of the patient  
4 and on guidelines, which shall be established by the chief medical  
5 officer to support clinical decisionmaking.

6 (3) Referrals shall not be restricted or provided solely because  
7 of financial considerations. The chief medical officer shall monitor  
8 referral patterns and intervene as necessary to assure that referrals  
9 are neither restricted nor provided solely because of financial  
10 considerations.

11 (4) For the first six months of the system's operation, no  
12 specialist referral shall be required for patients who had been  
13 receiving care from a specialist prior to the initiation of the system.  
14 Beginning with the seventh month ~~the~~ *of the* system's operation,  
15 all patients shall be required to obtain a referral from a primary or  
16 emergency care provider for specialty care if the care is to be paid  
17 for by the system. No referral is required if a patient pays the full  
18 cost of the specialty care and the specialist accepts that payment  
19 arrangement.

20 (5) Where referral processes are in place prior to the initiation  
21 of the system, the chief medical officer shall review the referral  
22 processes to assure that they meet the system's standards for care  
23 quality and shall assure needed changes are implemented so that  
24 all Californians receive the same standards of care quality *and*  
25 *access to specialty care.*

26 (6) A specialist may serve as the primary care provider if the  
27 patient and the provider agree to this arrangement and if the  
28 provider agrees to coordinate the patient's care or to ensure that  
29 the care the patient receives is coordinated.

30 (7) The commissioner shall establish or ensure the establishment  
31 of a computerized referral registry to facilitate the referral process  
32 and to allow a specialist and a patient to easily determine whether  
33 a referral has been made pursuant to this division.

34 (8) A patient may appeal the denial of a referral through the  
35 dispute resolution procedures established by the commissioner  
36 and may request the assistance of the patient advocate during the  
37 dispute resolution process.

38 140602. (a) The purpose of the Office of Health Planning is  
39 to plan for the short- and long-term health *care* needs of the

1 population pursuant to the health care and finance standards  
2 established by the commissioner and by this division.

3 (b) The office shall be headed by a director appointed by the  
4 commissioner. The director shall serve pursuant to provisions of  
5 subdivisions (c), (d), and (e) of Section 140100 and subdivisions  
6 (j) and (k) of Section 140101.

7 (c) The director shall do all the following:

8 (1) Administer all aspects of the Office of Health Planning.

9 (2) Serve on the ~~Universal~~ Healthcare Policy Board.

10 (3) Establish performance criteria in measurable terms for health  
11 care goals in consultation with the chief medical officer, the  
12 regional planning directors, and ~~medical directors~~ *regional medical*  
13 *officers* and others with experience in health care outcomes  
14 measurement and evaluation.

15 (4) Evaluate the effectiveness of performance criteria in  
16 accurately measuring quality of care, administration, and planning.

17 (5) Assist the health care regions to develop operating and  
18 capital requests pursuant to health care and financial guidelines  
19 established by the commissioner and by this division. In assisting  
20 regions, the director shall do all of the following:

21 (A) Identify medically underserved areas and health care service  
22 and asset shortages.

23 (B) Identify disparities in health outcomes.

24 (C) Establish conventions for the definition, collection, storage,  
25 analysis, and transmission of data for use by the system.

26 (D) Establish electronic systems that support dissemination of  
27 information to health care providers and patients about integrated  
28 health network and integrated health care delivery systems and  
29 community-based health care resources.

30 (E) Support establishment of comprehensive health care  
31 databases using uniform methodology that is compatible among  
32 the regions and between the regions and the agency.

33 (F) Provide information to support effective regional planning  
34 and innovation.

35 (G) Provide information to support interregional planning,  
36 including planning for access to specialized centers that perform  
37 a high volume of procedures for conditions requiring highly  
38 specialized treatments, including emergency and trauma, and other  
39 interregional access to needed care, and planning for coordinated  
40 interregional capital investment.

1 (H) Provide information for, and participate in, earthquake  
2 retrofit planning.

3 (I) Evaluate regional budget requests and make  
4 recommendations to the commissioner about regional revenue  
5 allocations.

6 (6) Estimate the health care workforce required to meet the  
7 health care needs of the population pursuant to the standards and  
8 goals established by the commissioner, the costs of providing the  
9 needed workforce, and, in collaboration with regional planners,  
10 educational institutions, the Governor, and the Legislature, develop  
11 short- and long-term plans to meet those needs, including a plan  
12 to finance needed training.

13 (7) Estimate the number and types of health facilities required  
14 to meet the short- and long-term health care needs of the population  
15 and the projected costs of needed facilities. In collaboration with  
16 the commissioner, regional planning directors and ~~medical directors~~  
17 *regional medical officers*, the chief medical officer, the Governor,  
18 and the Legislature, develop plans to finance and build needed  
19 facilities.

20 140603. The Technology Advisory Group shall explore the  
21 feasibility and the value to the health of the population of the  
22 following electronic initiatives:

23 (a) Establish integrated statewide health care databases to  
24 support health care planning and determine which databases should  
25 be established on a statewide basis and which should be established  
26 on a regional basis.

27 (b) Assure that databases have uniform methodology and formats  
28 that are compatible among the regions and between the regions  
29 and the agency.

30 (c) Establish mandatory database reporting requirements and  
31 penalties for noncompliance. Monitor the effectiveness of reporting  
32 and make needed improvements.

33 (d) Establish means for anonymous reporting to the chief  
34 medical officer and regional ~~medical directors~~ *officers* of medical  
35 errors and other related problems, and for anonymous reporting  
36 to the commissioner and regional planning directors of problems  
37 related to ineffective management, and establish guidelines for the  
38 protection of persons coming forward to report these problems.

39 (e) In collaboration with the chief medical officer, the Office  
40 of Patient Advocacy, and regional patient advocates, investigate

1 the costs and benefits of electronic and online scheduling systems  
2 and means of health care provider-patient communication that  
3 allow for electronic visits, and make recommendations to the chief  
4 medical officer regarding the use of these concepts in the system.

5 (f) In collaboration with the chief medical officer, establish  
6 electronic systems and other means that support the use of  
7 standards of care based on clinical efficacy to guide clinical  
8 decisionmaking by all who provide services in the system.

9 (g) In collaboration with the chief medical officer, support the  
10 development of disease management programs and their use in  
11 the system.

12 (h) Establish electronic initiatives that reduce administration  
13 costs.

14 (i) Collaborate with the chief medical officer and regional  
15 ~~medical-directors~~ *officers* to assure the development of software  
16 systems that link clinical guidelines to individual patient conditions,  
17 and guide clinicians through diagnosis and treatment algorithms  
18 derived from research based on clinical efficacy and best medical  
19 practices.

20 (j) Collaborate with the chief medical officer and regional  
21 ~~medical-directors~~ *officers* to assure the development of software  
22 systems that offer health care providers access to guidelines that  
23 are appropriate for their specialty and that include current  
24 information on prevention and treatment of disease.

25 (k) In collaboration with the Partnerships for Health and regional  
26 ~~medical-directors~~ *officers*, establish Web-based, patient-centered  
27 information systems that assist people to promote and maintain  
28 health and provide information on health conditions and recent  
29 developments in treatment.

30 (l) Establish electronic systems and other means to provide  
31 patients with easily understandable information about the  
32 performance of health care providers. This shall include, but not  
33 be limited to, information about the experience that health care  
34 providers have in the field or fields in which they deliver care, the  
35 number of years they have practiced in their field and, in the case  
36 of medical and surgical procedures, the number of procedures they  
37 have performed in their area or areas of specialization.

38 (m) Establish electronic systems that facilitate health care  
39 provider continuing medical education that meets licensure  
40 requirements.

1 (n) Recommend to the commissioner means to link health care  
2 research with the goals and priorities of the system.

3 140604. (a) The Director of the Office of Health Planning  
4 shall establish standards for culturally and linguistically competent  
5 care, which shall include, but not be limited to, all of the following:

6 (1) State Department of Health Care Services and the  
7 Department of Managed Care guidelines for culturally and  
8 linguistically sensitive care.

9 (2) Medi-Cal Managed Care Division (MMCD) Policy Letters  
10 99-01 to 99-04 and MMCD All Plan Letter 99005 by the Cultural  
11 and Linguistic.

12 (3) Subchapter 5 of the Civil Rights Act of 1964 (42 U.S.C.  
13 Sec. 2000d).

14 (4) United States Department of Health and Human Services'  
15 Office of Civil Rights; Title VI of the Civil Rights Act of 1964;  
16 Policy Guidance on Prohibition Against National Origin  
17 Discrimination as It Affects Persons with Limited English  
18 Proficiency (February 1, 2002).

19 (5) United States Department of Health and Human Services'  
20 Office of Minority Health; National Standards on Culturally and  
21 Linguistically Appropriate Services (CLAS) in Health Care—Final  
22 Report (December 22, 2000).

23 (b) The director shall annually evaluate the effectiveness of  
24 standards for culturally and linguistically competent care and make  
25 recommendations to the commissioner, the Office of Patient  
26 Advocacy, and the chief medical officer for needed improvements.  
27 In evaluating the standards for culturally and linguistically sensitive  
28 care, the director shall establish a process to receive concerns and  
29 comments from consumers.

30 (c) The director shall pursue available federal financial  
31 participation for the provision of a language services program that  
32 supports the system's goals.

33 140605. (a) Within the agency, the commissioner shall  
34 establish the Office of Health Care Quality.

35 (b) The office shall be headed by the chief medical officer who  
36 shall serve pursuant to provisions of subdivisions (c), (d), and (e)  
37 of Section 140100 and subdivisions (j) and (k) of Section 140101  
38 regarding qualifications for appointed officers of the system.

39 (c) The purpose of the Office of Health Care Quality is the  
40 following:

1 (1) Support the delivery of high quality, coordinated health care  
2 services that enhance health; prevent illness, disease, and disability;  
3 slow the progression of chronic diseases; and improve personal  
4 health management.

5 (2) Promote efficient care delivery.

6 (3) Establish processes for measuring, monitoring, and  
7 evaluating the quality of care delivered in the system, including  
8 the performance of individual health care providers.

9 (4) Establish means to make changes needed to improve health  
10 care quality, including innovative programs that improve quality.

11 (5) Promote patient, health care provider, and employer  
12 satisfaction with the system.

13 (6) Assist regional planning directors and ~~medical directors~~  
14 *officers* in the development and evaluation of regional operating  
15 and capital budget requests.

16 140606. (a) In supporting the goals of the Office of Health  
17 Care Quality, the chief medical officer shall do all of the following:

18 (1) Administer all aspects of the office.

19 (2) Serve on the ~~Universal~~ Healthcare Policy Board.

20 (3) Collaborate with regional ~~medical directors~~ *officers*, regional  
21 planning directors, health care providers, consumers, the Director  
22 of the Office of *Health* Planning, the patient advocate of the Office  
23 of Patient Advocacy, and directors of Partnerships for Health to  
24 develop community-based networks of solo providers, small group  
25 practices, essential community providers, and providers of patient  
26 care support services in order to offer comprehensive,  
27 multidisciplinary, coordinated services to patients.

28 (4) Establish standards of care based on clinical efficacy for the  
29 system that shall serve as guidelines to support health care  
30 providers in the delivery of high quality care. Standards shall be  
31 based on the best evidence available at the time and shall be  
32 continually updated. Standards are intended to support the clinical  
33 judgment of individual health care providers, not to replace it, and  
34 to support clinical decisions based on the needs of individual  
35 patients.

36 (b) In establishing standards, the chief medical officer shall do  
37 all of the following:

38 (1) Draw on existing standards established by California health  
39 care institutions, on peer-created standards, and on standards  
40 developed by others institutions that have had a positive impact

1 on care quality, such as the Centers for Disease Control, the  
2 National Quality Forum, and the Agency for Health Care Quality  
3 and Research.

4 (2) Collaborate with regional medical ~~directors~~ *officers* in  
5 establishing regional goals, priorities, and a timetable for  
6 implementation of standards of care.

7 (3) Assure a process for patients to provide their views on  
8 standards of care to the patient advocate of the Office of Patient  
9 Advocacy who shall report those views to the chief medical officer.

10 (4) Collaborate with the Director of the Office of Health  
11 Planning and regional medical ~~directors~~ *officers* to support the  
12 development of computer software systems that link clinical  
13 guidelines to individual patient conditions, guide clinicians through  
14 diagnosis and treatment algorithms based on research and best  
15 medical practices based on clinical efficacy, offer access to  
16 guidelines appropriate to each medical specialty and to current  
17 information on disease prevention and treatment, and that support  
18 continuing medical education.

19 (5) Where referral processes for access to specialty care are in  
20 place prior to the initiation of the system, the chief medical officer  
21 shall review the referral processes to assure that they meet the  
22 system's standards for care quality and shall assure that needed  
23 changes are implemented so that all Californians receive the same  
24 standards of care quality.

25 (c) In collaboration with the Director of the Office of Health  
26 Planning and regional medical ~~directors~~ *officers*, the chief medical  
27 officer shall implement means to measure and monitor the quality  
28 of care delivered in the system. Monitoring systems shall include,  
29 but shall not be limited to, peer and patient performance reviews.

30 (d) The chief medical officer shall establish means to support  
31 individual health care providers and health systems in correcting  
32 quality of care problems, including timeframes for making needed  
33 improvements and means to evaluate the effectiveness of  
34 interventions.

35 (e) In collaboration with regional medical ~~directors~~ *officers*,  
36 regional planning directors, and the director of the Office of Health  
37 Planning, the chief medical officer shall establish means to identify  
38 medical errors and their causes and develop plans to prevent them.  
39 Means shall include a process for anonymous reporting of errors  
40 and guidelines to protect those who report the errors against



1 recrimination, including job demotion, promotion discrimination,  
2 or job loss.

3 (f) The chief medical officer shall convene an annual statewide  
4 conference to discuss medical errors that occurred during the year,  
5 their causes, means to prevent errors, and the effectiveness of  
6 efforts to decrease errors.

7 (g) The chief medical officer shall recommend to the  
8 commissioner a benefits package based on clinical efficacy for the  
9 system, including priorities for needed benefit improvements. In  
10 making recommendations, the chief medical officer shall do all of  
11 the following:

12 (1) Identify safe and effective treatments.

13 (2) Evaluate and draw on existing benefit packages.

14 (3) Receive comments and recommendations from health care  
15 providers about benefits that meet the needs of their patients.

16 (4) Receive comments and recommendations made directly by  
17 patients or indirectly through the Office of Patient Advocacy.

18 (5) Identify and recommend to the commissioner and the  
19 ~~Universal~~ Healthcare Policy Board innovative approaches to health  
20 promotion, disease and injury prevention, education, research, and  
21 care delivery for possible inclusion in the benefit package.

22 (6) Identify complementary and alternative modalities that have  
23 been shown by the National Institutes of Health, Division of  
24 Complementary and Alternative Medicine to be safe and effective  
25 for possible inclusion as covered benefits.

26 (7) Recommend to the commissioner and update as appropriate,  
27 pharmaceutical and durable and nondurable medical equipment  
28 formularies based on clinical efficacy. In establishing the  
29 formularies, the chief medical officer shall establish a Pharmacy  
30 and Therapeutics Committee composed of pharmacy and health  
31 care providers, representatives of health facilities and organizations  
32 having system formularies in place at the time the system is  
33 implemented, and other experts that shall do all the following:

34 (A) Identify safe and effective pharmaceutical agents for use in  
35 the system.

36 (B) Draw on existing standards and formularies.

37 (C) Identify experimental drugs and drug treatment protocols  
38 for possible inclusion in the formulary.

1 (D) Review formularies in a timely fashion to ensure that safe  
2 and effective drugs are available and that unsafe drugs are removed  
3 from use.

4 (E) Assure the timely dissemination of information needed to  
5 prescribe safely and effectively to all California health care  
6 providers and the development and utilization of electronic  
7 dispensing systems that decrease pharmaceutical dispensing errors.

8 (8) Establish standards and criteria and a process for health care  
9 providers to seek authorization for prescribing pharmaceutical  
10 agents and durable and nondurable medical equipment that are not  
11 included in the system's formulary. No standard or criteria shall  
12 impose an undue administrative burden on patients or health care  
13 providers, including pharmacies and pharmacists, and none shall  
14 delay care a patient needs.

15 (9) Develop standards and criteria and a process for health care  
16 providers to request authorization for services and treatments,  
17 including experimental treatments that are not included in the  
18 system's benefit package.

19 (A) Where such processes are in place when the system is  
20 initiated, the chief medical officer shall review those processes to  
21 assure that they meet the system's standards for care quality and  
22 shall assure that needed changes are implemented so that all  
23 Californians receive the same standards of care quality.

24 (B) No standard or criteria shall impose an undue administrative  
25 burden on a health care provider or a patient and none shall delay  
26 the care a patient needs.

27 (10) In collaboration with the Director of the Office of Health  
28 Planning, regional planning directors and regional medical ~~directors~~  
29 *officers*, identify *on a regional basis* appropriate ratios of general  
30 medical providers to specialty medical providers ~~on a regional~~  
31 *basis and appropriate ratios of medical providers to patients* in  
32 order to meet the health care needs of the population and the goals  
33 of the system.

34 (11) Recommend to the commissioner and to the Payments  
35 Board, financial and nonfinancial incentives and other means to  
36 achieve recommended provider ratios.

37 (12) Collaborate with the Director of the Office of Health  
38 Planning and regional medical ~~directors~~ *officers* and patient  
39 advocates in *the* development of electronic initiatives, pursuant to  
40 Section 140603.

1 (13) Collaborate with the commissioner, the regional medical  
2 ~~directors~~ *officers*, and the directors of the Payments Board and the  
3 Universal Healthcare Fund to formulate a health care provider  
4 reimbursement model that promotes the delivery of coordinated,  
5 high quality health care services in all sectors of the system and  
6 creates financial and other incentives for the delivery of high  
7 quality health care.

8 (14) Establish or assure the establishment of continuing medical  
9 education programs about advances in the delivery of high quality  
10 of health care.

11 (15) Convene an annual statewide quality of care conference to  
12 discuss problems with health care quality and to make  
13 recommendations for changes needed to improve health care  
14 quality. Participants shall include regional medical ~~directors~~  
15 *officers*, health care providers, other providers, patients, policy  
16 experts, experts in quality of care measurement, and others.

17 (16) Annually report to the commissioner, the ~~Universal~~  
18 Healthcare Policy Board, and the public on the quality of health  
19 care delivered in the system, including improvements that have  
20 been made and problems that have been identified during the year,  
21 goals for care improvement in the coming year, and plans to meet  
22 these goals.

23 (h) No person working within the agency or a member of the  
24 Pharmacy and Therapeutics Committee or serving as a consultant  
25 to the agency or to the Pharmacy and Therapeutics Committee,  
26 may receive fees or remuneration of any kind from a  
27 pharmaceutical company.

28 140607. (a) The patient advocate of the Office of Patient  
29 Advocacy, in collaboration with the chief medical officer, the  
30 regional patient advocates, medical ~~directors~~ *officers*, and planning  
31 directors shall establish a program in the agency and in each region  
32 called the Partnerships for Health.

33 (b) The purpose of the Partnerships for Health is to improve  
34 health through community health initiatives, to support the  
35 development of innovative means to improve health care quality,  
36 to promote efficient coordinated care delivery, and to educate the  
37 public about the following:

- 38 (1) Personal maintenance of health.  
39 (2) Prevention of disease.

1 (3) Improvement in communication between patients and  
2 providers.

3 (4) Improving quality of care.

4 (c) The patient advocate shall work with the community and  
5 health care providers in proposing Partnerships for Health projects  
6 and in developing project budget requests that shall be included  
7 in the regional budget request to the commissioner.

8 (d) In developing educational programs, the Partnerships for  
9 Health shall collaborate with educators in the region.

10 (e) Partnerships for Health shall support the coordination of  
11 system and public health programs.

12 140610. (a) The patient advocate of the Office of Patient  
13 Advocacy, in consultation with the chief medical officer, shall  
14 establish a grievance system for all grievances involving the delay,  
15 denial, or modification of health care services. The patient advocate  
16 shall do all of the following with regard to the grievance regarding  
17 delay, denial, or modification of health care services:

18 (1) Establish and maintain a grievance system approved by the  
19 commissioner under which enrollees of the system may submit  
20 their grievances to the system. The system shall provide reasonable  
21 procedures that shall ensure adequate consideration of enrollee  
22 grievances and rectification when appropriate.

23 (2) Inform enrollees upon enrollment in the system and annually  
24 hereafter of the procedure for processing and resolving grievances.  
25 The information shall include the location and telephone number  
26 where grievances may be submitted.

27 (3) Provide printed and electronic access for enrollees who wish  
28 to register grievances. The forms used by the system shall be  
29 approved by the commissioner in advance as to format.

30 (4) (A) Provide for a written acknowledgment within five  
31 calendar days of the receipt of a grievance. Grievances received  
32 by telephone, by facsimile, by e-mail, or online through the  
33 system's Internet Web site that are resolved by the next business  
34 day following receipt are exempt from the requirements of this  
35 subparagraph and paragraph (5). The acknowledgment shall advise  
36 the complainant of the following:

37 (i) That the grievance has been received.

38 (ii) The date of receipt.

39 (iii) The name, telephone number, and address of the system  
40 representative who may be contacted about the grievance.

- 1 (B) The patient advocate shall maintain a log of all grievances.  
2 The log shall be periodically reviewed by the patient advocate and  
3 shall include the following information for each complaint:  
4 (i) The date of the call.  
5 (ii) The name of the enrollee.  
6 (iii) The enrollee’s system identification number.  
7 (iv) The nature of the grievance.  
8 (v) The nature of the resolution.  
9 (vi) The name of the system representative who took the call  
10 and resolved the grievance.
- 11 (5) Provide enrollees of the system with written responses to  
12 grievances, with a clear and concise explanation of the reasons for  
13 the system’s response. The system response shall describe the  
14 criteria used and the clinical reasons for its decision, including all  
15 criteria and clinical reasons related to medical necessity.
- 16 (6) Keep in its files copies of all grievances, and the responses  
17 thereto, for a period of five years.
- 18 (7) Establish and maintain an Internet Web site that shall provide  
19 an online form that enrollees of the system can use to file with a  
20 grievance online.
- 21 (b) In any case determined by the patient advocate to be a case  
22 involving an imminent and serious threat to the health of the  
23 enrollee, including, but not limited to, severe pain or the potential  
24 loss of life, limb, or major bodily function, or in any other case  
25 where the patient advocate determines that an earlier review is  
26 warranted, an enrollee shall not be required to complete the  
27 grievance process.
- 28 (c) If the enrollee is a minor, or is incompetent or incapacitated,  
29 the parent, guardian, conservator, relative, or other designee of the  
30 enrollee, as appropriate, may submit the grievance to the patient  
31 advocate as a designated agent of the enrollee. Further, a health  
32 care provider may join with, or otherwise assist, an enrollee, or  
33 the agent, to submit the grievance to the patient advocate. In  
34 addition, following submission of the grievance to the patient  
35 advocate, the enrollee, or the agent, may authorize the health care  
36 provider to assist, including advocating on behalf of the enrollee.  
37 For purposes of this section, a “relative” includes the parent,  
38 stepparent, spouse, domestic partner, adult son or daughter,  
39 grandparent, brother, sister, uncle, or aunt of the enrollee.

1 (d) The patient advocate shall review the written documents  
2 submitted with the enrollee’s grievance. The patient advocate may  
3 ask for additional information, and may hold an informal meeting  
4 with the involved parties, including health care providers who have  
5 joined in submitting the grievance or who are otherwise assisting  
6 or advocating on behalf of the enrollee. If after reviewing the  
7 record, the patient advocate concludes that the grievance, in whole  
8 or in part, is eligible for review under the independent medical  
9 review system, the patient advocate shall immediately notify the  
10 enrollee of that option and shall, if requested orally or in writing,  
11 assist the enrollee in participating in the independent medical  
12 review system.

13 (e) The patient advocate shall send a written notice of the final  
14 disposition of the grievance, and the reasons therefor, to the  
15 enrollee, to any health care provider that has joined with or is  
16 otherwise assisting the enrollee, and to the commissioner within  
17 30 calendar days of receipt of the grievance, unless the patient  
18 advocate, in his or her discretion, determines that additional time  
19 is reasonably necessary to fully and fairly evaluate the grievance.  
20 In any case not eligible for independent medical review, the patient  
21 advocate’s written notice shall include, at a minimum, the  
22 following:

23 (1) A summary of findings and the reasons why the patient  
24 advocate found the system to be, or not to be, in compliance with  
25 any applicable laws, regulations, or orders of the commissioner.

26 (2) A discussion of the patient advocate’s contact with any  
27 health care provider, or any other independent expert relied on by  
28 the patient advocate, along with a summary of the views and  
29 qualifications of that health care provider or expert.

30 (3) If the enrollee’s grievance is sustained in whole or in part,  
31 information about any corrective action taken.

32 (f) The patient advocate’s order shall be binding on the system.

33 (g) The patient advocate shall establish and maintain a system  
34 of aging of grievances that are pending and unresolved for 30 days  
35 or more that shall include a brief explanation of the reasons each  
36 grievance is pending and unresolved for 30 days or more.

37 (h) The grievance or resolution procedures authorized by this  
38 section shall be in addition to any other procedures that may be  
39 available to any person, and failure to pursue, exhaust, or engage

1 in the procedures described in this section shall not preclude the  
2 use of any other remedy provided by law.

3 (i) Nothing in this section shall be construed to allow the  
4 submission to the patient advocate of any health care provider  
5 grievance under this section. However, as part of a health care  
6 provider’s duty to advocate for medically appropriate health care  
7 for his or her patients pursuant to Sections 510 and 2056 of the  
8 Business and Professions Code, nothing in this subdivision shall  
9 be construed to prohibit a health care provider from contacting  
10 and informing the patient advocate about any concerns he or she  
11 has regarding compliance with or enforcement of this division.

12 140612. (a) The patient advocate shall establish an independent  
13 medical review system to act as an independent, external medical  
14 review process for the system to provide timely examinations of  
15 disputed health care services and coverage decisions regarding  
16 experimental and investigational therapies to ensure the system  
17 provides efficient, appropriate, high quality health care, and that  
18 the system is responsive to enrollee disputes.

19 (b) For the purposes of this section, “disputed health care  
20 service” means any health care service eligible for coverage and  
21 payment under the system that has been denied, modified, or  
22 delayed by a decision of the system, or by one of its contracting  
23 health care providers, in whole or in part due to a finding that the  
24 service is not medically necessary. A decision regarding a disputed  
25 health care service relates to the practice of medicine and is not a  
26 coverage decision. If the system, or one of its contracting providers,  
27 issues a decision denying, modifying, or delaying health care  
28 services, based in whole or in part on a finding that the proposed  
29 health care services are not a covered benefit under the system,  
30 the statement of decision shall clearly specify the provisions of  
31 the system that exclude coverage.

32 (c) For the purposes of this section, “coverage decision” means  
33 the approval or denial of the system, or by one of its contracting  
34 entities, substantially based on a finding that the provision of a  
35 particular service is included or excluded as a covered benefit  
36 under the terms and conditions of the system.

37 (d) Coverage decisions regarding experimental or investigational  
38 therapies for individual enrollees who meet all of the following  
39 criteria are eligible for review by the independent medical review  
40 system:

1 (1) (A) The enrollee has a life-threatening or seriously  
2 debilitating condition.

3 (B) For purposes of this section, “life-threatening” means either  
4 or both of the following:

5 (i) Diseases or conditions where the likelihood of death is high  
6 unless the course of the disease is interrupted.

7 (ii) Diseases or conditions with potentially fatal outcomes, where  
8 the end point of clinical intervention is survival.

9 (C) For purposes of this section, “seriously debilitating” means  
10 diseases or conditions that cause major irreversible morbidity.

11 (2) The enrollee’s physician certifies that the enrollee has a  
12 condition, as defined in paragraph (1), for which standard therapies  
13 have not been effective in improving the condition of the enrollee,  
14 for which standard therapies would not be medically appropriate  
15 for the enrollee, or for which there is no more beneficial standard  
16 therapy covered by the system than the therapy proposed pursuant  
17 to paragraph (3).

18 (3) Either (A) the enrollee’s physician, who is under contract  
19 with the system, has recommended a drug, device, procedure, or  
20 other therapy that the physician certifies in writing is likely to be  
21 more beneficial to the enrollee than any available standard  
22 therapies, or (B) the enrollee, or the enrollee’s physician who is a  
23 licensed, board-certified or board-eligible physician qualified to  
24 practice in the area of practice appropriate to treat the enrollee’s  
25 condition, has requested a therapy that, based on two documents  
26 from the medical and scientific evidence, is likely to be more  
27 beneficial for the enrollee than any available standard therapy. The  
28 physician certification pursuant to this section shall include a  
29 statement of the evidence relied upon by the physician in certifying  
30 his or her recommendation. Nothing in this subdivision shall be  
31 construed to require the system to pay for the services of a  
32 nonparticipating physician provided pursuant to this division, that  
33 are not otherwise covered pursuant to the system’s benefits  
34 package.

35 (4) The enrollee has been denied coverage by the system for a  
36 drug, device, procedure, or other therapy recommended or  
37 requested pursuant to paragraph (3).

38 (5) The specific drug, device, procedure, or other therapy  
39 recommended pursuant to paragraph (3) would be a covered



1 service, except for the system's determination that the therapy is  
2 experimental or investigational.

3 (e) (1) All enrollee grievances involving a disputed health care  
4 service are eligible for review under the independent medical  
5 review system if the requirements of this section are met. If the  
6 patient advocate finds that a grievance involving a disputed health  
7 care service does not meet the requirements of this section for  
8 review under the independent medical review system, the enrollee's  
9 grievance shall be treated as a request for the patient advocate to  
10 review the grievance. All other enrollee grievances, including  
11 grievances involving coverage decisions, remain eligible for review  
12 by the patient advocate.

13 (2) In any case in which an enrollee or health care provider  
14 asserts that a decision to deny, modify, or delay health care services  
15 was based, in whole or in part, on consideration of medical  
16 appropriateness, the patient advocate shall have the final authority  
17 to determine whether the grievance is more properly resolved  
18 pursuant to an independent medical review as provided under this  
19 section.

20 (3) The patient advocate shall be the final arbiter when there is  
21 a question as to whether an enrollee grievance is a disputed health  
22 care service or a coverage decision. The patient advocate shall  
23 establish a process to complete an initial screening of an enrollee  
24 grievance. If there appears to be any medical appropriateness issue,  
25 the grievance shall be resolved pursuant to an independent medical  
26 review.

27 (f) For purposes of this chapter, an enrollee may designate an  
28 agent to act on his or her behalf. The agent may join with or  
29 otherwise assist the enrollee in seeking an independent medical  
30 review, and may advocate on behalf of the enrollee.

31 (g) The independent medical review process authorized by this  
32 section is in addition to any other procedures or remedies that may  
33 be available.

34 (h) The office of the patient advocate shall prominently display  
35 in every relevant informational brochure, on copies of the system's  
36 procedures for resolving grievances, on letters of denials issued  
37 by either the system or its contracting providers, on the grievance  
38 forms, and on all written responses to grievances, information  
39 concerning the right of an enrollee to request an independent  
40 medical review in cases where the enrollee believes that health

1 care services have been improperly denied, modified, or delayed  
2 by the system, or by one of its contracting providers.

3 (i) An enrollee may apply to the patient advocate for an  
4 independent medical review when all of the following conditions  
5 are met:

6 (1) (A) The enrollee's health care provider has recommended  
7 a health care service as medically appropriate.

8 (B) The enrollee has received urgent care or emergency services  
9 that a health care provider determined was medically appropriate.

10 (C) The enrollee seeks coverage for experimental or  
11 investigational therapies.

12 (D) The enrollee, in the absence of a health care provider  
13 recommendation under subparagraph (A) or the receipt of urgent  
14 care or emergency services by a health care provider under  
15 subparagraph (B), has been seen by a system health care provider  
16 for the diagnosis or treatment of the medical condition for which  
17 the enrollee seeks independent review. The system shall expedite  
18 access to a system health care provider upon request of an enrollee.  
19 The system health care provider need not recommend the disputed  
20 health care service as a condition for the enrollee to be eligible for  
21 an independent medical review.

22 (2) The disputed health care service has been denied, modified,  
23 or delayed by the system, or by one of its contracting providers,  
24 based in whole or in part on a decision that the health care service  
25 is not medically appropriate.

26 (3) The enrollee has filed a grievance with the patient advocate  
27 and the disputed decision is upheld or the grievance remains  
28 unresolved after 30 days. The enrollee shall not be required to  
29 participate in the system's grievance process for more than 30  
30 days. In the case of a grievance that requires expedited review, the  
31 enrollee shall not be required to participate in the system's  
32 grievance process for more than three days.

33 (j) An enrollee may apply to the patient advocate for an  
34 independent medical review of a decision to deny, modify, or delay  
35 health care services, based in whole or in part on a finding that the  
36 disputed health care services are not medically appropriate, within  
37 six months of any of the qualifying periods or events. The patient  
38 advocate may extend the application deadline beyond six months  
39 if the circumstances of a case warrant the extension.

1 (k) The enrollee shall pay no application or processing fees of  
2 any kind.

3 (l) Upon notice from the patient advocate that the enrollee has  
4 applied for an independent medical review, the system or its  
5 contracting providers shall provide to the independent medical  
6 review organization designated by the patient advocate a copy of  
7 all of the following documents within three business days of the  
8 system's receipt of the patient advocate's notice of a request by  
9 an enrollee for an independent medical review:

10 (1) (A) A copy of all of the enrollee's medical records in the  
11 possession of the system or its contracting providers relevant to  
12 each of the following:

13 (i) The enrollee's medical condition.

14 (ii) The health care services being provided by the system and  
15 its contracting providers for the condition.

16 (iii) The disputed health care services requested by the enrollee  
17 for the condition.

18 (B) Any newly developed or discovered relevant medical records  
19 in the possession of the system or its contracting providers after  
20 the initial documents are provided to the independent medical  
21 review organization shall be forwarded immediately to the  
22 independent medical review organization. The system shall  
23 concurrently provide a copy of medical records required by this  
24 subparagraph to the enrollee or the enrollee's health care provider,  
25 if authorized by the enrollee, unless the offer of medical records  
26 is declined or otherwise prohibited by law. The confidentiality of  
27 all medical record information shall be maintained pursuant to  
28 applicable state and federal laws.

29 (2) A copy of all information provided to the enrollee by the  
30 system and any of its contracting providers concerning their  
31 decisions regarding the enrollee's condition and care, and a copy  
32 of any materials the enrollee or the enrollee's health care provider  
33 submitted to the system and to the system's contracting providers  
34 in support of the enrollee's request for disputed health care service.  
35 This documentation shall include the written response to the  
36 enrollee's grievance. The confidentiality of any enrollee medical  
37 information shall be maintained pursuant to applicable state and  
38 federal laws.

39 (3) A copy of any other relevant documents or information used  
40 by the system or its contracting providers in determining whether

1 disputed health care services should have been provided, and any  
2 statements by the system and its contracting providers explaining  
3 the reasons for the decision to deny, modify, or delay disputed  
4 health care services on the basis of medical necessity. The system  
5 shall concurrently provide a copy of documents required by this  
6 paragraph, except for any information found by the patient advocate  
7 to be legally privileged information, to the enrollee and the  
8 enrollee's health care provider.

9 The patient advocate and the independent review organization  
10 shall maintain the confidentiality of any information found by the  
11 patient advocate to be the proprietary information of the system.

12 140614. (a) If there is an imminent and serious threat to the  
13 health of the enrollee, all necessary information and documents  
14 shall be delivered to an independent medical review organization  
15 within 24 hours of approval of the request for review. In reviewing  
16 a request for review, the patient advocate may waive the  
17 requirement that the enrollee follow the system's grievance process  
18 in extraordinary and compelling cases, if the patient advocate finds  
19 that the enrollee has acted reasonably.

20 (b) The patient advocate shall expeditiously review requests  
21 and immediately notify the enrollee in writing as to whether the  
22 request for an independent medical review has been approved, in  
23 whole or in part, and, if not approved, the reasons therefor. The  
24 system shall promptly issue a notification to the enrollee, after  
25 submitting all of the required material to the independent medical  
26 review organization that includes an annotated list of documents  
27 submitted and offer the enrollee the opportunity to request copies  
28 of those documents from the system. The patient advocate shall  
29 promptly approve an enrollee's ~~requests~~ *request* whenever the  
30 system has agreed that the case is eligible for an independent  
31 medical review. To the extent an enrollee's request for independent  
32 review is not approved by the patient advocate, the enrollee's  
33 request shall be treated as an immediate request for the patient  
34 advocate to review the grievance.

35 (c) An independent medical review organization shall conduct  
36 the review in accordance with a process approved by the patient  
37 advocate. The review shall be limited to an examination of the  
38 medical necessity of the disputed health care services and shall  
39 not include any consideration of coverage decisions or other issues.

1 (d) The patient advocate shall contract with one or more  
2 independent medical review organizations in the state to conduct  
3 reviews for purposes of this section. The independent medical  
4 review organizations shall be independent of the system. The  
5 patient advocate may establish additional requirements, including  
6 conflict-of-interest standards, consistent with the purposes of this  
7 section that an organization shall be required to meet in order to  
8 qualify for participation in the independent medical review system  
9 and to assist the patient advocate in carrying out its responsibilities.

10 (e) The independent medical review organizations and the  
11 medical professionals retained to conduct reviews shall be deemed  
12 to be medical consultants for purposes of Section 43.98 of the Civil  
13 Code.

14 (f) The independent medical review organization, any experts  
15 it designates to conduct a review, or any officer, patient advocate,  
16 or employee of the independent medical review organization shall  
17 not have any material professional, familial, or financial affiliation,  
18 as determined by the patient advocate, with any of the following:

19 (1) The system.

20 (2) Any officer or employee of the system.

21 (3) A physician, the physician's medical group, or the  
22 independent practice association involved in the health care service  
23 in dispute.

24 (4) The facility or institution at which either the proposed health  
25 care service, or the alternative service, if any, recommended by  
26 the system, would be provided.

27 (5) The development or manufacture of the principal drug,  
28 device, procedure, or other therapy proposed by the enrollee whose  
29 treatment is under review, or the alternative therapy, if any,  
30 recommended by the system.

31 (6) The enrollee or the enrollee's immediate family.

32 (g) In order to contract with the patient advocate for purposes  
33 of this section, an independent medical review organization shall  
34 meet all of the requirements pursuant to subdivision (d) of Section  
35 1374.32.

36 140616. (a) Upon receipt of information and documents related  
37 to a case, the medical professional reviewer or reviewers selected  
38 to conduct the review by the independent medical review  
39 organization shall promptly review all pertinent medical records  
40 of the enrollee, provider reports, as well as any other information

1 submitted to the organization as authorized by the patient advocate  
2 or requested from any of the parties to the dispute by the reviewers.  
3 If reviewers request information from any of the parties, a copy  
4 of the request and the response shall be provided to all of the  
5 parties. The reviewer or reviewers shall also review relevant  
6 information related to the criteria set forth in subdivision (b).

7 (b) Following its review, the reviewer or reviewers shall  
8 determine whether the disputed health care service was medically  
9 appropriate based on the specific medical needs of the patient and  
10 any of the following:

11 (1) Peer-reviewed scientific and medical evidence regarding  
12 the effectiveness of the disputed service.

13 (2) Nationally recognized professional standards.

14 (3) Expert opinion.

15 (4) Generally accepted standards of medical practice.

16 (5) Treatments likely to provide a benefit to an enrollee for  
17 conditions for which other treatments are not clinically efficacious.

18 (c) The organization shall complete its review and make its  
19 determination in writing, and in layperson's terms to the maximum  
20 extent practicable, within 30 days of the receipt of the application  
21 for review and supporting documentation, or within less time as  
22 prescribed by the patient advocate. If the disputed health care  
23 service has not been provided and the enrollee's health care  
24 provider or the patient advocate certifies in writing that an  
25 imminent and serious threat to the health of the enrollee may exist,  
26 including, but not limited to, serious pain, the potential loss of life,  
27 limb, or major bodily function, or the immediate and serious  
28 deterioration of the health of the enrollee, the analyses and  
29 determinations of the reviewers shall be expedited and rendered  
30 within three days of the receipt of the information. Subject to the  
31 approval of the patient advocate, the deadlines for analyses and  
32 determinations involving both regular and expedited reviews may  
33 be extended by the patient advocate for up to three days in  
34 extraordinary circumstances or for good cause.

35 (d) The medical professionals' analyses and determinations  
36 shall state whether the disputed health care service is medically  
37 appropriate. Each analysis shall cite the enrollee's medical  
38 condition, the relevant documents in the record, and the relevant  
39 findings associated with the provisions of subdivision (b) to support  
40 the determination. If more than one medical professional reviews

1 the case, the recommendation of the majority shall prevail. If the  
2 medical professionals reviewing the case are evenly split as to  
3 whether the disputed health care service should be provided, the  
4 decision shall be in favor of providing the service.

5 (e) The independent medical review organization shall provide  
6 the patient advocate, the system, the enrollee, and the enrollee's  
7 health care provider with the analyses and determinations of the  
8 medical professionals reviewing the case, and a description of the  
9 qualifications of the medical professionals. The independent  
10 medical review organization shall keep the names of the reviewers  
11 confidential in all communications with entities or individuals  
12 outside the independent medical review organization, except in  
13 cases where the reviewer is called to testify and in response to  
14 court orders. If more than one medical professional reviewed the  
15 case and the result was differing determinations, the independent  
16 medical review organization shall provide each of the separate  
17 reviewer's analyses and determinations.

18 (f) The patient advocate shall immediately adopt the  
19 determination of the independent medical review organization and  
20 shall promptly issue a written decision to the parties that shall be  
21 binding on the system.

22 (g) After removing the names of the parties, including, but not  
23 limited to, the enrollee and all medical providers, the patient  
24 advocate's decisions adopting a determination of an independent  
25 medical review organization shall be made available by the patient  
26 advocate to the public upon request, at the patient advocate's cost  
27 and after considering applicable laws governing disclosure of  
28 public records, confidentiality, and personal privacy.

29 140618. (a) Upon receiving the decision adopted by the patient  
30 advocate that a disputed health care service is medically  
31 appropriate, the system shall promptly implement the decision. In  
32 the case of reimbursement for services already rendered, the health  
33 care provider or enrollee, whichever applies, shall be paid within  
34 five working days. In the case of services not yet rendered, the  
35 system shall authorize the services within five working days of  
36 receipt of the written decision from the patient advocate, or sooner  
37 if appropriate for the nature of the enrollee's medical condition,  
38 and shall inform the enrollee and health care provider of the  
39 authorization.

1 (b) The system shall not engage in any conduct that has the  
2 effect of prolonging the independent medical review process.

3 (c) The patient advocate shall require the system to promptly  
4 reimburse the enrollee for any reasonable costs associated with  
5 those services when the patient advocate finds that the disputed  
6 health care services were a covered benefit and the services are  
7 found by the independent medical review organization to have  
8 been medically appropriate and the enrollee's decision to secure  
9 the services outside of the system was reasonable under the  
10 emergency or urgent medical circumstances.

11 140619. (a) The patient advocate shall utilize a competitive  
12 bidding process and use any other information on program costs  
13 reasonable to establish a per-case reimbursement schedule to pay  
14 the costs of independent medical review organization reviews,  
15 which may vary depending on the type of medical condition under  
16 review and on other relevant factors.

17 (b) The costs of the independent medical review system for  
18 enrollees shall be borne by the system.

19 140620. The patient advocate shall, on a biannual basis, report  
20 to the chief medical officer on the number, types, and outcomes  
21 of all patient grievances relating to the denial, delay, or  
22 modification of health *care* services.

23  
24 CHAPTER 7. OTHER PROVISIONS  
25

26 140700. Notwithstanding any other provisions of law, the  
27 operative date of this division, other than Article 2 (commencing  
28 with Section 140230) of Chapter 3, shall be the date the Secretary  
29 of *California* Health and Human Services notifies the Secretary  
30 of the Senate and the Chief Clerk of the Assembly that he or she  
31 has determined that the ~~Universal~~ Healthcare Fund will have  
32 sufficient revenues to fund the costs of implementing this division.

33 No state entity shall incur any transition or planning costs prior  
34 to that date. However, this prohibition shall not apply to activities  
35 of the California ~~Universal~~ Healthcare Premium Commission, and  
36 Article 2 (commencing with Section 140230) of Chapter 3 of this  
37 division shall become operative on January 1, 2008.

38 SEC. 2. No reimbursement is required by this act pursuant to  
39 Section 6 of Article XIII B of the California Constitution because  
40 the only costs that may be incurred by a local agency or school



1 district will be incurred because this act creates a new crime or  
2 infraction, eliminates a crime or infraction, or changes the penalty  
3 for a crime or infraction, within the meaning of Section 17556 of  
4 the Government Code, or changes the definition of a crime within  
5 the meaning of Section 6 of Article XIII B of the California  
6 Constitution.

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