

AMENDED IN ASSEMBLY JULY 10, 2007

AMENDED IN ASSEMBLY JUNE 27, 2007

AMENDED IN SENATE APRIL 30, 2007

SENATE BILL

No. 840

Introduced by Senator Kuehl

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

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

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

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

February 23, 2007

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 Healthcare System to be administered by the newly created California Healthcare Agency under the control of a 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 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 Healthcare System, which would then assume responsibility for all benefits and services previously paid for with those funds.

The bill would create the 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 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 Healthcare System. The bill would create the Healthcare Fund and the Payments Board to administer the finances of the California Healthcare System. The bill would create the California Healthcare Premium Commission (Premium Commission) to determine the cost of the California 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 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 Healthcare System, which shall be administered by the
11 California Healthcare Agency, an independent agency under the
12 control of the Healthcare Commissioner.

13 140000.6. No health care service plan contract or health
14 insurance policy, except for the California Healthcare System plan,
15 may be sold in California for services provided by the system.

1 140001. This division shall be known and may be cited as the
2 California Universal Healthcare Act.

3 140002. This division shall be liberally construed to accomplish
4 its purposes.

5 140003. The California Healthcare Agency is hereby created
6 and designated as the single state agency with full power to
7 supervise every phase of the administration of the California
8 Healthcare System and to receive grants-in-aid made by the United
9 States government, by the state, or by other sources in order to
10 secure full compliance with the applicable provisions of state and
11 federal law.

12 140004. The California Healthcare Agency shall be comprised
13 of the following entities:

- 14 (a) The Healthcare Policy Board.
- 15 (b) The Office of Patient Advocacy.
- 16 (c) The Office of Health Planning.
- 17 (d) The Office of Health Care Quality.
- 18 (e) The Healthcare Fund.
- 19 (f) The Public Advisory Committee.
- 20 (g) The Payments Board.
- 21 (h) Partnerships for Health.

22 140005. The Legislature finds and declares all of the following:

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

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

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

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

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

38 (f) As a result, one-half of all bankruptcies in the United States
39 now relate to medical costs, though three-fourths of bankrupted

1 families had health care coverage at the time of sustaining the
2 injury or illness.

3 (g) Health insurance companies have insufficient business
4 motive to provide comprehensive and affordable health care
5 coverage to residents who are likely to require health care services,
6 including seniors, disabled residents, residents with or at risk of
7 developing a chronic illness, and women of child-bearing age.

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

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

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

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

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

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

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

36 (o) Multiple quantitative analyses indicate that under a single
37 payer health care coverage system, the amount currently spent for
38 health care is more than adequate to finance comprehensive high
39 quality health care coverage for every resident of the state while

1 guaranteeing the right of every resident to choose his or her own
2 physician.

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

10 140005.1 (a) It is the intent of the Legislature to establish a
11 system of universal health care coverage in this state that provides
12 all residents with comprehensive health care benefits, guarantees
13 a single standard of care for all residents, stabilizes the growth in
14 health care spending, and improves the quality of health care for
15 all residents.

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

26 140006. This division shall have all of the following purposes:

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

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

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

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

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

37 (f) To implement policies that strengthen and improve culturally
38 and linguistically sensitive care and sensitive care provided to
39 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 Healthcare Agency.

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

15 (c) “Commissioner” means the Healthcare Commissioner.

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

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

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

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

29 (3) A “federally qualified health center” as defined under Section
30 1395x (aa)(4) or 1396d (l)(2) of Title 42 of the United States Code.

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

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

36 (6) Any clinic exempt from licensure under subdivision (h) of
37 Section 1206.

38 (f) “Health care provider” means any professional person,
39 medical group, independent practice association, organization,

1 health facility, or other person or institution licensed or authorized
2 by the state to deliver or furnish health care services.

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

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

15 (i) “Integrated health care delivery system” means a provider
16 organization that meets both of the following criteria:

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

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

24 (j) “Large employer” means a person, firm, proprietary or
25 nonprofit corporation, partnership, public agency, or association
26 that is actively engaged in business or service, that, on at least 50
27 percent of its working days during the preceding calendar year
28 employed at least 50 employees, or, if the employer was not in
29 business during any part of the preceding calendar year, employed
30 at least 50 employees on at least 50 percent of its working days
31 during the preceding calendar quarter.

32 (k) “Premium Commission” means the California Healthcare
33 Premium Commission.

34 (l) “Primary care provider” means a direct care provider that is
35 a family physician, internist, general practitioner, pediatrician, an
36 obstetrician-gynecologist, or a family nurse practitioner or
37 physician assistant practicing under supervision as defined in
38 California codes or essential community providers who employ
39 primary care providers.

1 (m) “Small employer” means a person, firm, proprietary or
2 nonprofit corporation, partnership, public agency, or association
3 that is actively engaged in business or service and that, on at least
4 50 percent of its working days during the preceding calendar year
5 employed at least two but no more than 49 employees, or, if the
6 employer was not in business during any part of the preceding
7 calendar year, employed at least two but no more than 49 eligible
8 employees on at least 50 percent of its working days during the
9 preceding calendar quarter.

10 (n) “System” means the California Healthcare System.
11 140008. The definitions contained in Section 140007 shall
12 govern the construction of this division, unless the context requires
13 otherwise.

14
15 CHAPTER 2. GOVERNANCE
16

17 140100. (a) (1) The commissioner shall be appointed by the
18 Governor on or before March 1, 2008, subject to confirmation by
19 the Senate. If in session, the Senate shall act on the appointment
20 within 30 days of the appointment date. If the Senate does not act
21 on the appointment within that period, the nominee shall be deemed
22 confirmed and may take office. If the Senate is not in session at
23 the time of the appointment, the Senate shall act on the appointment
24 within 30 days of the commencement of the next legislative
25 session. If the Senate does not act on the appointment within that
26 period, the appointee shall be deemed confirmed and may take
27 office.

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

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

36 (c) The commissioner may not be a state legislator or a Member
37 of the United States Congress while holding the position of
38 commissioner.

39 (d) The commissioner shall not have been employed in any
40 capacity by a for-profit insurance, pharmaceutical, or medical

1 equipment company that sells products to the system for a period
2 of two years prior to appointment as commissioner.

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

8 (f) The compensation and benefits of the commissioner shall
9 be established by the California Citizens Compensation
10 Commission in accordance with Section 8 of Article III of the
11 California Constitution.

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

14 140101. (a) The commissioner shall be the chief officer of the
15 agency and shall administer all aspects of the agency.

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

31 (c) The commissioner shall appoint a deputy commissioner, the
32 Director of the Healthcare Fund, the patient advocate of the Office
33 of Patient Advocacy, the chief medical officer, the Director of the
34 Payments Board, the Director of the Office of Health Planning,
35 the Director of the Partnerships for Health, the regional health
36 planning directors, the chief enforcement counsel, and legal counsel
37 in any action brought by or against the commissioner under or
38 pursuant to any provision of any law under the commissioner's
39 jurisdiction, or in which the commissioner joins or intervenes as
40 to a matter within the commissioner's jurisdiction, as a friend of

1 the court or otherwise, and stenographic reporters to take and
2 transcribe the testimony in any formal hearing or investigation
3 before the commissioner or before a person authorized by the
4 commissioner.

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

10 (e) The personnel of the agency shall perform duties as assigned
11 to them by the commissioner. The commissioner shall designate
12 certain employees by the rule or order that are to take and subscribe
13 to the constitutional oath within 15 days after their appointments,
14 and to file that oath with the Secretary of State. The commissioner
15 shall also designate those employees that are to be subject to Title
16 9 (commencing with Section 81000) of the Government Code.

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

22 (g) The administration of the agency shall be supported from
23 the Healthcare Fund created pursuant to Section 140200.

24 (h) The commissioner, as a general rule, shall publish or make
25 available for public inspection any information filed with or
26 obtained by the agency, unless the commissioner finds that this
27 availability or publication is contrary to law. No provision of this
28 division authorizes the commissioner or any of the commissioner’s
29 assistants, clerks, or deputies to disclose any information withheld
30 from public inspection except among themselves or when necessary
31 or appropriate in a proceeding or investigation under this division
32 or to other federal or state regulatory agencies. No provision of
33 this division either creates or derogates from any privilege that
34 exists at common law or otherwise when documentary or other
35 evidence is sought under a subpoena directed to the commissioner
36 or any of his or her assistants, clerks, and deputies.

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

1 (j) The commissioner shall avoid political activity that may
2 create the appearance of political bias or impropriety. Prohibited
3 activities shall include, but not be limited to, leadership of, or
4 employment by, a political party or a political organization; public
5 endorsement of a political candidate; contribution of more than
6 five hundred dollars (\$500) to any one candidate in a calendar year
7 or a contribution in excess of an aggregate of one thousand dollars
8 (\$1,000) in a calendar year for all political parties or organizations;
9 and attempting to avoid compliance with this prohibition by making
10 contributions through a spouse or other family member.

11 (k) The commissioner shall not participate in making or in any
12 way attempt to use his or her official position to influence a
13 governmental decision in which he or she knows or has reason to
14 know that he or she or a family or a business partner or colleague
15 has a financial interest.

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

19 (m) The Attorney General shall render to the commissioner
20 opinions upon all questions of law, relating to the construction or
21 interpretation of any law under the commissioner's jurisdiction or
22 arising in the administration thereof, that may be submitted to the
23 Attorney General by the commissioner and upon the
24 commissioner's request shall act as the attorney for the
25 commissioner in actions and proceedings brought by or against
26 the commissioner or under or pursuant to any provision of any law
27 under the commissioner's jurisdiction.

28 140102. The commissioner shall do all of the following:

29 (a) Oversee the establishment, as part of the administration of
30 the agency, of all of the following:

- 31 (1) The Healthcare Policy Board, pursuant to Section 140103.
- 32 (2) The Office of Patient Advocacy, pursuant to Section 140105.
- 33 (3) The Office of Health Planning, pursuant to Section 140602.
- 34 (4) The Office of Healthcare Quality, pursuant to Section
35 140605.
- 36 (5) The Healthcare Fund, pursuant to Section 140200.
- 37 (6) The Public Advisory Committee, pursuant to Section 140104.
- 38 (7) The Payments Board, pursuant to Section 140208.
- 39 (8) Partnerships for Health.

1 (b) Determine goals, standards, guidelines, and priorities for
2 the system.

3 (c) Establish health planning regions, pursuant to Section
4 140112.

5 (d) Oversee the establishment of locally based integrated service
6 networks, including those that provide services through medical
7 technologies such as telemedicine, that include physicians in
8 fee-for-service, solo and group practice, essential community, and
9 ancillary care providers and facilities in order to pool and align
10 resources and form interdisciplinary teams that share responsibility
11 and accountability for patient care and provide a continuum of
12 coordinated high quality primary to tertiary care to all California
13 residents while preserving patient choice. This shall be
14 accomplished in collaboration with the chief medical officer, the
15 Director of the Office of Health Planning, the regional medical
16 officers, the regional planning boards, and the patient advocate.

17 (e) Annually assess projected revenues and expenditures to
18 assure financial solvency of the system.

19 (f) Develop the system's budget pursuant to Section 140206 to
20 ensure adequate funding to meet the health care needs of the
21 population. Review all budgets and allocations annually to ensure
22 they address disparities in service availability and health care
23 outcomes and for sufficiency of rates, fees, and prices.

24 (g) Establish a capital management framework for the system
25 pursuant to Section 140216, including, but not limited to, a
26 standardized process and format for the development and
27 submission of regional operating and regional capital budget
28 requests and ensure a smooth transition to system oversight.

29 (h) Establish standards and criteria for the development and
30 submission of provider operating and capital budget requests.

31 (i) Establish standards and criteria for the allocation of funds
32 from the Healthcare Fund as described in Chapter 3 (commencing
33 with Section 140200).

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

37 (k) Establish an enrollment system that ensures all eligible
38 California residents, including those who travel out-of-state; those
39 who have disabilities that limit their mobility, hearing, or vision
40 or their mental or cognitive capacity; those who cannot read; and

1 those who do not speak or write English are aware of their right
2 to health care and are formally enrolled in the system. The
3 commissioner may contract with a third party for eligibility and
4 enrollment services if the commissioner finds that doing so would
5 meet the system's goals and standards, and result in greater
6 efficiency and cost savings to the system.

7 (l) Establish an electronic claims and payments system for the
8 system where all claims under the system shall be filed and paid,
9 and implement, to the extent permitted by federal law, standardized
10 claims and reporting methods. The commissioner may contract
11 with a third party for claims and payment services if the
12 commissioner finds that doing so would meet the system's goals
13 and standards, and result in greater efficiency and cost savings to
14 the system.

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

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

20 (o) Establish standards based on clinical efficacy to guide
21 delivery of care and a process to identify areas where no such
22 standards exist, set priorities and a timetable for their development,
23 and ensure a smooth transition to clinical decisionmaking under
24 statewide standards.

25 (p) Implement policies to ensure that all Californians receive
26 culturally and linguistically sensitive care, pursuant to Section
27 140604, and that all disabled Californians receive care in
28 accordance with the federal Americans with Disabilities Act (42
29 U.S.C. Sec. 12101 et seq.) and Section 504 of the Rehabilitation
30 Act of 1973 (29 U.S.C. Sec. 794) and develop mechanisms and
31 incentives to achieve these purposes and a means to monitor the
32 effectiveness of efforts to achieve these purposes.

33 (q) Create a systematic approach to the measurement,
34 management, and accountability for care quality that assures the
35 delivery of high quality care to all California residents, including
36 a system of performance contracts that contain measurable goals
37 and outcomes.

38 (r) Establish and maintain appropriate statewide and regional
39 health care databases.

- 1 (s) Establish standards for mandatory reporting by health care
2 providers and penalties for failure to report.
- 3 (t) Develop methods and a framework to measure the
4 performance of health care coverage and health delivery system
5 upper level managers, including a system of performance contracts
6 that contain measurable goals and outcomes.
- 7 (u) Implement policies to ensure that all residents of this state
8 have access to medically appropriate, coordinated mental health
9 services.
- 10 (v) Ensure the establishment of policies that support the public
11 health.
- 12 (w) Ensure that the system's policies and providers support all
13 Californians in achieving and maintaining maximum physical and
14 mental functionality.
- 15 (x) Institute necessary cost controls pursuant to Section 140203
16 to assure financial solvency of the system.
- 17 (y) Meet regularly with the chief medical officer, the patient
18 advocate for the Office of Patient Advocacy, the Public Advisory
19 Committee, the Director of the Office of Health Planning, the
20 Director of the Payments Board, the Director of the Partnerships
21 for Health, regional planning directors, and regional medical
22 officers to review the impact of the agency and its policies on the
23 health of the population and on satisfaction with the system.
- 24 (z) Negotiate for or set rates, fees, and prices involving any
25 aspect of the system and establish procedures thereto.
- 26 (aa) Establish a formulary based on clinical efficacy for all
27 prescription drugs and durable and nondurable medical equipment
28 for use by the system.
- 29 (bb) Establish guidelines for prescribing medications, nutritional
30 supplements, and durable medical equipment that are not included
31 in the system's formularies.
- 32 (cc) Utilize the purchasing power of the state to negotiate price
33 discounts for prescription drugs and durable and nondurable
34 medical equipment for use by the system.
- 35 (dd) Ensure that use of state purchasing power achieves the
36 lowest possible prices for the system without adversely affecting
37 needed pharmaceutical research.
- 38 (ee) Create incentives and guidelines for research needed to
39 meet the goals of the system and disincentives for research that
40 does not achieve the system goals.

- 1 (ff) Implement eligibility standards for the system, including
2 guidelines to prevent an influx of persons to the state for the
3 purpose of obtaining medical care.
- 4 (gg) Determine an appropriate level of, and provide support
5 during the transition for, training and job placement for persons
6 who are displaced from employment as a result of the initiation of
7 the system.
- 8 (hh) Oversee the establishment of a system for resolution of
9 disputes pursuant to Sections 140608 and 140610.
- 10 (ii) [Reserved.]
- 11 (jj) Investigate the costs and benefits to the health of the
12 population of advances in information technology, including those
13 that support data collection, analysis, and distribution.
- 14 (kk) Ensure that consumers of health care have access to
15 information needed to support their choice of a physician.
- 16 (ll) Collaborate with the boards that license health facilities to
17 ensure that facility performance is monitored and that deficient
18 practices are recognized and corrected in a timely fashion and that
19 consumers and providers of health care have access to information
20 needed to support their choice of facility.
- 21 (mm) Establish an Internet Web site that provides information
22 to the public about the system that includes, but is not limited to,
23 information that supports choice of providers and facilities, informs
24 the public about meetings of state and regional health planning
25 boards and activities of the Partnerships for Health.
- 26 (nn) Procure funds, including loans, for the system, enter into
27 leases, and obtain insurance for the system and its employees and
28 agents.
- 29 (oo) Collaborate with state and local authorities, including
30 regional planning directors, to plan for needed earthquake retrofits
31 in a manner that does not disrupt patient care.
- 32 (pp) Establish a process that is accessible to all Californians for
33 the system to receive the concerns, opinions, ideas, and
34 recommendation of the public regarding all aspects of the system.
- 35 (qq) Annually report to the Legislature and the Governor, on
36 or before October of each year and at other times pursuant to this
37 division, on the performance of the system, its fiscal condition and
38 need for rate adjustments, consumer copayments or consumer
39 deductible payments, recommendations for statutory changes,
40 receipt of payments from the federal government and other sources,

1 whether current year goals and priorities are met, future goals, and
2 priorities, and major new technology or prescription drugs or other
3 circumstances that may affect the cost of health care.

4 140103. (a) The commissioner shall establish a Healthcare
5 Policy Board and shall serve as the president of the board.

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

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

9 (2) Establish the scope of services to be provided to the
10 population in accordance with Chapter 5 (commencing with Section
11 140500).

12 (3) Establish guidelines for evaluating the performance of the
13 system, its officers, health planning regions, and health care
14 providers.

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

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

18 (1) The commissioner.

19 (2) The deputy commissioner.

20 (3) The Director of the Healthcare Fund.

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

22 (5) The chief medical officer.

23 (6) The Director of the Office of Health Planning.

24 (7) The Director of the Partnerships for Health.

25 (8) The Director of the Payments Board.

26 (9) The State Public Health Officer.

27 (10) One member of the Public Advisory Committee who shall
28 serve on a rotating basis to be determined by the Public Advisory
29 Committee.

30 (11) Two representatives from regional planning boards.

31 (A) A regional representative shall serve a term of one year and
32 terms shall be rotated in order to allow every region to be
33 represented within a five-year period.

34 (B) A regional planning director shall appoint the regional
35 representative to serve on the board.

36 (d) It is unlawful for the board members or any of their
37 assistants, clerks, or deputies to use for personal benefit any
38 information that is filed with or obtained by the board and that is
39 not then generally available to the public.

- 1 140104. (a) The commissioner shall establish the Public
2 Advisory Committee to advise the Healthcare Policy Board on all
3 matters of policy for the system.
- 4 (b) Members of the Public Advisory Committee shall include
5 all of the following:
- 6 (1) Four physicians all of whom shall be board certified in their
7 field and at least one of whom shall be a psychiatrist. The Senate
8 Committee on Rules and the Governor shall each appoint one
9 member. The Speaker of the Assembly shall appoint two of these
10 members, both of whom shall be primary care providers.
- 11 (2) One registered nurse, to be appointed by the Senate
12 Committee on Rules.
- 13 (3) One licensed vocational nurse, to be appointed by the Senate
14 Committee on Rules.
- 15 (4) One licensed allied health practitioner, to be appointed by
16 the Speaker of the Assembly.
- 17 (5) One mental health care provider, to be appointed by the
18 Senate Committee on Rules.
- 19 (6) One dentist, to be appointed by the Governor.
- 20 (7) One representative of private hospitals, to be appointed by
21 the Governor.
- 22 (8) One representative of public hospitals, to be appointed by
23 the Governor.
- 24 (9) One representative of an integrated health care delivery
25 system, to be appointed by the Governor.
- 26 (10) Four consumers of health care. The Governor shall appoint
27 two of these members, one of whom shall be a member of the
28 disability community. The Senate Committee on Rules shall
29 appoint a member who is 65 years of age or older. The Speaker
30 of the Assembly shall appoint the fourth member.
- 31 (11) One representative of organized labor, to be appointed by
32 the Speaker of the Assembly.
- 33 (12) One representative of essential community providers, to
34 be appointed by the Senate Committee on Rules.
- 35 (13) One union member, to be appointed by the Senate
36 Committee on Rules.
- 37 (14) One representative of small business, to be appointed by
38 the Governor.
- 39 (15) One representative of large business, to be appointed by
40 the Speaker of the Assembly.

1 (16) One pharmacist, to be appointed by the Speaker of the
2 Assembly.

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

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

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

17 (f) Members of the Public Advisory Committee shall serve
18 without compensation, but shall be reimbursed for actual and
19 necessary expenses incurred in the performance of their duties to
20 the extent that reimbursement for those expenses is not otherwise
21 provided or payable by another public agency or agencies, and
22 shall receive one hundred dollars (\$100) for each full day of
23 attending meetings of the committee. For purposes of this section,
24 “full day of attending a meeting” means presence at, and
25 participation in, not less than 75 percent of the total meeting time
26 of the committee during any particular 24-hour period.

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

33 (h) The Public Advisory Committee shall elect a chair who shall
34 serve for two years and who may be reelected for an additional
35 two years.

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

39 (j) The Public Advisory Committee shall elect a member to
40 serve on the Healthcare Policy Board. The elected member shall

1 serve for one year, and may be recalled by the Public Advisory
2 Committee for cause. In that case, a new member shall be elected
3 to serve on that board. The Public Advisory Committee
4 representative shall represent to the board the views of the
5 committee members.

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

10 140105. (a) (1) There is within the agency an Office of Patient
11 Advocacy to represent the interests of the consumers of health
12 care. The goal of the office shall be to help residents of the state
13 secure the health care services and benefits to which they are
14 entitled under the laws administered by the agency and to advocate
15 on behalf of and represent the interests of consumers in governance
16 bodies created by this division and in other forums.

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

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

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

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

24 (2) Assure that services of the Office of Patient Advocacy are
25 available to all California residents.

26 (3) Serve on the Healthcare Policy Board and participate in the
27 regional Partnerships for Health.

28 (4) Oversee the establishment and maintenance of the grievance
29 process pursuant to Sections 140608 and 140610.

30 (5) Participate in the grievance process and independent medical
31 review system on behalf of consumers pursuant to Section 140610.

32 (6) Receive, evaluate, and respond to consumer complaints
33 about the system.

34 (7) Provide a means to receive recommendations from the public
35 about ways to improve the system and hold public hearings at least
36 once annually to discuss problems and receive recommendations
37 from the public.

38 (8) Develop educational and informational guides for consumers
39 describing their rights and responsibilities and informing them
40 about effective ways to exercise their rights to secure health care

1 services and to participate in the system. The guides shall be easy
2 to read and understand, available in English and other languages,
3 including Braille and formats suitable for those with hearing
4 limitations, and shall be made available to the public by the agency,
5 including access on the agency's Internet Web site and through
6 public outreach and educational programs, and displayed in
7 provider offices and health care facilities.

8 (9) Establish a toll-free telephone number, including a TDD
9 number, to receive complaints regarding the agency and its
10 services. Those with hearing and speech limitations may use the
11 California Relay Service's toll-free telephone numbers to contact
12 the Office of Patient Advocacy. The agency's Internet Web site
13 shall have complaint forms and instructions on their use.

14 (10) Report annually to the public, the commissioner, and the
15 Legislature about the consumer perspective on the performance
16 of the system, including recommendations for needed
17 improvements.

18 (c) Nothing in this division shall prohibit a consumer or class
19 of consumers or the patient advocate from seeking relief through
20 the judicial system.

21 (d) The patient advocate in pursuit of his or her duties shall have
22 unlimited access to all nonconfidential and all nonprivileged
23 documents in the custody and control of the agency.

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

28 140106. (a) There is within the Office of the Attorney General
29 an Office of the Inspector General for the California Healthcare
30 System. The Inspector General shall be appointed by the Governor
31 and subject to Senate confirmation.

32 (b) The Inspector General shall have broad powers to investigate,
33 audit, and review the financial and business records of individuals,
34 public and private agencies and institutions, and private
35 corporations that provide services or products to the system, the
36 costs of which are reimbursed by the system.

37 (c) The Inspector General shall investigate allegations of
38 misconduct on the part of an employee or appointee of the agency
39 and on the part of any health care provider of services that are

1 reimbursed by the system and shall report any findings of
2 misconduct to the Attorney General.

3 (d) The Inspector General shall investigate patterns of medical
4 practice that may indicate fraud and abuse related to over or under
5 utilization or other inappropriate utilization of medical products
6 and services.

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

10 (f) The Inspector General shall conduct additional reviews or
11 investigations of financial and business records when requested
12 by the Governor or by any Member of the Legislature and shall
13 report findings of the review or investigation to the Governor and
14 the Legislature.

15 (g) The Inspector General shall establish a telephone hotline
16 for anonymous reporting of allegations of failure to make health
17 insurance premium payments established by this division. The
18 Inspector General shall investigate information provided to the
19 hotline and shall report any findings of misconduct to the Attorney
20 General.

21 (h) The Inspector General shall annually report
22 recommendations for improvements to the system or the agency
23 to the Governor, the Legislature, and the commissioner.

24 140107. The provisions of the Insurance Frauds Prevention
25 Act (Chapter 12 (commencing with Section 1871) of Part 2 of
26 Division 1 of the Insurance Code), and the provisions of Article
27 6 (commencing with Section 650) of Chapter 1 of Division 2 of
28 the Business and Professions Code shall be applicable to health
29 care providers who receive payments for services through the
30 system under this division.

31 140108. (a) Nothing contained in this division is intended to
32 repeal any legislation or regulation governing the professional
33 conduct of any person licensed by the State of California or any
34 legislation governing the licensure of any facility licensed by the
35 State of California.

36 (b) All federal legislation and regulations governing referral
37 fees and fee-splitting, including, but not limited to, Sections
38 1320a-7b and 1395nn of Title 42 of the United States Code, shall
39 be applicable to all health care providers of services reimbursed

1 under this division, whether or not the health care provider is paid
2 with funds coming from the federal government.

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

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

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

14 (d) The commissioner shall implement means to assist persons
15 who are displaced from employment as a result of the initiation of
16 the system, including determination of the period of time during
17 which assistance shall be provided and possible sources of funds,
18 including funds from the system, to support retraining and job
19 placement. That support shall be provided for a period of five years
20 from the date that this division becomes operative.

21 140111. (a) The commissioner shall appoint a transition
22 advisory group to assist with the transition to the system. The
23 transition advisory group shall include, but not be limited to, the
24 following members:

25 (1) The commissioner.

26 (2) The patient advocate of the Office of Patient Advocacy.

27 (3) The chief medical officer.

28 (4) The Director of the Office of Health Planning.

29 (5) The Director of the Healthcare Fund.

30 (6) The State Public Health Officer.

31 (7) Experts in health care financing and health care
32 administration.

33 (8) Direct care providers.

34 (9) Representatives of retirement boards.

35 (10) Employer and employee representatives.

36 (11) Hospital, integrated health care delivery system, essential
37 community provider, and long-term care facility representatives.

38 (12) Representatives from state departments and regulatory
39 bodies that shall or may relinquish some or all parts of their
40 delivery of health care services to the system.

- 1 (13) Representatives of counties.
- 2 (14) Consumers of health care services.
- 3 (b) The transition advisory group shall advise the commissioner
- 4 on all aspects of the implementation of this division.
- 5 (c) The transition advisory group shall make recommendations
- 6 to the commissioner, the Governor, and the Legislature on how to
- 7 integrate health care delivery services and responsibilities relating
- 8 to the delivery of the services of the following departments and
- 9 agencies into the system:
 - 10 (1) The State Department of Health Care Services.
 - 11 (2) The Department of Managed Health Care.
 - 12 (3) The Department of Aging.
 - 13 (4) The Department of Developmental Services.
 - 14 (5) The Health and Welfare Data Center.
 - 15 (6) The State Department of Mental Health.
 - 16 (7) The State Department of Alcohol and Drug Programs.
 - 17 (8) The Department of Rehabilitation.
 - 18 (9) The Emergency Medical Services Authority.
 - 19 (10) The Managed Risk Medical Insurance Board.
 - 20 (11) The Office of Statewide Health Planning and Development.
 - 21 (12) The Department of Insurance.
 - 22 (13) The State Department of Public Health.
- 23 (d) The transition advisory group shall make recommendations
- 24 to the Governor, the Legislature, and the commissioner regarding
- 25 research needed to support transition to the system.
- 26 140112. (a) The transition advisory group shall make
- 27 recommendations to the commissioner relative to how the system
- 28 shall be regionalized for the purposes of local and
- 29 community-based planning for the delivery of high quality
- 30 cost-effective care and efficient service delivery.
- 31 (b) The commissioner, in consultation with the Director of the
- 32 Office of Health Planning, shall establish up to 10 health planning
- 33 regions composed of geographically contiguous counties grouped
- 34 on the basis of the following considerations:
 - 35 (1) Patterns of utilization of health care services.
 - 36 (2) Health care resources, including workforce resources.
 - 37 (3) Health needs of the population, including public health
 - 38 needs.
 - 39 (4) Geography.
 - 40 (5) Population and demographic characteristics.

1 (6) Other considerations as determined by the commissioner,
2 the Director of the Office of Health Planning, or the chief medical
3 officer.

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

8 (d) Each regional planning director shall appoint a regional
9 medical officer.

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

15 (f) The regional planning director and the regional medical
16 officer shall be subject to Title 9 (commencing with Section 81000)
17 of the Government Code and shall comply with the qualifications
18 for office described in subdivisions (c), (d), and (e) of Section
19 140100 and subdivisions (j) and (k) of Section 140101.

20 140113. (a) Regional planning directors shall administer the
21 health planning region. The regional planning director shall be
22 responsible for all duties, the exercise of all powers and
23 jurisdiction, and the assumptions and discharge of all
24 responsibilities vested by law in the regional agency. The regional
25 planning director shall perform all duties imposed upon him or
26 her by this division and by other laws related to health care, and
27 shall enforce execution of those provisions and laws to promote
28 their underlying aims and purposes.

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

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

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

36 (2) Appoint regional planning board members and serve as
37 president of the board.

38 (3) Identify and prioritize regional health care needs and goals,
39 in collaboration with the regional medical officer, regional health
40 care providers, the regional planning board, and regional director

- 1 of Partnerships for Health pursuant to the priorities and goals of
2 the system established by the commissioner.
- 3 (4) Regularly assess projected revenues and expenditures to
4 ensure fiscal solvency of the regional planning system and advise
5 the commissioner of potential revenue shortfalls and the possible
6 need for cost controls.
- 7 (5) Assure that regional administrative costs meet standards
8 established by the division and seek innovative means to lower
9 the costs of administration of the regional planning office and those
10 of regional providers.
- 11 (6) Plan for the delivery of, and equal access to, high quality
12 and culturally and linguistically sensitive care and such care for
13 disabled persons that meets the needs of all regional residents
14 pursuant to standards established by the commissioner.
- 15 (7) Seek innovative and systemic means to improve care quality
16 and efficiency of care delivery and to achieve access to programs
17 for all state residents.
- 18 (8) Recommend means to and implement policies established
19 by the commissioner to provide support to persons displaced from
20 employment as a result of the initiation of the new system.
- 21 (9) Make needed revenue sharing arrangements so that
22 regionalization does not limit a patient's choice of provider.
- 23 (10) Implement procedures established by the commissioner
24 for the resolution of disputes.
- 25 (11) Implement processes established by the commissioner and
26 recommend needed changes to permit the public to share concerns,
27 provide ideas, opinions, and recommendations regarding all aspects
28 of the system's policies.
- 29 (12) Report regularly to the public and, at intervals determined
30 by the commissioner and pursuant to this division, to the
31 commissioner on the status of the regional planning system,
32 including evaluating access to care, quality of care delivered, and
33 provider performance, and other issues related to regional health
34 care needs, and recommending needed improvements.
- 35 (13) Identify or establish guidelines for providers to identify,
36 maintain, and provide to the regional planning director inventories
37 of regional health care assets.
- 38 (14) Establish and maintain regional health care databases that
39 are coordinated with other regional and statewide databases.

1 (15) In collaboration with the regional medical officer, enforce
2 reporting requirements established by the system and make
3 recommendations to the commissioner, the Director of the Office
4 of Health Planning, and the chief medical officer for needed
5 changes in reporting requirements.

6 (16) Establish and implement a regional capital management
7 plan pursuant to the capital management plan established by the
8 commissioner for the system.

9 (17) Implement standards and formats established by the
10 commissioner for the development and submission of operating
11 and capital budget requests and make recommendations to the
12 commissioner and the Director of the Office of Health Planning
13 for needed changes.

14 (18) Support regional providers in developing operating and
15 capital budget requests.

16 (19) Receive, evaluate, and prioritize provider operating and
17 capital budget requests pursuant to standards and criteria
18 established by the commissioner.

19 (20) Prepare a three-year regional operating and capital budget
20 request that meets the health care needs of the region pursuant to
21 this division, for submission to the commissioner.

22 (21) Establish a comprehensive three-year regional planning
23 budget using funds allocated to the region by the commissioner.

24 140114. The regional medical officers shall do all of the
25 following:

26 (a) Administer all aspects of the regional office of health care
27 quality.

28 (b) Serve as a member of the regional planning board.

29 (c) In collaboration with the commissioner, the chief medical
30 officer, the regional medical officer, regional planning boards, the
31 patient advocate of the Office of Patient Advocacy, regional
32 providers, and patients, oversee the establishment of integrated
33 service networks, including those that provide services through
34 medical technologies such as telemedicine, that include physicians
35 in fee-for-service, solo and group practice, essential community,
36 and ancillary care providers and facilities that pool and align
37 resources and form interdisciplinary teams that share responsibility
38 and accountability for patient care and provide a continuum of
39 coordinated high quality primary to tertiary care to all residents
40 of the region.

- 1 (d) Assure the evaluation and measurement of the quality of
2 care delivered in the region, including assessment of the
3 performance of individual providers, pursuant to standards and
4 methods established by the chief medical officer to ensure a single
5 standard of high quality care is delivered to all state residents.
- 6 (e) In collaboration with the chief medical officer and regional
7 providers, evaluate standards of care in use at the time the system
8 becomes operative.
- 9 (f) Ensure a smooth transition toward use of standards based
10 on clinical efficacy that guide clinical decisionmaking. Identify
11 areas of medical practice where standards have not been established
12 and collaborated with the chief medical officer and health care
13 providers, to establish priorities in developing needed standards.
- 14 (g) Support the development and distribution of user-friendly
15 software for use by providers in order to support the delivery of
16 high quality care.
- 17 (h) Provide feedback to, and support and supervision of, health
18 care providers to ensure the delivery of high quality care pursuant
19 to standards established by the system.
- 20 (i) Collaborate with the regional Partnerships for Health to
21 develop patient education to assist consumers in evaluating and
22 appropriately utilizing health care providers and facilities.
- 23 (j) Collaborate with regional public health officers to establish
24 regional health policies that support the public health.
- 25 (k) Establish a regional program to monitor and decrease
26 medical errors and their causes pursuant to standards and methods
27 established by the chief medical officer.
- 28 (l) Support the development and implementation of innovative
29 means to provide high quality care and assist providers in securing
30 funds for innovative demonstration projects that seek to improve
31 care quality.
- 32 (m) Establish means to assess the impact of the system's policies
33 intended to assure the delivery of high quality care.
- 34 (n) Collaborate with the chief medical officer, the Director of
35 the Office of Health Planning, the regional planning director, and
36 health care providers in the development and maintenance of
37 regional health care databases.
- 38 (o) Ensure the enforcement of, and recommend needed changes
39 in, the system's reporting requirements.
- 40 (p) Support providers in developing regional budget requests.

1 (q) Annually report to the commissioner, the public, the regional
2 planning board, and the chief medical officer on the status of
3 regional health care programs, needed improvements, and plans
4 to implement and evaluate delivery of care improvements.

5 140115. (a) Each region shall have a regional planning board
6 consisting of 13 members who shall be appointed by the regional
7 planning director. Members shall serve eight-year terms that
8 coincide with the term of the regional planning director and may
9 be reappointed for a second term.

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

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

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

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

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

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

24 (4) One expert in health care financing.

25 (5) One expert in health care planning.

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

28 (7) One member who represents ancillary health care workers
29 in the region.

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

31 (9) One member representing essential community providers
32 in the region.

33 (10) One member representing the public.

34 (e) The regional planning director shall serve as chair of the
35 board.

36 (f) The purpose of the regional planning boards is to advise and
37 make recommendations to the regional planning director on all
38 aspects of regional health policy.

39 (g) Meetings of the board shall be open to the public pursuant
40 to the Bagley-Keene Open Meeting Act (Article 9 (commencing

1 with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title
2 2 of the Government Code).

3 140116. The following conflict-of-interest prohibitions shall
4 apply to all appointees of the commissioner or transition advisory
5 group, including, but not limited to, the patient advocate, the
6 Director of the Healthcare Fund, the purchasing director, the
7 Director of the Office of Health Planning, the Director of the
8 Payments Board, the chief medical officer, the Director of the
9 Partnerships for Health, regional planning directors, and the
10 Inspector General:

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

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

20 (c) The appointee shall avoid political activity that may create
21 the appearance of political bias or impropriety. Prohibited activities
22 shall include, but not be limited to, leadership of, or employment
23 by, a political party or a political organization; public endorsement
24 of a political candidate; contribution of more than five hundred
25 dollars (\$500) to any one candidate in a calendar year or a
26 contribution in excess of an aggregate of one thousand dollars
27 (\$1,000) in a calendar year for all political parties or organizations;
28 and attempting to avoid compliance with this prohibition by making
29 contributions through a spouse or other family member.

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

34

35 CHAPTER 3. FUNDING

36

37 Article 1. General Provisions

38

39 140200. (a) In order to support the agency effectively in the
40 administration of this division, there is hereby established in the

1 State Treasury the Healthcare Fund. The fund shall be administered
2 by a director appointed by the commissioner.

3 (b) All moneys collected, received, and transferred pursuant to
4 this division shall be transmitted to the State Treasury to be
5 deposited to the credit of the Healthcare Fund for the purpose of
6 financing the California Healthcare System.

7 (c) Moneys deposited in the Healthcare Fund shall be used
8 exclusively to support this division.

9 (d) All claims for health care services rendered pursuant to the
10 system shall be made to the Healthcare Fund through an electronic
11 claims and payment system. The commissioner shall investigate
12 the costs, benefits, and means of supporting health care providers
13 in obtaining electronic systems for claims and payments
14 transactions; however, alternative provisions shall be made for
15 health care providers without electronic systems.

16 (e) All payments made for health care services shall be disbursed
17 from the Healthcare Fund through an electronic claims and
18 payments system; however, alternative provisions shall be made
19 for health care providers without electronic systems.

20 (f) The director of the fund shall serve on the Healthcare Policy
21 Board.

22 140201. (a) The Director of the Healthcare Fund shall establish
23 the following accounts within the Healthcare Fund:

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

26 (2) A reserve account.

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

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

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

37 (e) Moneys currently held in reserve by state, ~~city, and county~~
38 ~~health programs~~ *health programs, city and county contributions*
39 *as determined by the commissioner pursuant to subdivision (c) of*
40 *Section 140240*, and federal moneys for health care held in reserve

1 in federal trust accounts shall be transferred to the reserve account
2 when the state assumes financial responsibility for health care
3 under this division that is currently provided by those programs.

4 (f) The commissioner may implement arrangements to
5 self-insure the system against unforeseen expenditures or revenue
6 shortfalls not covered by reserves and may borrow funds to cover
7 temporary revenue shortfalls not covered by system reserves,
8 including the issuance of bonds for this purpose, whichever is the
9 more cost effective.

10 (g) Funds held in the reserve account and other Healthcare Fund
11 accounts may be prudently invested to increase their value
12 according to the Department of Insurance’s standards for liquidity
13 and asset management.

14 140203. (a) The Director of the Healthcare Fund shall
15 immediately notify the commissioner when regional or statewide
16 revenue and expenditure trends indicate that expenditures may
17 exceed revenues.

18 (b) If the commissioner determines that statewide revenue trends
19 indicate the need for statewide cost control measures, the
20 commissioner shall convene the Healthcare Policy Board to discuss
21 the need for cost control measures and shall immediately report
22 to the Legislature and the public regarding the possible need for
23 cost control measures.

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

25 (1) Changes in the system or health facility administration that
26 improve efficiency.

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

29 (3) Postponement of introduction of new benefits or benefit
30 improvements.

31 (4) Seeking statutory authority for a temporary decrease in
32 benefits.

33 (5) Postponement of planned capital expenditures.

34 (6) Adjustments of health care provider payments to correct for
35 deficiencies in care quality and failure to meet compensation
36 contract performance goals, pursuant to subdivisions (a) to (f),
37 inclusive, of Section 140106, paragraph (4) of subdivision (a) of
38 Section 140204, subdivision (a) of Section 140213, and
39 subdivisions (c) and (d) of Section 140606.

1 (7) Adjustments to the compensation of managerial employees
2 and upper level managers under contract with the system to correct
3 for deficiencies in management and failure to meet contract
4 performance goals.

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

8 (9) Limitations on aggregate reimbursements to manufacturers
9 of pharmaceutical and durable and nondurable medical equipment.

10 (10) Deferred funding of the reserve account.

11 (11) Imposition of copayments or deductible payments. Any
12 copayment or deductible payments imposed under this section
13 shall be subject to all of the following requirements:

14 (A) No copayment or deductible may be established when
15 prohibited by federal law.

16 (B) All copayments and deductibles shall meet federal guidelines
17 for copayments and deductible payments that may lawfully be
18 imposed on persons with low income.

19 (C) The commissioner shall establish standards and procedures
20 for waiving copayments or deductible payments and a waiver card
21 that shall be issued to a patient or to a family to indicate the waiver.
22 Procedures for copayment waiver may include a determination by
23 a patient's primary care provider that imposition of a copayment
24 would be a financial hardship. Copayment and deductible waivers
25 shall be reviewed annually by the regional planning director.

26 (D) Waivers shall not affect the reimbursement of health care
27 providers.

28 (E) Any copayments or deductible payments established
29 pursuant to this section shall be transmitted to the Treasurer to be
30 deposited to the credit of the Healthcare Fund.

31 (12) Imposition of an eligibility waiting period and other means
32 if the commissioner determines that large numbers of people are
33 emigrating to the state for the purpose of obtaining health care
34 through the system.

35 (d) Nothing in this division shall be construed to diminish the
36 benefits that an individual has under a collective bargaining
37 agreement or statute.

38 (e) Nothing in this division shall preclude employees from
39 receiving benefits available to them under a collective bargaining

1 agreement or other employee-employer agreement or a statute that
2 are superior to benefits under this division.

3 (f) Cost control measures implemented by the commissioner
4 and the Healthcare Policy Board shall remain in place in the state
5 until the commissioner and the Healthcare Policy Board determine
6 that the cause of a revenue shortfall has been corrected.

7 (g) If the Healthcare Policy Board determines that cost control
8 measures described in subdivision (c) will not be sufficient to meet
9 a revenue shortfall, the commissioner shall report to the Legislature
10 and to the public on the causes of the shortfall and the reasons for
11 the failure of cost controls and shall recommend measures to
12 correct the shortfall, including an increase in premium payments
13 to the system.

14 140204. (a) If the commissioner or a regional planning director
15 determines that regional revenue and expenditure trends indicate
16 a need for regional cost control measures, the regional planning
17 director shall convene the regional planning board to discuss the
18 possible need for cost control measures and to make a
19 recommendation about appropriate measures to control costs.
20 These may include any of the following:

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

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

25 (3) Postponement of planned regional capital expenditures.

26 (4) Adjustment of payments to health care providers to reflect
27 deficiencies in care quality and failure to meet compensation
28 contract performance goals and payments to upper level managers
29 to reflect deficiencies in management and failure to meet
30 compensation contract performance goals.

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

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

36 (b) If a regional planning board is convened to implement cost
37 control measures, the commissioner shall participate in the regional
38 planning board meeting.

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

4 (d) Imposition of copayments or deductibles, postponement of
5 new benefits or benefit improvements, deferred funding of the
6 reserve account, establishment of eligibility waiting periods, and
7 increases in premium payments under the system may occur on a
8 statewide basis only and with the concurrence of the commissioner
9 and the Healthcare Policy Board.

10 (e) If a regional planning director and regional planning board
11 are considering imposition of cost control measures, the regional
12 planning director shall immediately report to the residents of the
13 region regarding the possible need for cost control measures.

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

17 140205. (a) If, on June 30 of any year, the Budget Act for the
18 fiscal year beginning on July 1 has not been enacted, all moneys
19 in the reserve account of the Healthcare Fund shall be used to
20 implement this division until funds are available through the
21 Budget Act.

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

27 (1) The Controller shall annually transfer from the General
28 Fund, in the form of one or more loans, an amount to the ~~Universal~~
29 Healthcare Fund for the purpose of making payments to health
30 care providers and to persons and businesses under contract with
31 the system or with health care providers to provide services,
32 medical equipment, and pharmaceuticals to the system.

33 (2) Upon enactment of the Budget Act in any fiscal year to
34 which paragraph (1) applies, the Controller shall transfer all
35 expenditures and unexpected funds loaned to the Healthcare Fund
36 to the appropriate Budget Act item.

37 (3) The amount of any loan made pursuant to paragraph (1) for
38 which moneys were expended from the Healthcare Fund shall be
39 repaid by debiting the appropriate Budget Act item in accordance
40 with procedures prescribed by the Department of Finance.

1 140206. (a) The commissioner annually shall prepare a budget
2 for the system that includes all expenditures, specifies a limit on
3 total annual state expenditures, and establishes allocations for each
4 health care region that shall cover a three-year period and that shall
5 be disbursed on a quarterly basis.

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

15 (c) The commissioner shall adjust the system's budget so that
16 aggregate spending in the state on health care shall not exceed
17 spending under this division by more than 5 percent.

18 (d) The commissioner shall project the system's revenues and
19 expenditures for 3, 6, 9, and 12 years pursuant to parameters
20 prescribed in subdivision (f).

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

- 22 (1) Transition budget.
- 23 (2) Providers and managers budget.
- 24 (3) Capitated operating budgets.
- 25 (4) Noncapitated operating budgets.
- 26 (5) Capital investment budget.
- 27 (6) Purchasing budget, including prescription drugs and durable
28 and nondurable medical equipment pursuant to Section 140220.
- 29 (7) Research and innovation budget pursuant to Section 140221.
- 30 (8) Workforce training and development budget pursuant to
31 Section 140222.
- 32 (9) Reserve account pursuant to Section 140223.
- 33 (10) System administration budget pursuant to Section 140224.
- 34 (11) Regional budgets.

35 (f) In establishing budgets, the commissioner shall make
36 adjustments based on all of the following:

- 37 (1) Costs of transition to the new system.
- 38 (2) Projections regarding the health care services anticipated to
39 be used by California residents.

- 1 (3) Differences in cost of living between the regions, including
- 2 the overhead costs of maintaining medical practices.
- 3 (4) Health risk of enrollees.
- 4 (5) Scope of services provided.
- 5 (6) Innovative programs that improve care quality,
- 6 administrative efficiency, and workplace safety.
- 7 (7) Unrecovered cost of providing care to persons who are not
- 8 enrollees of the system. The commissioner shall seek to recover
- 9 the costs of care provided to persons who are not enrollees of the
- 10 system.
- 11 (8) Costs of workforce training and development.
- 12 (9) Costs of correcting health outcome disparities and the unmet
- 13 needs of previously uninsured and underinsured enrollees.
- 14 (10) Relative usage of different health care providers.
- 15 (11) Needed improvements in access to care.
- 16 (12) Projected savings in administrative costs.
- 17 (13) Projected savings due to provision of primary and
- 18 preventive care to the population, including savings from decreases
- 19 in preventable emergency room visits and hospitalizations.
- 20 (14) Projected savings from improvements in care quality.
- 21 (15) Projected savings from decreases in medical errors.
- 22 (16) Projected savings from systemwide management of capital
- 23 expenditures.
- 24 (17) Cost of incentives and bonuses to support the delivery of
- 25 high quality care, including incentives and bonuses needed to
- 26 recruit and retain an adequate supply of needed providers and
- 27 managers and to attract health care providers to medically
- 28 underserved areas.
- 29 (18) Costs of treating complex illnesses, including disease
- 30 management programs.
- 31 (19) Cost of implementing standards of care, care coordination,
- 32 electronic medical records, and other electronic initiatives.
- 33 (20) Costs of new technology.
- 34 (21) Technology research and development costs and costs
- 35 related to the system's use of new technologies.
- 36 (g) Moneys in the reserve account shall not be considered as
- 37 available revenues for the purposes of preparing the system's
- 38 budget, except when the annual Budget Act has not been enacted
- 39 by June 30 of any fiscal year.

1 140207. The commissioner shall annually establish the total
2 funds to be allocated for provider and manager compensation
3 pursuant to this section. In establishing the provider and manager
4 budgets, the commissioner shall allot sufficient funds to assure
5 that California can attract and retain those providers and managers
6 needed to meet the health care needs of the population. In
7 establishing provider and manager budgets, the commissioner shall
8 allocate funds for both salaries, incentives, bonuses, and benefits
9 to be provided to officers and upper level managers of the system
10 who are exempt from state civil service statutes.

11 140208. (a) The commissioner shall establish the Payments
12 Board and shall appoint a director and members of the board.

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

16 (c) The Payments Board shall be composed of experts in health
17 care finance and insurance systems, a designated representative
18 of the commissioner, a designated representative of the Healthcare
19 Fund, and a representative of the regional planning directors. The
20 position of regional representative shall rotate among the directors
21 of the regional planning boards every two years.

22 (d) The board shall establish and supervise a uniform payments
23 system for health care providers and managers and shall maintain
24 a compensation plan for all of the following health care providers
25 and managers pursuant to the provider and manager budget
26 established by the commissioner:

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

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

33 (3) Health care providers including, but not limited to,
34 physicians, osteopathic physicians, dentists, podiatrists, nurse
35 practitioners, physician assistants, chiropractors, acupuncturists,
36 psychologists, social workers, marriage, family and child
37 counselors, and other professional health care providers who are
38 required by law to be licensed to practice in California and who
39 provide services pursuant to the system.

1 (4) Compensation for employees of the system that was
2 determined through employer-union negotiations before
3 implementation of this division shall be determined by negotiations
4 between the system and the unions after implementation of this
5 division.

6 (5) Health care providers licensed and accredited to provide
7 services in California may choose to be compensated for their
8 services either by the system or by a person to whom they provide
9 services.

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

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

16 (8) Health care providers who accept any payment from the
17 system under this division shall not bill a patient for any covered
18 service, *except as authorized by the commissioner*.

19 (e) Health care providers licensed or accredited to provide
20 services in California, who choose to be compensated by the system
21 instead of by patients to whom they provide services, may choose
22 how they wish to be compensated under this division, as
23 fee-for-service providers or ~~as salaried providers in~~ *providers*
24 *employed by, or under contract with,* health care systems that
25 provide comprehensive, coordinated services.

26 (f) Notwithstanding provisions of the Business and Professions
27 Code, nurse practitioners, physician assistants, and others who
28 under California law must be supervised by a physician and
29 surgeon, an osteopathic physician, a dentist, or a podiatrist, may
30 choose fee-for-service compensation while under lawfully required
31 supervision. However, nothing in this section shall interfere with
32 the right of a supervising health care provider to enter into a
33 contractual arrangement that provides for salaried compensation
34 for employees who must be supervised under the law by a
35 physician and surgeon, an osteopathic physician, a dentist, or a
36 podiatrist.

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

38 (1) Actuarially sound payments that include a just and fair return
39 for health care providers in the fee-for-service sector and for health
40 care providers working in health systems where comprehensive

1 and coordinated services are provided, including the actuarial basis
2 for the payment.

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

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

6 (A) Bonus payments for health care providers and upper level
7 managers who, in providing services and managing facilities,
8 practices, and integrated health systems pursuant to this division,
9 meet performance standards and outcome goals established by the
10 system.

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

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

17 (D) Incentive payments required to recruit and retain nurse
18 practitioners and physician assistants in order to provide primary
19 and preventive care to the population.

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

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

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

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

32 (j) Reimbursement to health care providers and compensation
33 to managers may not exceed the amount allocated by the
34 commissioner to provider and manager annual budgets.

35 140209. (a) Fee-for-service health care providers shall choose
36 representatives of their specialties to negotiate reimbursement rates
37 with the Payments Board on their behalf.

38 (b) The Payments Board shall establish a uniform system of
39 payments for all services provided pursuant to this division.

1 (c) Payment schedules shall be available to health care providers
2 in printed and in electronic documents.

3 (d) Payment schedules shall be in effect for three years, at which
4 time payment schedules may be renegotiated. Payment adjustments
5 may be made at the discretion of the Payments Board to meet the
6 goals of the system.

7 (e) In establishing a uniform system of payments, the Payments
8 Board shall collaborate with regional planning directors and health
9 care providers and shall take into consideration regional differences
10 in the cost of living and the need to recruit and retain skilled health
11 care providers in the region.

12 (f) Fee-for-service health care providers shall submit claims
13 electronically to the Healthcare Fund and shall be paid within 30
14 business days for claims filed in compliance with procedures
15 established by the Healthcare Fund.

16 140210. (a) Compensation for health care providers and upper
17 level managers employed by, or under contract with, integrated
18 health care delivery systems, group medical practices, and essential
19 community providers that provide comprehensive, coordinated
20 services shall be determined according to the following guidelines:

21 (b) Health care providers and upper level managers employed
22 by, or under contract with, systems that provide comprehensive,
23 coordinated health care services shall be represented by their
24 respective employers or contractors for the purposes of negotiating
25 reimbursement with the Payments Board.

26 (c) In negotiating reimbursement with systems providing
27 comprehensive, coordinated services, the Payments Board shall
28 take into consideration the need for comprehensive systems to
29 have flexibility in establishing health care provider and upper level
30 manager reimbursement.

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

34 (e) The Payments Board shall take into consideration regional
35 differences in the cost of living and the need to recruit and retain
36 skilled health care providers and upper level managers to the
37 regions.

38 (f) The Payments Board shall establish a timetable for
39 reimbursement for fee-for-service health care providers
40 negotiations. If an agreement on reimbursement is not reached

1 according to the timetable established by the Payments Board, the
2 Payments Board shall establish reimbursement rates, which shall
3 be binding.

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

6 140211. (a) The Payments Board shall annually report to the
7 commissioner on the status of health care provider and upper level
8 manager reimbursement, including satisfaction with reimbursement
9 levels and the sufficiency of funds allocated by the commissioner
10 for provider and upper level manager reimbursement. The
11 Payments Board shall recommend needed adjustments in the
12 allocation for health care provider payments.

13 (b) The Office of Health Care Quality shall annually report to
14 the commissioner on the impact of the bonus payments in
15 improving quality of care, health outcomes, and management
16 effectiveness. The Payments Board shall recommend needed
17 adjustments in bonus allocations.

18 (c) The Office of Health Planning shall annually report to the
19 commissioner on the impact of the incentive payments in recruiting
20 health care providers and upper level managers to underserved
21 areas, in establishing the needed ratio of generalist to specialist
22 health care providers and in attracting and retaining nurse
23 practitioners and physician assistants to the state and shall
24 recommend needed adjustments.

25 140212. (a) The commissioner shall establish an allocation
26 for each region to fund regional operating and capital budgets for
27 a period of three years. Allocations shall be disbursed to the regions
28 on a quarterly basis.

29 (b) Integrated health care delivery systems, essential community
30 providers, and group medical practices that provide comprehensive,
31 coordinated services may choose to be reimbursed on the basis of
32 a capitated system operating budget or a noncapitated system
33 operating budget that covers all costs of providing health care
34 services.

35 (c) Health care providers choosing to function on the basis of
36 a capitated or a noncapitated system operating budget shall submit
37 three-year operating budget requests to the regional planning
38 director, pursuant to standards and guidelines established by the
39 commissioner.

1 (1) Health care providers may include in their operating budget
2 requests reimbursement for ancillary health care or social services
3 that were previously funded by money now received and disbursed
4 by the Healthcare Fund.

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

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

10 (e) Operating and capitated budgets shall include health care
11 workforce labor costs other than those described in paragraphs
12 (1), (2), and (3) of subdivision (d) of Section 140208. If unions
13 represent employees working in systems functioning under
14 capitated or noncapitated budgets, unions shall represent those
15 employees in negotiations with the regional planning director and
16 the Payments Board for the purpose of establishing their
17 reimbursement.

18 140213. (a) Health systems and medical practices functioning
19 under capitated and noncapitated operating budgets shall
20 immediately report any projected operating deficit to the regional
21 planning director. The regional planning director shall determine
22 whether projected deficits reflect appropriate increases in
23 expenditures, in which case the director shall make an adjustment
24 to the operating budget. If the director determines that deficits are
25 not justifiable, no adjustment shall be made.

26 (b) If a regional planning director determines that adjustments
27 to operating budgets will cause a regional revenue shortfall and
28 that cost control measures may be required, the regional planning
29 director shall report the possible revenue shortfall to the
30 commissioner and take actions required pursuant to Section
31 140203.

32 140215. (a) Margins generated by a facility operating under
33 a system operating budget may be retained and used to meet the
34 health care needs of the population.

35 (b) No margin may be retained if that margin was generated
36 through inappropriate limitations on access to health care or
37 compromises in the quality of care or in any way that adversely
38 affected or is likely to adversely affect the health of the persons
39 receiving services from a facility, integrated health care delivery

1 system, group medical practice, or essential community provider
2 functioning under a system operating budget.

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

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

7 (3) Penalty payments collected pursuant to violations of this
8 section shall be remitted to the Healthcare Fund for use in the
9 California Healthcare System.

10 (c) Facilities operating under system operating budgets of the
11 California Healthcare System may raise and expend funds from
12 sources other than the system including, but not limited to, private
13 or foundation donors for purposes related to the goals of this
14 division and in accordance with provisions of this division.

15 140216. (a) During the transition, the commissioner shall
16 develop a capital management plan that shall include
17 conflict-of-interest standards and that shall govern all capital
18 investments and acquisitions undertaken in the system. The plan
19 shall include a framework, standards, and guidelines for all of the
20 following:

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

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

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

29 (4) Development by the commissioner of a multiyear system
30 capital development plan that supports the system's goals,
31 priorities, and performance standards and meets the health care
32 needs of the population.

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

35 (6) Evaluation of, and support for, noninvestment means to
36 meet health care needs, including, but not limited to, improvements
37 in administrative efficiency, care quality, and innovative service
38 delivery, use, adaptation or refurbishment of existing land and
39 property, and identification of publicly owned land or property

1 that may be available to the system and that may meet a capital
2 need.

3 (7) Development and maintenance of capital inventories on a
4 regional basis, including the condition, utilization capacity,
5 maintenance plan and costs, deferred maintenance of existing
6 capital inventory, and excess capital capacity.

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

16 (9) Standards and a process whereby the regional planning
17 directors shall evaluate, accept, reject, or modify a business plan
18 for a capital investment or acquisition. Decisions of a regional
19 planning director may be appealed through a dispute resolution
20 process established by the commissioner.

21 (10) Standards for binding project contracts between the system
22 and the party developing a capital project or making a capital
23 acquisition that shall govern all terms and conditions of capital
24 investments and acquisitions, including terms and conditions for
25 grants, loans, lines of credit, and lease-purchase arrangements by
26 the system.

27 (11) A process and standards whereby the Director of the
28 Healthcare Fund shall negotiate terms and conditions of the liens,
29 grants, lines of credit, and lease-purchase arrangements for capital
30 investments and acquisitions by the system. Terms and conditions
31 negotiated by the Director of the Healthcare Fund shall be included
32 in project contracts.

33 (12) A plan for the commissioner and for the regional planning
34 directors to issue requests for proposals and to oversee a process
35 of competitive bidding for the development of capital projects that
36 meet the needs of the system and to fund, partially fund, or
37 participate in seeking funding for, those capital projects.

38 (13) Responses to requests for proposals and competitive bids
39 shall include a description of how a project meets the service needs

1 of the region and addresses the environmental impact report and
2 shall include the full life-cycle costs of a capital asset.

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

7 (15) A process and standards for periodic revisions in the capital
8 management plan, including annual meetings in each region to
9 discuss the plan and make recommendations for improvements in
10 the plan.

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

14 (b) No registered lobbyist shall participate in or in any way
15 attempt to influence the request for proposals or competitive bid
16 process.

17 (c) Development of performance standards and a process to
18 monitor and measure performance of those making capital health
19 care investments and acquisitions, including those making capital
20 investments pursuant to a state competitive bidding process.

21 (d) A process for earned autonomy from state capital investment
22 oversight for those who demonstrate the ability to manage capital
23 investment and capital assets effectively in accordance with the
24 system's standards, and standards for loss of earned autonomy
25 when capital management is ineffective.

26 (e) Terms and conditions of capital project oversight by the
27 system shall be based on the performance history of the project
28 developer. Health care providers may earn autonomy from
29 oversight if they demonstrate effective capital planning and project
30 management, pursuant to the goals and guidelines established by
31 the commissioner. Health care providers who do not demonstrate
32 such proficiency shall remain subject to oversight by the regional
33 planning director or shall lose autonomy from oversight.

34 (f) In general, no capital investment may be made from an
35 operating budget. However, guidelines shall be established for the
36 types and levels of small capital investments that may be
37 undertaken from an operating budget without the approval of the
38 regional planning director.

39 (g) Any capital investments required for compliance with
40 federal, state, or local regulatory requirements or quality assurance

1 standards shall be exempt from paragraph (2) of subdivision (c)
2 of Section 140212.

3 140217. (a) Regional planning directors shall develop a
4 regional capital development plan pursuant to the system's capital
5 management plan established by the commissioner. In developing
6 the regional capital development plan, the regional planning
7 director shall do all of the following:

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

10 (2) Develop a multiyear regional capital health management
11 plan that supports regional goals and the state capital management
12 plan.

13 (3) Assist regional health care providers to develop capital
14 budget requests pursuant to the regional capital budget plan and
15 the system's capital management plan established by the
16 commissioner.

17 (4) Receive and evaluate capital budget requests from regional
18 health care providers.

19 (5) Establish ranking criteria to assess competing demands for
20 capital.

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

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

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

30 140218. (a) Assets financed by state grants, loans, lines of
31 credit, and lease-purchase arrangements shall be owned, operated,
32 and maintained by the recipient of the grant, loan, line of credit,
33 or lease-purchase arrangement, according to terms established at
34 the time of issuance of the grant, loan, or line of credit, or
35 lease-purchase arrangement.

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

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

11 140219. The regional planning directors shall make financial
12 information available to the public when the system's contribution
13 to a capital project is greater than twenty-five million dollars
14 (\$25,000,000). Information shall include the purpose of the project
15 or acquisition, its relation to the system's goals, the project budget
16 and the timetable for completion, environmental impact reports,
17 any terms-related conflicts of interest, and performance standards
18 and benchmarks.

19 140220. (a) The commissioner shall establish a budget for the
20 purchase of prescription drugs and durable and nondurable medical
21 equipment for the system.

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

25 (c) The commissioner shall make discounted prices available
26 to all California residents, licensed and accredited providers and
27 facilities under the terms of their licenses and accreditation, health
28 care providers, prescription drug and medical equipment
29 wholesalers, and retailers of products approved for use and included
30 in the benefit package of the system.

31 140221. (a) The commissioner shall establish a budget to
32 support research and innovation that has been recommended by
33 the chief medical officer, the Director of the Office of Health
34 Planning, the patient advocates, the Partnerships for Health, ~~the~~
35 ~~Technology Advisory Committee~~, and others as required by the
36 commissioner.

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

39 140222. (a) The commissioner shall establish a budget to
40 support the training, development, and continuing education of

1 health care providers and the health care workforce needed to meet
2 the health care needs of the population and the goals and standards
3 of the system.

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

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

11 140223. (a) The commissioner shall establish a reserve account
12 pursuant to this section.

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

15 140224. (a) The commissioner shall establish a budget that
16 covers all costs of administering the system.

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

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

23 (d) The commissioner shall ensure that the percentage of the
24 budget allocated to support system administration stays within the
25 allowable limits and shall continually seek means to lower system
26 administrative costs.

27 (e) The commissioner shall report to the public, the regional
28 planning directors, and others attending the annual system revenue
29 and expenditure conference pursuant to Section 140206 on the
30 costs of administering the system and the regions and shall make
31 recommendations for reducing administrative costs and receive
32 recommendations for reducing administrative costs.

33

34 Article 2. California Healthcare Premium Commission

35

36 140230. (a) There is hereby created the California Healthcare
37 Premium Commission, referred to in this division as the Premium
38 Commission.

39 (b) The Premium Commission shall be composed of the
40 following members:

- 1 (1) Three health economists with experience relevant to the
2 functions of the Premium Commission. One shall be appointed by
3 the Speaker of the Assembly, one shall be appointed by the Senate
4 Committee on Rules, and one shall be appointed by the Governor.
5 (2) Two representatives of California's business community,
6 with one representing small business. One shall be appointed by
7 the Governor, and the representative of small business shall be
8 appointed by the Senate Committee on Rules.
9 (3) Two representatives from organized labor. One shall be
10 appointed by the Senate Committee on Rules, and one shall be
11 appointed by the Speaker of the Assembly.
12 (4) Two representatives of nonprofit organizations whose
13 principal purpose includes promoting the establishment of a system
14 of universal health care in California. One shall be appointed by
15 the Senate Committee on Rules and one shall be appointed by the
16 Speaker of the Assembly.
17 (5) One representative of a nonprofit advocacy organization
18 with expertise in taxation policy whose principal purpose includes
19 advocating for sustainable funding for the public infrastructure.
20 This person shall be appointed by the Speaker of the Assembly.
21 (6) Two members of the Legislature who shall be members of
22 a policy committee having jurisdiction over health care issues.
23 One shall be appointed by the Senate Committee on Rules and one
24 shall be appointed by the Speaker of the Assembly.
25 (7) The Executive Officer of the Franchise Tax Board.
26 (8) The Chair of the State Board of Equalization.
27 (9) The Director of the Employment Development Department.
28 (10) The Legislative Analyst.
29 (11) The Secretary of California Health and Human Services.
30 (12) The Director of the Department of Finance.
31 (13) The Controller.
32 (14) The Treasurer.
33 (15) The Lieutenant Governor.
34 (c) Upon appointment, the Premium Commission shall meet at
35 least once a month. The Premium Commission shall elect a chair
36 from its membership during its first meeting. The Premium
37 Commission shall receive public comments during a portion of
38 each of its meetings, and all of its meetings shall be conducted
39 pursuant to the Bagley-Keene Open Meeting Act (Article 9

1 (commencing with Section 11120) of Chapter 1 of Part 1 of
2 Division 3 of Title 2 of the Government Code).

3 140231. (a) The Premium Commission shall perform the
4 following functions:

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

7 (2) Develop an equitable and affordable premium structure that
8 will generate adequate revenue for the Healthcare Fund established
9 pursuant to Section 140200 and ensure stable and actuarially sound
10 funding for the system.

11 (b) The Premium Commission shall perform the functions
12 described in this section by considering existing financial
13 simulations and analyses of universal health care proposals,
14 including, but not limited to, the analysis completed by the Lewin
15 Group in January 2005, of Senate Bill 921 of the 2003–04 Regular
16 Session.

17 140232. (a) The premium structure developed by the Premium
18 Commission shall satisfy the following criteria:

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

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

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

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

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

32 (6) Be consistent with state and federal requirements governing
33 financial contributions for persons eligible for existing public
34 programs.

35 (7) Comply with federal requirements.

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

1 (b) The Premium Commission shall seek expert and legal advice
2 regarding the best method to structure premium payments
3 consistent with existing employer-employee health care financing
4 structures.

5 140233. The Premium Commission may take all of the
6 following actions:

7 (a) Obtain grants from, and contract with, individuals and
8 private, local, state, and federal agencies, organizations, and
9 institutions, including institutions of higher education.

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

12 140234. (a) The Premium Commission may consult with
13 additional persons, advisory entities, governmental agencies,
14 Members of the Legislature, and legislative staff as it deems
15 necessary to perform its functions.

16 (b) The Premium Commission shall seek structured input from
17 representatives of stakeholder organizations, policy institutes, and
18 other persons with expertise in health care, health care financing,
19 or universal health care models in order to ensure that it has the
20 necessary information, expertise, and experience to perform its
21 functions.

22 (c) The Premium Commission shall be supported by a reasonable
23 amount of staff time, which shall be provided by the state agencies
24 with membership on the Premium Commission. The Premium
25 Commission may request data from, and utilize the technical
26 expertise of, other state agencies.

27 140235. (a) On or before January 1, 2010, the Premium
28 Commission shall submit to the Governor and the Legislature a
29 detailed recommendation for a premium structure.

30 (b) The Premium Commission shall submit a draft
31 recommendation to the Governor, Legislature, and the public at
32 least 90 days prior to submission of the final recommendation
33 described in subdivision (a). The Premium Commission shall seek
34 input from the public on the draft recommendation.

35 140236. The Premium Commission shall be funded upon an
36 appropriation by the Legislature in the Budget Act of 2008.

1 Article 3. Governmental Payments

2
3 140240. (a) (1) The commissioner shall seek all necessary
4 waivers, exemptions, agreements, or legislation, so that all current
5 federal payments to the state for health care services be paid
6 directly to the system, which shall then assume responsibility for
7 all benefits and services previously paid for by the federal
8 government with those funds.

9 (2) In obtaining the waivers, exemptions, agreements, or
10 legislation, the commissioner shall seek from the federal
11 government a contribution for health care services in California
12 that shall not decrease in relation to the contribution to other states
13 as a result of the waivers, exemptions, agreements, or legislation.

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

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

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

30 (d) The commissioner shall seek all necessary waivers,
31 exemptions, agreements, or legislation, so that all county or other
32 local government agency payments shall be paid directly to the
33 system.

34 140241. The system's responsibility for providing health care
35 services shall be secondary to existing federal, state, or local
36 governmental programs for health care services to the extent that
37 funding for these programs is not transferred to the Healthcare
38 Fund or that the transfer is delayed beyond the date on which initial
39 benefits are provided under the system.

1 140242. In order to minimize the administrative burden of
 2 maintaining eligibility records for programs transferred to the
 3 system, the commissioner shall strive to reach an agreement with
 4 federal, state, and local governments in which their contributions
 5 to the Healthcare Fund shall be fixed to the rate of change of the
 6 state gross domestic product, the size and age of population, and
 7 the number of residents living below the federal poverty level.

8 140243. If and to the extent that federal law and regulations
 9 allow the transfer of Medi-Cal program funding to the system, the
 10 commissioner shall pay from the Healthcare Fund all premiums,
 11 deductible payments, and coinsurance for qualified Medicare
 12 beneficiaries who are receiving benefits pursuant to Chapter 3
 13 (commencing with Section 12000) of Part 3 of Division 9 of the
 14 Welfare and Institutions Code.

15 140244. If and to the extent that the commissioner obtains
 16 authorization to incorporate Medicare revenues into the Healthcare
 17 Fund, Medicare Part B payments that previously were made by
 18 individuals or the commissioner shall be paid by the system for
 19 all individuals eligible for both the system and the Medicare
 20 Program.

21

Article 4. Federal Preemption

22

23
 24 140300. (a) The commissioner shall pursue all reasonable
 25 means to secure a repeal or a waiver of any provision of federal
 26 law that preempts any provision of this division.

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

32 140301. (a) To the extent permitted by federal law, an
 33 employee entitled to health or related benefits under a contract or
 34 plan that, under federal law, preempts provisions of this division,
 35 shall first seek benefits under that contract or plan before receiving
 36 benefits from the system under this division.

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

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

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

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

10
11 Article 5. Subrogation
12

13 140302. (a) It is the intent of this division to establish a single
14 public payer for all health care services in the State of California.
15 However, until such time as the role of all other payers for health
16 care services has been terminated, costs for health care services
17 shall be collected from collateral sources whenever health care
18 services provided to an individual are, or may be, covered services
19 under a policy of insurance, health care service plan, or other
20 collateral source available to that individual, or for which the
21 individual has a right of action for compensation to the extent
22 permitted by law.

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

25 (1) Insurance policies written by insurers, including the medical
26 components of automobile, homeowners, and other forms of
27 insurance.

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

29 (3) Employers.

30 (4) Employee benefit contracts.

31 (5) Government benefit programs.

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

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

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

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

37 (2) Any governmental unit, agency, or service, to the extent that
38 subrogation is prohibited by law. An entity described in subdivision
39 (b) is not excluded from the obligations imposed by this article by

1 virtue of a contract or relationship with a governmental unit,
2 agency, or service.

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

6 140303. Whenever an individual receives health care services
7 under the system and he or she is entitled to coverage,
8 reimbursement, indemnity, or other compensation from a collateral
9 source, he or she shall notify the health care provider and provide
10 information identifying the collateral source, the nature and extent
11 of coverage or entitlement, and other relevant information. The
12 health care provider shall forward this information to the
13 commissioner. The individual entitled to coverage, reimbursement,
14 indemnity, or other compensation from a collateral source shall
15 provide additional information as requested by the commissioner.

16 140304. (a) The system shall seek reimbursement from the
17 collateral source for services provided to the individual and may
18 institute appropriate action, including suit, to recover the
19 reimbursement. Upon demand, the collateral source shall pay to
20 the Healthcare Fund the sums it would have paid or expended on
21 behalf of the individual for the health care services provided by
22 the system.

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

29 140305. (a) If a collateral source is exempt from subrogation
30 or the obligation to reimburse the system as provided in this article,
31 the commissioner may require that an individual who is entitled
32 to health care services from the source first seek those services
33 from that source before seeking those services from the system.

34 (b) To the extent permitted by federal law, contractual retiree
35 health benefits provided by employers shall be subject to the same
36 subrogation as other contracts, allowing the system to recover the
37 cost of health care services provided to individuals covered by the
38 retiree benefits, unless and until arrangements are made to transfer
39 the revenues of the benefits directly to the system.

1 140306. (a) Default, underpayment, or late payment of any
2 tax or other obligation imposed by this division shall result in the
3 remedies and penalties provided by law, except as provided in this
4 section.

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

9 140307. The agency and the commissioner shall be exempt
10 from the regulatory oversight and review of the Office of
11 Administrative Law pursuant to Chapter 3.5 (commencing with
12 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
13 Code. Actions taken by the agency, including, but not limited to,
14 the negotiating or setting of rates, fees, or prices, and the
15 promulgation of any and all regulations, shall be exempt from any
16 review by the Office of Administrative Law, except for Sections
17 11344.1, 11344.2, 11344.3, and 11344.6 of the Government Code,
18 addressing the publication of regulations.

19 140308. The agency shall adopt regulations to implement the
20 provisions of this division. The regulations may initially be adopted
21 as emergency regulations in accordance with the Administrative
22 Procedure Act (Chapter 3.5 (commencing with Section 11340) of
23 Part 1 of Division 3 of Title 2 of the Government Code), but those
24 emergency regulations shall be in effect only from the effective
25 date of this division until the conclusion of the transition period.

26
27 CHAPTER 4. ELIGIBILITY
28

29 140400. All California residents shall be eligible for the system.
30 Residency shall be based upon physical presence in the state with
31 the intent to reside. The commissioner shall establish standards
32 and a simplified procedure to demonstrate proof of residency.

33 140401. The commissioner shall establish a procedure to enroll
34 eligible residents and provide each eligible individual with
35 identification that can be used by health care providers to determine
36 eligibility for services.

37 140402. (a) It is the intent of the Legislature for the system to
38 provide health care coverage to California residents who are
39 temporarily out of the state. The commissioner shall determine
40 eligibility standards for residents temporarily out of state for longer

1 than 90 days who intend to return and reside in California and for
2 nonresidents temporarily employed in California. The
3 commissioner may establish financial arrangements with medical
4 providers in other states and foreign countries in order to facilitate
5 coverage for California residents who are temporarily out of the
6 state.

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

14 140403. Visitors to California shall be billed for all services
15 received under the system. The commissioner may establish
16 intergovernmental arrangements with other states and countries
17 to provide reciprocal coverage for temporary visitors.

18 140404. All persons eligible for health care benefits from
19 California employers but who are working in another jurisdiction
20 shall be eligible for health care benefits under this division
21 providing that they make payments equivalent to the payments
22 they would be required to make if they were residing in California.

23 140404.1. All persons who under an employer-employee
24 contract or under statute are eligible for retiree health care benefits,
25 including retirees who elect to reside outside of California, shall
26 remain eligible for those benefits in accordance with the contract
27 or the statute.

28 140405. Unmarried, unemancipated minors shall be deemed
29 to have the residency of their parent or guardian. If a minor's
30 parents are deceased and a legal guardian has not been appointed,
31 or if a minor has been emancipated by court order, the minor may
32 establish his or her own residency.

33 140406. (a) An individual shall be presumed to be eligible if
34 he or she arrives at a health facility and is unconscious, comatose,
35 or otherwise unable, because of his or her physical or mental
36 condition, to document eligibility or to act in his or her own behalf,
37 or if the patient is a minor, the patient shall be presumed to be
38 eligible, and the health facility shall provide care as if the patient
39 were eligible.

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

4 (c) Any individual involuntarily committed to an acute
5 psychiatric facility or to a hospital with psychiatric beds pursuant
6 to any provision of Section 5150 of the Welfare and Institutions
7 Code, providing for involuntary commitment, shall be presumed
8 eligible.

9 (d) All health facilities subject to state and federal provisions
10 governing emergency medical treatment shall continue to comply
11 with those provisions.

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

16
17 CHAPTER 5. BENEFITS
18

19 140500. Any eligible individual may choose to receive services
20 under the system from any willing professional health care provider
21 participating in the system. No health care provider may refuse to
22 care for a patient solely on any basis that is specified in the
23 prohibition of employment discrimination contained in the Fair
24 Employment and Housing Act (Part 2.8 (commencing with Section
25 12900) of Division 3 of Title 2 of the Government Code).

26 140500.01. A resident of the state in a family with an annual
27 or monthly net nonexempt household income equal to or less than
28 200 percent of the federal poverty level is eligible for no-cost
29 Medi-Cal and shall be entitled to not less than the full scope of
30 benefits available under the Medi-Cal program, pursuant to Section
31 14021 of, and Article 4 (commencing with Section 14131) of
32 Chapter of Division 9 of, the Welfare and Institutions Code, as
33 provided on January 1, 2008.

34 140501. Covered benefits under this chapter shall include all
35 medical care determined to be medically appropriate by the
36 individual's health care provider, but are subject to limitations set
37 forth in Section 140503. Covered benefits include, but are not
38 limited to, all of the following:

39 (a) Inpatient and outpatient health facility services.

- 1 (b) Inpatient and outpatient professional health care provider
- 2 services by licensed health care professionals.
- 3 (c) Diagnostic imaging, laboratory services, and other diagnostic
- 4 and evaluative services.
- 5 (d) Durable medical equipment, appliances, and assistive
- 6 technology, including prosthetics, eyeglasses, and hearing aids
- 7 and their repair.
- 8 (e) Rehabilitative care.
- 9 (f) Emergency transportation and necessary transportation for
- 10 health care services for disabled and indigent persons.
- 11 (g) Language interpretation and translation for health care
- 12 services, including sign language for those unable to speak, or
- 13 hear, or who are language impaired, and Braille translation or other
- 14 services for those with no or low vision.
- 15 (h) Child and adult immunizations and preventive care.
- 16 (i) Health education.
- 17 (j) Hospice care.
- 18 (k) Home health care.
- 19 (l) Prescription drugs that are listed on the system's formulary.
- 20 Nonformulary prescription drugs may be included if standards and
- 21 criteria established by the commissioner are met.
- 22 (m) Mental and behavioral health care.
- 23 (n) Dental care.
- 24 (o) Podiatric care.
- 25 (p) Chiropractic care.
- 26 (q) Acupuncture.
- 27 (r) Blood and blood products.
- 28 (s) Emergency care services.
- 29 (t) Vision care.
- 30 (u) Adult day care.
- 31 (v) Case management and coordination to ensure services
- 32 necessary to enable a person to remain safely in the least restrictive
- 33 setting.
- 34 (w) Substance abuse treatment.
- 35 (x) Care of up to 100 days in a skilled nursing facility following
- 36 hospitalization.
- 37 (y) Dialysis.
- 38 (z) Benefits offered by a bona fide church, sect, denomination,
- 39 or organization whose principles include healing entirely by prayer
- 40 or spiritual means provided by a duly authorized and accredited

1 practitioner or nurse of that bona fide church, sect, denomination,
2 or organization.

3 (aa) Chronic disease management.

4 (ab) Family planning services and supplies.

5 (ac) For persons under 21 years of age, early and periodic
6 screening, diagnosis, and treatment services, as defined in 42
7 U.S.C. Sec. 1396d(r), whether or not those services are covered
8 benefits for persons who are 21 years of age or older.

9 140502. The commissioner may expand benefits beyond the
10 minimum benefits described in this chapter when expansion meets
11 the intent of this division and when there are sufficient funds to
12 cover the expansion.

13 140503. The following health care services shall be excluded
14 from coverage by the system:

15 (a) Health care services determined to have no medical
16 indication by the commissioner and the chief medical officer.

17 (b) Surgery, dermatology, orthodontia, prescription drugs, and
18 other procedures primarily for cosmetic purposes, unless required
19 to correct a congenital defect, restore or correct a part of the body
20 that has been altered as a result of injury, disease, or surgery, or
21 determined to be medically necessary by a qualified, licensed
22 health care provider in the system.

23 (c) Private rooms in inpatient health facilities where appropriate
24 nonprivate rooms are available, unless determined to be medically
25 necessary by a qualified, licensed health care provider in the
26 system.

27 (d) Services of a health care provider or facility that is not
28 licensed or accredited by the state except for approved services
29 provided to a California resident who is temporarily out of the
30 state.

31 140504. (a) During the initial two years of the system's
32 operation, the commissioner shall not impose a deductible payment
33 or copayment other than for treatment by a specialist if no referral
34 was made by the primary care provider pursuant to Section 140601.
35 The commissioner shall determine the amount of the copayment
36 or deductible imposed pursuant to this subdivision. The
37 commissioner and the Healthcare Policy Board shall review the
38 deductible and copayment provisions annually, commencing in
39 the third year of the system's operation, to determine whether they
40 should be included in the system.

1 (b) Commencing in the third year of the system's operation, the
2 commissioner may impose a deductible payment and copayment
3 pursuant to the determination made under subdivision (a). The
4 amount of the deductible payment and the copayment *combined*
5 shall not exceed two hundred fifty dollars (\$250) per person each
6 year and five hundred dollars (\$500) per family each year, except
7 the deductible payment and copayment for treatment by a specialist
8 without a referral from the primary care provider pursuant to
9 Section 140601 shall not be subject to this limitation and shall be
10 established by the commissioner.

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

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

16 (e) No deductible payments or copayments may be imposed on
17 a person who is eligible for benefits under the Medi-Cal program
18 (Chapter 7 (commencing with Section 14000) of Part 3 of Division
19 9 of the Welfare and Institutions Code), except for treatment by a
20 specialist without a referral from the primary care provider pursuant
21 to Section 140601.

22 (f) The commissioner shall establish standards and procedures
23 for waiving copayments or deductible payments for a person who
24 demonstrates, to the commissioner's satisfaction, that the person
25 lacks the financial means to pay the copayment or deductible.
26 Waivers of copayments or deductible payments shall not affect
27 the reimbursement of health care providers.

28 (g) Any copayments established pursuant to this section and
29 collected by health care providers shall be transmitted to the
30 Treasurer to be deposited to the credit of the ~~Universal~~ Healthcare
31 Fund.

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

35 (i) Nothing in this division shall preclude employees from
36 receiving benefits available to them under a collective bargaining
37 agreement or other employee-employer agreement that are superior
38 to benefits under this division.

CHAPTER 6. DELIVERY OF CARE

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

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

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

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

(e) A health care provider shall not refuse to care for a patient solely on any basis that is specified in the prohibition of employment discrimination contained in the Fair Employment and Housing Act (Part 2.8 (commencing with Section 12900) of Division 3 of Title 2 of the Government Code).

(f) Choice of health care provider:

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

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

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

(2) Persons who choose to enroll with integrated health care delivery systems, group medical practices, or essential community providers that offer comprehensive services, shall retain membership for at least one year after an initial three-month

1 evaluation period during which time they may withdraw for any
2 reason.

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

5 (B) Persons who want to withdraw after the initial three-month
6 period shall request a withdrawal pursuant to dispute resolution
7 procedures established by the commissioner and may request
8 assistance from the patient advocate in the dispute process. The
9 dispute shall be resolved in a timely fashion and shall have no
10 adverse effect on the care a patient receives.

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

14 140601. (a) Primary care providers shall coordinate the care
15 a patient receives or shall ensure that a patient’s care is coordinated.

16 (b) (1) Patients shall have a referral from their primary care
17 provider, or from a health care provider rendering care to them in
18 the emergency room or other accredited emergency setting, or
19 from a health care provider treating a patient for an emergency
20 condition in any setting, or from their obstetrician-gynecologist,
21 to see a physician or nonphysician specialist whose services are
22 covered by this division, unless the patient agrees to assume the
23 costs of care or pay a copayment, if implemented by the
24 commissioner pursuant to Section 140504. A referral shall not be
25 required to see a dentist *or to see an ophthalmologist or optometrist*
26 *for a routine vision examination.*

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

30 (3) Referrals shall not be restricted or provided solely because
31 of financial considerations. The chief medical officer shall monitor
32 referral patterns and intervene as necessary to assure that referrals
33 are neither restricted nor provided solely because of financial
34 considerations.

35 (4) For the first six months of the system’s operation, no
36 specialist referral *or copayment* shall be required for patients who
37 had been receiving care from a specialist prior to the initiation of
38 the system. Beginning with the seventh month of the system’s
39 operation, all patients shall be required to obtain a referral from a
40 primary or emergency care provider for specialty care if the care

1 is to be paid for by the system. No referral is required if a patient
2 pays the full cost of the specialty care and the specialist accepts
3 that payment arrangement.

4 (5) Where referral processes are in place prior to the initiation
5 of the system, the chief medical officer shall review the referral
6 processes to assure that they meet the system's standards for care
7 quality and shall assure needed changes are implemented so that
8 all Californians receive the same standards of care quality and
9 access to specialty care.

10 (6) A specialist may serve as the primary care provider if the
11 patient and the provider agree to this arrangement and if the
12 provider agrees to coordinate the patient's care or to ensure that
13 the care the patient receives is coordinated.

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

18 (8) A patient may appeal the denial of a referral through the
19 dispute resolution procedures established by the commissioner
20 and may request the assistance of the patient advocate during the
21 dispute resolution process.

22 140602. (a) The purpose of the Office of Health Planning is
23 to plan for the short- and long-term health care needs of the
24 population pursuant to the health care and finance standards
25 established by the commissioner and by this division.

26 (b) The office shall be headed by a director appointed by the
27 commissioner. The director shall serve pursuant to provisions of
28 subdivisions (c), (d), and (e) of Section 140100 and subdivisions
29 (j) and (k) of Section 140101.

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

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

32 (2) Serve on the Healthcare Policy Board.

33 (3) Establish performance criteria in measurable terms for health
34 care goals in consultation with the chief medical officer, the
35 regional planning directors, and regional medical officers and
36 others with experience in health care outcomes measurement and
37 evaluation.

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

- 1 (5) Assist the health care regions to develop operating and
2 capital requests pursuant to health care and financial guidelines
3 established by the commissioner and by this division. In assisting
4 regions, the director shall do all of the following:
- 5 (A) Identify medically underserved areas and health care service
6 and asset shortages.
 - 7 (B) Identify disparities in health outcomes.
 - 8 (C) Establish conventions for the definition, collection, storage,
9 analysis, and transmission of data for use by the system.
 - 10 (D) Establish electronic systems that support dissemination of
11 information to health care providers and patients about integrated
12 health network and integrated health care delivery systems and
13 community-based health care resources.
 - 14 (E) Support establishment of comprehensive health care
15 databases using uniform methodology that is compatible among
16 the regions and between the regions and the agency.
 - 17 (F) Provide information to support effective regional planning
18 and innovation.
 - 19 (G) Provide information to support interregional planning,
20 including planning for access to specialized centers that perform
21 a high volume of procedures for conditions requiring highly
22 specialized treatments, including emergency and trauma, and other
23 interregional access to needed care, and planning for coordinated
24 interregional capital investment.
 - 25 (H) Provide information for, and participate in, earthquake
26 retrofit planning.
 - 27 (I) Evaluate regional budget requests and make
28 recommendations to the commissioner about regional revenue
29 allocations.
- 30 (6) Estimate the health care workforce required to meet the
31 health care needs of the population pursuant to the standards and
32 goals established by the commissioner, the costs of providing the
33 needed workforce, and, in collaboration with regional planners,
34 educational institutions, the Governor, and the Legislature, develop
35 short- and long-term plans to meet those needs, including a plan
36 to finance needed training.
- 37 (7) Estimate the number and types of health facilities required
38 to meet the short- and long-term health care needs of the population
39 and the projected costs of needed facilities. In collaboration with
40 the commissioner, regional planning directors and regional medical

1 officers, the chief medical officer, the Governor, and the
2 Legislature, develop plans to finance and build needed facilities.

3 140603. The Technology Advisory Group shall explore the
4 feasibility and the value to the health of the population of the
5 following electronic initiatives:

6 (a) Establish integrated statewide health care databases to
7 support health care planning and determine which databases should
8 be established on a statewide basis and which should be established
9 on a regional basis.

10 (b) Assure that databases have uniform methodology and formats
11 that are compatible among the regions and between the regions
12 and the agency.

13 (c) Establish mandatory database reporting requirements and
14 penalties for noncompliance. Monitor the effectiveness of reporting
15 and make needed improvements.

16 (d) Establish means for anonymous reporting to the chief
17 medical officer and regional medical officers of medical errors
18 and other related problems, and for anonymous reporting to the
19 commissioner and regional planning directors of problems related
20 to ineffective management, and establish guidelines for the
21 protection of persons coming forward to report these problems.

22 (e) In collaboration with the chief medical officer, the Office
23 of Patient Advocacy, and regional patient advocates, investigate
24 the costs and benefits of electronic and online scheduling systems
25 and means of health care provider-patient communication that
26 allow for electronic visits, and make recommendations to the chief
27 medical officer regarding the use of these concepts in the system.

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

32 (g) In collaboration with the chief medical officer, support the
33 development of disease management programs and their use in
34 the system.

35 (h) Establish electronic initiatives that reduce administration
36 costs.

37 (i) Collaborate with the chief medical officer and regional
38 medical officers to assure the development of software systems
39 that link clinical guidelines to individual patient conditions, and

1 guide clinicians through diagnosis and treatment algorithms derived
2 from research based on clinical efficacy and best medical practices.

3 (j) Collaborate with the chief medical officer and regional
4 medical officers to assure the development of software systems
5 that offer health care providers access to guidelines that are
6 appropriate for their specialty and that include current information
7 on prevention and treatment of disease.

8 (k) In collaboration with the Partnerships for Health and regional
9 medical officers, establish Web-based, patient-centered information
10 systems that assist people to promote and maintain health and
11 provide information on health conditions and recent developments
12 in treatment.

13 (l) Establish electronic systems and other means to provide
14 patients with easily understandable information about the
15 performance of health care providers. This shall include, but not
16 be limited to, information about the experience that health care
17 providers have in the field or fields in which they deliver care, the
18 number of years they have practiced in their field and, in the case
19 of medical and surgical procedures, the number of procedures they
20 have performed in their area or areas of specialization.

21 (m) Establish electronic systems that facilitate health care
22 provider continuing medical education that meets licensure
23 requirements.

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

26 140604. (a) The Director of the Office of Health Planning
27 shall establish standards for culturally and linguistically competent
28 care, which shall include, but not be limited to, all of the following:

29 (1) State Department of Health Care Services and the
30 Department of Managed Care guidelines for culturally and
31 linguistically sensitive care.

32 (2) Medi-Cal Managed Care Division (MMCD) Policy Letters
33 99-01 to 99-04 and MMCD All Plan Letter 99005 by the Cultural
34 and Linguistic.

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

37 (4) United States Department of Health and Human Services'
38 Office of Civil Rights; Title VI of the Civil Rights Act of 1964;
39 Policy Guidance on Prohibition Against National Origin

1 Discrimination as It Affects Persons with Limited English
2 Proficiency (February 1, 2002).

3 (5) United States Department of Health and Human Services’
4 Office of Minority Health; National Standards on Culturally and
5 Linguistically Appropriate Services (CLAS) in Health Care—Final
6 Report (December 22, 2000).

7 (b) The director shall annually evaluate the effectiveness of
8 standards for culturally and linguistically competent care and make
9 recommendations to the commissioner, the Office of Patient
10 Advocacy, and the chief medical officer for needed improvements.
11 In evaluating the standards for culturally and linguistically sensitive
12 care, the director shall establish a process to receive concerns and
13 comments from consumers.

14 (c) The director shall pursue available federal financial
15 participation for the provision of a language services program that
16 supports the system’s goals.

17 140605. (a) Within the agency, the commissioner shall
18 establish the Office of Health Care Quality.

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

23 (c) The purpose of the Office of Health Care Quality is the
24 following:

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

29 (2) Promote efficient care delivery.

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

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

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

37 (6) Assist regional planning directors and medical officers in
38 the development and evaluation of regional operating and capital
39 budget requests.

1 140606. (a) In supporting the goals of the Office of Health
2 Care Quality, the chief medical officer shall do all of the following:

3 (1) Administer all aspects of the office.

4 (2) Serve on the Healthcare Policy Board.

5 (3) Collaborate with regional medical officers, regional planning
6 directors, health care providers, consumers, the Director of the
7 Office of Health Planning, the patient advocate of the Office of
8 Patient Advocacy, and directors of Partnerships for Health to
9 develop community-based networks of solo providers, small group
10 practices, essential community providers, and providers of patient
11 care support services in order to offer comprehensive,
12 multidisciplinary, coordinated services to patients.

13 (4) Establish standards of care based on clinical efficacy for the
14 system that shall serve as guidelines to support health care
15 providers in the delivery of high quality care. Standards shall be
16 based on the best evidence available at the time and shall be
17 continually updated. Standards are intended to support the clinical
18 judgment of individual health care providers, not to replace it, and
19 to support clinical decisions based on the needs of individual
20 patients.

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

23 (1) Draw on existing standards established by California health
24 care institutions, on peer-created standards, and on standards
25 developed by others institutions that have had a positive impact
26 on care quality, such as the Centers for Disease Control, the
27 National Quality Forum, and the Agency for Health Care Quality
28 and Research.

29 (2) Collaborate with regional medical officers in establishing
30 regional goals, priorities, and a timetable for implementation of
31 standards of care.

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

35 (4) Collaborate with the Director of the Office of Health
36 Planning and regional medical officers to support the development
37 of computer software systems that link clinical guidelines to
38 individual patient conditions, guide clinicians through diagnosis
39 and treatment algorithms based on research and best medical
40 practices based on clinical efficacy, offer access to guidelines

1 appropriate to each medical specialty and to current information
2 on disease prevention and treatment, and that support continuing
3 medical education.

4 (5) Where referral processes for access to specialty care are in
5 place prior to the initiation of the system, the chief medical officer
6 shall review the referral processes to assure that they meet the
7 system's standards for care quality and shall assure that needed
8 changes are implemented so that all Californians receive the same
9 standards of care quality.

10 (c) In collaboration with the Director of the Office of Health
11 Planning and regional medical officers, the chief medical officer
12 shall implement means to measure and monitor the quality of care
13 delivered in the system. Monitoring systems shall include, but
14 shall not be limited to, peer and patient performance reviews.

15 (d) The chief medical officer shall establish means to support
16 individual health care providers and health systems in correcting
17 quality of care problems, including timeframes for making needed
18 improvements and means to evaluate the effectiveness of
19 interventions.

20 (e) In collaboration with regional medical officers, regional
21 planning directors, and the Director of the Office of Health
22 Planning, the chief medical officer shall establish means to identify
23 medical errors and their causes and develop plans to prevent them.
24 Means shall include a process for anonymous reporting of errors
25 and guidelines to protect those who report the errors against
26 recrimination, including job demotion, promotion discrimination,
27 or job loss.

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

32 (g) The chief medical officer shall recommend to the
33 commissioner a benefits package based on clinical efficacy for the
34 system, including priorities for needed benefit improvements. In
35 making recommendations, the chief medical officer shall do all of
36 the following:

- 37 (1) Identify safe and effective treatments.
- 38 (2) Evaluate and draw on existing benefit packages.
- 39 (3) Receive comments and recommendations from health care
40 providers about benefits that meet the needs of their patients.

- 1 (4) Receive comments and recommendations made directly by
2 patients or indirectly through the Office of Patient Advocacy.
- 3 (5) Identify and recommend to the commissioner and the
4 Healthcare Policy Board innovative approaches to health
5 promotion, disease and injury prevention, education, research, and
6 care delivery for possible inclusion in the benefit package.
- 7 (6) Identify complementary and alternative modalities that have
8 been shown by the National Institutes of Health, Division of
9 Complementary and Alternative Medicine to be safe and effective
10 for possible inclusion as covered benefits.
- 11 (7) Recommend to the commissioner and update as appropriate,
12 pharmaceutical and durable and nondurable medical equipment
13 formularies based on clinical efficacy. In establishing the
14 formularies, the chief medical officer shall establish a Pharmacy
15 and Therapeutics Committee composed of pharmacy and health
16 care providers, representatives of health facilities and organizations
17 having system formularies in place at the time the system is
18 implemented, and other experts that shall do all the following:
- 19 (A) Identify safe and effective pharmaceutical agents for use in
20 the system.
- 21 (B) Draw on existing standards and formularies.
- 22 (C) Identify experimental drugs and drug treatment protocols
23 for possible inclusion in the formulary.
- 24 (D) Review formularies in a timely fashion to ensure that safe
25 and effective drugs are available and that unsafe drugs are removed
26 from use.
- 27 (E) Assure the timely dissemination of information needed to
28 prescribe safely and effectively to all California health care
29 providers and the development and utilization of electronic
30 dispensing systems that decrease pharmaceutical dispensing errors.
- 31 (8) Establish standards and criteria and a process for health care
32 providers to seek authorization for prescribing pharmaceutical
33 agents and durable and nondurable medical equipment that are not
34 included in the system's formulary. No standard or criteria shall
35 impose an undue administrative burden on patients or health care
36 providers, including pharmacies and pharmacists, and none shall
37 delay care a patient needs.
- 38 (9) Develop standards and criteria and a process for health care
39 providers to request authorization for services and treatments,

1 including experimental treatments that are not included in the
2 system's benefit package.

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

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

11 (10) In collaboration with the Director of the Office of Health
12 Planning, regional planning directors and regional medical officers,
13 identify on a regional basis appropriate ratios of general medical
14 providers to specialty medical providers and appropriate ratios of
15 medical providers to patients in order to meet the health care needs
16 of the population and the goals of the system.

17 (11) Recommend to the commissioner and to the Payments
18 Board, financial and nonfinancial incentives and other means to
19 achieve recommended provider ratios.

20 (12) Collaborate with the Director of the Office of Health
21 Planning and regional medical officers and patient advocates in
22 the development of electronic initiatives, pursuant to Section
23 140603.

24 (13) Collaborate with the commissioner, the regional medical
25 officers, and the directors of the Payments Board and the
26 Healthcare Fund to formulate a health care provider reimbursement
27 model that promotes the delivery of coordinated, high quality
28 health care services in all sectors of the system and creates financial
29 and other incentives for the delivery of high quality health care.

30 (14) Establish or assure the establishment of continuing medical
31 education programs about advances in the delivery of high quality
32 health care.

33 (15) Convene an annual statewide quality of care conference to
34 discuss problems with health care quality and to make
35 recommendations for changes needed to improve health care
36 quality. Participants shall include regional medical officers, health
37 care providers, other providers, patients, policy experts, experts
38 in quality of care measurement, and others.

39 (16) Annually report to the commissioner, the Healthcare Policy
40 Board, and the public on the quality of health care delivered in the

1 system, including improvements that have been made and problems
2 that have been identified during the year, goals for care
3 improvement in the coming year, and plans to meet these goals.

4 (h) No person working within the agency or a member of the
5 Pharmacy and Therapeutics Committee or serving as a consultant
6 to the agency or to the Pharmacy and Therapeutics Committee,
7 may receive fees or remuneration of any kind from a
8 pharmaceutical company.

9 140607. (a) The patient advocate of the Office of Patient
10 Advocacy, in collaboration with the chief medical officer, the
11 regional patient advocates, medical officers, and planning directors
12 shall establish a program in the agency and in each region called
13 the Partnerships for Health.

14 (b) The purpose of the Partnerships for Health is to improve
15 health through community health initiatives, to support the
16 development of innovative means to improve health care quality,
17 to promote efficient coordinated care delivery, and to educate the
18 public about the following:

- 19 (1) Personal maintenance of health.
- 20 (2) Prevention of disease.
- 21 (3) Improvement in communication between patients and
22 providers.

23 (4) Improving quality of care.
24 (c) The patient advocate shall work with the community and
25 health care providers in proposing Partnerships for Health projects
26 and in developing project budget requests that shall be included
27 in the regional budget request to the commissioner.

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

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

32 140610. (a) The patient advocate of the Office of Patient
33 Advocacy, in consultation with the chief medical officer, shall
34 establish a grievance system for all grievances involving the delay,
35 denial, or modification of health care services. The patient advocate
36 shall do all of the following with regard to the grievance regarding
37 delay, denial, or modification of health care services:

- 38 (1) Establish and maintain a grievance system approved by the
39 commissioner under which enrollees of the system may submit
40 their grievances to the system. The system shall provide reasonable

1 procedures that shall ensure adequate consideration of enrollee
2 grievances and rectification when appropriate.

3 (2) Inform enrollees upon enrollment in the system and annually
4 hereafter of the procedure for processing and resolving grievances.
5 The information shall include the location and telephone number
6 where grievances may be submitted.

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

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

17 (i) That the grievance has been received.

18 (ii) The date of receipt.

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

21 (B) The patient advocate shall maintain a log of all grievances.
22 The log shall be periodically reviewed by the patient advocate and
23 shall include the following information for each complaint:

24 (i) The date of the call.

25 (ii) The name of the enrollee.

26 (iii) The enrollee's system identification number.

27 (iv) The nature of the grievance.

28 (v) The nature of the resolution.

29 (vi) The name of the system representative who took the call
30 and resolved the grievance.

31 (5) Provide enrollees of the system with written responses to
32 grievances, with a clear and concise explanation of the reasons for
33 the system's response. The system response shall describe the
34 criteria used and the clinical reasons for its decision, including all
35 criteria and clinical reasons related to medical necessity.

36 (6) Keep in its files copies of all grievances, and the responses
37 thereto, for a period of five years.

38 (7) Establish and maintain an Internet Web site that shall provide
39 an online form that enrollees of the system can use to file with a
40 grievance online.

1 (b) In any case determined by the patient advocate to be a case
2 involving an imminent and serious threat to the health of the
3 enrollee, including, but not limited to, severe pain or the potential
4 loss of life, limb, or major bodily function, or in any other case
5 where the patient advocate determines that an earlier review is
6 warranted, an enrollee shall not be required to complete the
7 grievance process.

8 (c) If the enrollee is a minor, or is incompetent or incapacitated,
9 the parent, guardian, conservator, relative, or other designee of the
10 enrollee, as appropriate, may submit the grievance to the patient
11 advocate as a designated agent of the enrollee. Further, a health
12 care provider may join with, or otherwise assist, an enrollee, or
13 the agent, to submit the grievance to the patient advocate. In
14 addition, following submission of the grievance to the patient
15 advocate, the enrollee, or the agent, may authorize the health care
16 provider to assist, including advocating on behalf of the enrollee.
17 For purposes of this section, a “relative” includes the parent,
18 stepparent, spouse, domestic partner, adult son or daughter,
19 grandparent, brother, sister, uncle, or aunt of the enrollee.

20 (d) The patient advocate shall review the written documents
21 submitted with the enrollee’s grievance. The patient advocate may
22 ask for additional information, and may hold an informal meeting
23 with the involved parties, including health care providers who have
24 joined in submitting the grievance or who are otherwise assisting
25 or advocating on behalf of the enrollee. If after reviewing the
26 record, the patient advocate concludes that the grievance, in whole
27 or in part, is eligible for review under the independent medical
28 review system, the patient advocate shall immediately notify the
29 enrollee of that option and shall, if requested orally or in writing,
30 assist the enrollee in participating in the independent medical
31 review system.

32 (e) The patient advocate shall send a written notice of the final
33 disposition of the grievance, and the reasons therefor, to the
34 enrollee, to any health care provider that has joined with or is
35 otherwise assisting the enrollee, and to the commissioner within
36 30 calendar days of receipt of the grievance, unless the patient
37 advocate, in his or her discretion, determines that additional time
38 is reasonably necessary to fully and fairly evaluate the grievance.
39 In any case not eligible for independent medical review, the patient

1 advocate’s written notice shall include, at a minimum, the
2 following:

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

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

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

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

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

17 (h) The grievance or resolution procedures authorized by this
18 section shall be in addition to any other procedures that may be
19 available to any person, and failure to pursue, exhaust, or engage
20 in the procedures described in this section shall not preclude the
21 use of any other remedy provided by law.

22 (i) Nothing in this section shall be construed to allow the
23 submission to the patient advocate of any health care provider
24 grievance under this section. However, as part of a health care
25 provider’s duty to advocate for medically appropriate health care
26 for his or her patients pursuant to Sections 510 and 2056 of the
27 Business and Professions Code, nothing in this subdivision shall
28 be construed to prohibit a health care provider from contacting
29 and informing the patient advocate about any concerns he or she
30 has regarding compliance with or enforcement of this division.

31 140612. (a) The patient advocate shall establish an independent
32 medical review system to act as an independent, external medical
33 review process for the system to provide timely examinations of
34 disputed health care services and coverage decisions regarding
35 experimental and investigational therapies to ensure the system
36 provides efficient, appropriate, high quality health care, and that
37 the system is responsive to enrollee disputes.

38 (b) For the purposes of this section, “disputed health care
39 service” means any health care service eligible for coverage and
40 payment under the system that has been denied, modified, or

1 delayed by a decision of the system, or by one of its contracting
2 health care providers, in whole or in part due to a finding that the
3 service is not medically necessary. A decision regarding a disputed
4 health care service relates to the practice of medicine and is not a
5 coverage decision. If the system, or one of its contracting providers,
6 issues a decision denying, modifying, or delaying health care
7 services, based in whole or in part on a finding that the proposed
8 health care services are not a covered benefit under the system,
9 the statement of decision shall clearly specify the provisions of
10 the system that exclude coverage.

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

16 (d) Coverage decisions regarding experimental or investigational
17 therapies for individual enrollees who meet all of the following
18 criteria are eligible for review by the independent medical review
19 system:

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

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

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

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

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

30 (2) The enrollee’s physician certifies that the enrollee has a
31 condition, as defined in paragraph (1), for which standard therapies
32 have not been effective in improving the condition of the enrollee,
33 for which standard therapies would not be medically appropriate
34 for the enrollee, or for which there is no more beneficial standard
35 therapy covered by the system than the therapy proposed pursuant
36 to paragraph (3).

37 (3) Either (A) the enrollee’s physician, who is under contract
38 with the system, has recommended a drug, device, procedure, or
39 other therapy that the physician certifies in writing is likely to be
40 more beneficial to the enrollee than any available standard

1 therapies, or (B) the enrollee, or the enrollee’s physician who is a
2 licensed, board-certified or board-eligible physician qualified to
3 practice in the area of practice appropriate to treat the enrollee’s
4 condition, has requested a therapy that, based on two documents
5 from the medical and scientific evidence, is likely to be more
6 beneficial for the enrollee than any available standard therapy. The
7 physician certification pursuant to this section shall include a
8 statement of the evidence relied upon by the physician in certifying
9 his or her recommendation. Nothing in this subdivision shall be
10 construed to require the system to pay for the services of a
11 nonparticipating physician provided pursuant to this division, that
12 are not otherwise covered pursuant to the system’s benefits
13 package.

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

17 (5) The specific drug, device, procedure, or other therapy
18 recommended pursuant to paragraph (3) would be a covered
19 service, except for the system’s determination that the therapy is
20 experimental or investigational.

21 (e) (1) All enrollee grievances involving a disputed health care
22 service are eligible for review under the independent medical
23 review system if the requirements of this section are met. If the
24 patient advocate finds that a grievance involving a disputed health
25 care service does not meet the requirements of this section for
26 review under the independent medical review system, the enrollee’s
27 grievance shall be treated as a request for the patient advocate to
28 review the grievance. All other enrollee grievances, including
29 grievances involving coverage decisions, remain eligible for review
30 by the patient advocate.

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

38 (3) The patient advocate shall be the final arbiter when there is
39 a question as to whether an enrollee grievance is a disputed health
40 care service or a coverage decision. The patient advocate shall

1 establish a process to complete an initial screening of an enrollee
2 grievance. If there appears to be any medical appropriateness issue,
3 the grievance shall be resolved pursuant to an independent medical
4 review.

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

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

12 (h) The office of the patient advocate shall prominently display
13 in every relevant informational brochure, on copies of the system's
14 procedures for resolving grievances, on letters of denials issued
15 by either the system or its contracting providers, on the grievance
16 forms, and on all written responses to grievances, information
17 concerning the right of an enrollee to request an independent
18 medical review in cases where the enrollee believes that health
19 care services have been improperly denied, modified, or delayed
20 by the system, or by one of its contracting providers.

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

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

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

28 (C) The enrollee seeks coverage for experimental or
29 investigational therapies.

30 (D) The enrollee, in the absence of a health care provider
31 recommendation under subparagraph (A) or the receipt of urgent
32 care or emergency services by a health care provider under
33 subparagraph (B), has been seen by a system health care provider
34 for the diagnosis or treatment of the medical condition for which
35 the enrollee seeks independent review. The system shall expedite
36 access to a system health care provider upon request of an enrollee.
37 The system health care provider need not recommend the disputed
38 health care service as a condition for the enrollee to be eligible for
39 an independent medical review.

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

5 (3) The enrollee has filed a grievance with the patient advocate
6 and the disputed decision is upheld or the grievance remains
7 unresolved after 30 days. The enrollee shall not be required to
8 participate in the system's grievance process for more than 30
9 days. In the case of a grievance that requires expedited review, the
10 enrollee shall not be required to participate in the system's
11 grievance process for more than three days.

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

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

21 (l) Upon notice from the patient advocate that the enrollee has
22 applied for an independent medical review, the system or its
23 contracting providers shall provide to the independent medical
24 review organization designated by the patient advocate a copy of
25 all of the following documents within three business days of the
26 system's receipt of the patient advocate's notice of a request by
27 an enrollee for an independent medical review:

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

31 (i) The enrollee's medical condition.

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

34 (iii) The disputed health care services requested by the enrollee
35 for the condition.

36 (B) Any newly developed or discovered relevant medical records
37 in the possession of the system or its contracting providers after
38 the initial documents are provided to the independent medical
39 review organization shall be forwarded immediately to the
40 independent medical review organization. The system shall

1 concurrently provide a copy of medical records required by this
2 subparagraph to the enrollee or the enrollee's health care provider,
3 if authorized by the enrollee, unless the offer of medical records
4 is declined or otherwise prohibited by law. The confidentiality of
5 all medical record information shall be maintained pursuant to
6 applicable state and federal laws.

7 (2) A copy of all information provided to the enrollee by the
8 system and any of its contracting providers concerning their
9 decisions regarding the enrollee's condition and care, and a copy
10 of any materials the enrollee or the enrollee's health care provider
11 submitted to the system and to the system's contracting providers
12 in support of the enrollee's request for disputed health care service.
13 This documentation shall include the written response to the
14 enrollee's grievance. The confidentiality of any enrollee medical
15 information shall be maintained pursuant to applicable state and
16 federal laws.

17 (3) A copy of any other relevant documents or information used
18 by the system or its contracting providers in determining whether
19 disputed health care services should have been provided, and any
20 statements by the system and its contracting providers explaining
21 the reasons for the decision to deny, modify, or delay disputed
22 health care services on the basis of medical necessity. The system
23 shall concurrently provide a copy of documents required by this
24 paragraph, except for any information found by the patient advocate
25 to be legally privileged information, to the enrollee and the
26 enrollee's health care provider.

27 The patient advocate and the independent review organization
28 shall maintain the confidentiality of any information found by the
29 patient advocate to be the proprietary information of the system.

30 140614. (a) If there is an imminent and serious threat to the
31 health of the enrollee, all necessary information and documents
32 shall be delivered to an independent medical review organization
33 within 24 hours of approval of the request for review. In reviewing
34 a request for review, the patient advocate may waive the
35 requirement that the enrollee follow the system's grievance process
36 in extraordinary and compelling cases, if the patient advocate finds
37 that the enrollee has acted reasonably.

38 (b) The patient advocate shall expeditiously review requests
39 and immediately notify the enrollee in writing as to whether the
40 request for an independent medical review has been approved, in

1 whole or in part, and, if not approved, the reasons therefor. The
2 system shall promptly issue a notification to the enrollee, after
3 submitting all of the required material to the independent medical
4 review organization that includes an annotated list of documents
5 submitted and offer the enrollee the opportunity to request copies
6 of those documents from the system. The patient advocate shall
7 promptly approve an enrollee's request whenever the system has
8 agreed that the case is eligible for an independent medical review.
9 To the extent an enrollee's request for independent review is not
10 approved by the patient advocate, the enrollee's request shall be
11 treated as an immediate request for the patient advocate to review
12 the grievance.

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

18 (d) The patient advocate shall contract with one or more
19 independent medical review organizations in the state to conduct
20 reviews for purposes of this section. The independent medical
21 review organizations shall be independent of the system. The
22 patient advocate may establish additional requirements, including
23 conflict-of-interest standards, consistent with the purposes of this
24 section that an organization shall be required to meet in order to
25 qualify for participation in the independent medical review system
26 and to assist the patient advocate in carrying out its responsibilities.

27 (e) The independent medical review organizations and the
28 medical professionals retained to conduct reviews shall be deemed
29 to be medical consultants for purposes of Section 43.98 of the Civil
30 Code.

31 (f) The independent medical review organization, any experts
32 it designates to conduct a review, or any officer, patient advocate,
33 or employee of the independent medical review organization shall
34 not have any material professional, familial, or financial affiliation,
35 as determined by the patient advocate, with any of the following:

- 36 (1) The system.
- 37 (2) Any officer or employee of the system.
- 38 (3) A physician, the physician's medical group, or the
39 independent practice association involved in the health care service
40 in dispute.

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

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

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

9 (g) In order to contract with the patient advocate for purposes
10 of this section, an independent medical review organization shall
11 meet all of the requirements pursuant to subdivision (d) of Section
12 1374.32.

13 140616. (a) Upon receipt of information and documents related
14 to a case, the medical professional reviewer or reviewers selected
15 to conduct the review by the independent medical review
16 organization shall promptly review all pertinent medical records
17 of the enrollee, provider reports, as well as any other information
18 submitted to the organization as authorized by the patient advocate
19 or requested from any of the parties to the dispute by the reviewers.
20 If reviewers request information from any of the parties, a copy
21 of the request and the response shall be provided to all of the
22 parties. The reviewer or reviewers shall also review relevant
23 information related to the criteria set forth in subdivision (b).

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

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

30 (2) Nationally recognized professional standards.

31 (3) Expert opinion.

32 (4) Generally accepted standards of medical practice.

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

35 (c) The organization shall complete its review and make its
36 determination in writing, and in layperson's terms to the maximum
37 extent practicable, within 30 days of the receipt of the application
38 for review and supporting documentation, or within less time as
39 prescribed by the patient advocate. If the disputed health care
40 service has not been provided and the enrollee's health care

1 provider or the patient advocate certifies in writing that an
2 imminent and serious threat to the health of the enrollee may exist,
3 including, but not limited to, serious pain, the potential loss of life,
4 limb, or major bodily function, or the immediate and serious
5 deterioration of the health of the enrollee, the analyses and
6 determinations of the reviewers shall be expedited and rendered
7 within three days of the receipt of the information. Subject to the
8 approval of the patient advocate, the deadlines for analyses and
9 determinations involving both regular and expedited reviews may
10 be extended by the patient advocate for up to three days in
11 extraordinary circumstances or for good cause.

12 (d) The medical professionals' analyses and determinations
13 shall state whether the disputed health care service is medically
14 appropriate. Each analysis shall cite the enrollee's medical
15 condition, the relevant documents in the record, and the relevant
16 findings associated with the provisions of subdivision (b) to support
17 the determination. If more than one medical professional reviews
18 the case, the recommendation of the majority shall prevail. If the
19 medical professionals reviewing the case are evenly split as to
20 whether the disputed health care service should be provided, the
21 decision shall be in favor of providing the service.

22 (e) The independent medical review organization shall provide
23 the patient advocate, the system, the enrollee, and the enrollee's
24 health care provider with the analyses and determinations of the
25 medical professionals reviewing the case, and a description of the
26 qualifications of the medical professionals. The independent
27 medical review organization shall keep the names of the reviewers
28 confidential in all communications with entities or individuals
29 outside the independent medical review organization, except in
30 cases where the reviewer is called to testify and in response to
31 court orders. If more than one medical professional reviewed the
32 case and the result was differing determinations, the independent
33 medical review organization shall provide each of the separate
34 reviewer's analyses and determinations.

35 (f) The patient advocate shall immediately adopt the
36 determination of the independent medical review organization and
37 shall promptly issue a written decision to the parties that shall be
38 binding on the system.

39 (g) After removing the names of the parties, including, but not
40 limited to, the enrollee and all medical providers, the patient

1 advocate's decisions adopting a determination of an independent
2 medical review organization shall be made available by the patient
3 advocate to the public upon request, at the patient advocate's cost
4 and after considering applicable laws governing disclosure of
5 public records, confidentiality, and personal privacy.

6 140618. (a) Upon receiving the decision adopted by the patient
7 advocate that a disputed health care service is medically
8 appropriate, the system shall promptly implement the decision. In
9 the case of reimbursement for services already rendered, the health
10 care provider or enrollee, whichever applies, shall be paid within
11 five working days. In the case of services not yet rendered, the
12 system shall authorize the services within five working days of
13 receipt of the written decision from the patient advocate, or sooner
14 if appropriate for the nature of the enrollee's medical condition,
15 and shall inform the enrollee and health care provider of the
16 authorization.

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

19 (c) The patient advocate shall require the system to promptly
20 reimburse the enrollee for any reasonable costs associated with
21 those services when the patient advocate finds that the disputed
22 health care services were a covered benefit and the services are
23 found by the independent medical review organization to have
24 been medically appropriate and the enrollee's decision to secure
25 the services outside of the system was reasonable under the
26 emergency or urgent medical circumstances.

27 140619. (a) The patient advocate shall utilize a competitive
28 bidding process and use any other information on program costs
29 reasonable to establish a per case reimbursement schedule to pay
30 the costs of independent medical review organization reviews,
31 which may vary depending on the type of medical condition under
32 review and on other relevant factors.

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

35 140620. The patient advocate shall, on a biannual basis, report
36 to the chief medical officer on the number, types, and outcomes
37 of all patient grievances relating to the denial, delay, or
38 modification of health care services.

CHAPTER 7. OTHER PROVISIONS

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

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

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.