AMENDED IN SENATE SEPTEMBER 2, 2011

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CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 922

Introduced by Assembly Member Monning

February 18, 2011

An act to amend Section *13975 of the Government Code, and to amend Sections 1341 and* 1368.02 of, and to add Division 115 (commencing with Section 136000) to, the Health and Safety Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 922, as amended, Monning. Office of Patient Advocate.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law creates within the Department of Managed Health Care an Office of Patient Advocate to assist enrollees with regard to health care coverage, which is headed by a patient advocate recommended to the Governor by the Business, Transportation and Housing Agency. The Office of Patient Advocate is responsible for, among other things, developing educational and informational guides for consumers,

compiling an annual publication of a quality of care report card, and rendering advice and assistance to enrollees. The annual budget of the Office of Patient Advocate is separately identified in the annual budget request of the department. The California Health and Human Services Agency consists of, among others, the State Department of Health Care Services, the State Department of Mental Health, the State Department of Public Health, and the State Department of Social Services.

This bill would transfer ~~the Office of Patient Advocate from~~ the Department of Managed Health Care *and, effective July 1, 2012, the Office of Patient Advocate* to the California Health and Human Services Agency. The bill would delete the requirement that the patient advocate be recommended to the Governor by the Business, Transportation and Housing Agency. The bill, effective January 1, 2013, would add additional duties and responsibilities to the existing duties of the Office of Patient Advocate with regard to providing outreach and education about health care coverage to consumers. The bill, effective January 1, 2013, would authorize the office to contract with community organizations, subject to specified requirements, to provide ~~those~~ *certain* services and would also require the office to adopt certain standards and procedures regarding those organizations. The bill, effective January 1, 2013, would require specified state agencies to report to the office regarding consumer complaints submitted to those agencies by individuals with complaints about their health care coverage. The bill would provide that funding for the actual and necessary expenses of the office shall be provided, subject to appropriation by the Legislature, from transfers of moneys from the Managed Care Fund and the Insurance Fund, to be based on the number of covered lives in the state that are covered by plans or insurers, as determined by the Department of Managed Health Care and the Department of Insurance, in proportion to the total number of covered lives in the state. The bill would establish the Office of Patient Advocate Trust Fund for those purposes and would make moneys deposited into that fund available for purposes of administering the program, subject to appropriation by the Legislature. The bill would also authorize the office to apply to the federal government for moneys to fund the office and ~~require~~ *authorize* the office to request from the federal government specified grant moneys.

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

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

SECTION 1. Section 13975 of the Government Code is amended to read:

13975. The Business and Transportation Agency in state government is hereby renamed the Business, Transportation and Housing Agency. The agency consists of the State Department of Alcoholic Beverage Control, the Department of the California Highway Patrol, the Department of Corporations, the Department of Housing and Community Development, the Department of Motor Vehicles, the Department of Real Estate, the Department of Transportation, the Department of Financial Institutions, ~~the Department of Managed Health Care,~~ and the Board of Pilot Commissioners for the Bays of San Francisco, San Pablo, and ~~Suisun; and the~~ *Suisun. The* California Housing Finance Agency is also located within the Business, Transportation and Housing Agency, as specified in Division 31 (commencing with Section 50000) of the Health and Safety Code.

SEC. 2. Section 1341 of the Health and Safety Code is amended to read:

1341. (a) There is in state government, in the ~~Business, Transportation and Housing~~ *California Health and Human Services* Agency, a Department of Managed Health Care that has charge of the execution of the laws of this state relating to health care service plans and the health care service plan business including, but not limited to, those laws directing the department to ensure that health care service plans provide enrollees with access to quality health care services and protect and promote the interests of enrollees.

(b) The chief officer of the Department of Managed Health Care is the Director of the Department of Managed Health Care. The director shall be appointed by the Governor and shall hold office at the pleasure of the Governor. The director shall receive an annual salary as fixed in the Government Code. Within 15 days from the time of the director's appointment, the director shall take and subscribe to the constitutional oath of office and file it in the office of the Secretary of State.

(c) The director shall be responsible for the performance of all duties, the exercise of all powers and jurisdiction, and the assumption and discharge of all responsibilities vested by law in

the department. The director has and may exercise all powers necessary or convenient for the administration and enforcement of, among other laws, the laws described in subdivision (a).

~~SECTION 1.~~

SEC. 3. Section 1368.02 of the Health and Safety Code is amended to read:

1368.02. (a) The director shall establish and maintain a toll-free telephone number for the purpose of receiving complaints regarding health care service plans regulated by the director.

(b) Every health care service plan shall publish the department's toll-free telephone number, the department's TDD line for the hearing and speech impaired, the plan's telephone number, and the department's Internet Web site address, on every plan contract, on every evidence of coverage, on copies of plan grievance procedures, on plan complaint forms, and on all written notices to enrollees required under the grievance process of the plan, including any written communications to an enrollee that offer the enrollee the opportunity to participate in the grievance process of the plan and on all written responses to grievances. The department's telephone number, the department's TDD line, the plan's telephone number, and the department's Internet Web site address shall be displayed by the plan in each of these documents in 12-point boldface type in the following regular type statement:

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan's telephone number) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online."

~~SEC. 2.~~

SEC. 4. Division 115 (commencing with Section 136000) is added to the Health and Safety Code, to read:

DIVISION 115. OFFICE OF PATIENT ADVOCATE

136000. (a) (1) ~~There~~ *Effective July 1, 2012, there* is hereby transferred from the Department of Managed Health Care the Office of Patient Advocate to be established within the California Health and Human Services Agency, to ~~represent the interests of enrollees~~ *provide assistance to, and advocate on behalf of, individuals* served by health care service plans regulated by the Department of Managed Health Care, insureds covered by health insurers regulated by the Department of Insurance, and individuals who receive or are eligible for other health care coverage in California, including coverage available through the Medi-Cal program, the California Health Benefit Exchange, the Healthy Families Program, or any other county or state health care program. The goal of the office shall be to help those ~~enrollees, insureds, and~~ individuals ~~to~~ secure ~~health care coverage~~ *the health care services* to which they are entitled *or for which they are eligible* under the law. Notwithstanding any provision of this division, each regulator and ~~public~~ *health coverage* program shall retain its respective authority, *including its authority* to resolve complaints, grievances, and appeals.

(2) The office shall be headed by a patient advocate appointed by the Governor. The patient advocate shall serve at the pleasure of the Governor.

(3) The provisions of this division affecting insureds covered by health insurers regulated by the Department of Insurance and individuals who receive or are eligible for coverage available through the Medi-Cal program, the California Health Benefit Exchange, the Healthy Families Program, or any other county or state health care program shall commence on January 1, 2013, except that for the period July 1, 2012, to January 1, 2013, the

office shall continue with any duties, responsibilities, or activities of the office authorized as of July 1, 2011, shall continue to be authorized.

(b) (1) The duties of the office shall include, but not be limited to, all of the following:

(A) Developing*, in consultation with the Managed Risk Medical Insurance Board, the State Department of Health Care Services, the California Health Benefit Exchange, the Department of Managed Health Care, and the Department of Insurance,* educational and informational guides for consumers describing their rights and responsibilities, and informing them on effective ways to exercise their rights to secure health care coverage. The guides shall be easy to read and understand and shall be made available in English and other threshold languages, using an appropriate literacy level, and in a culturally competent manner. The informational guides shall be made available to the public by the office, including being made accessible on the office's Internet Web site and through public outreach and educational programs.

(B) Compiling an annual publication, to be made available on the office's Internet Web site, of a quality of care report card, including, but not limited to, health care service plans.

(C) Rendering ~~advice and~~ assistance to consumers regarding *procedures, rights, and responsibilities related to* the filing of complaints, grievances, and appeals, including appeals ~~of denials of care with the health care coverage program denying eligibility, and appeals with the internal appeal or grievance process of the health care service plan, health insurer, group health plan, or other county or state health care program involved, and provide information about any external appeal process.~~ *of coverage denials and information about any external appeal process.*

~~(D) Rendering advice and assistance to consumers with problems related to health care services, including care and service problems and claims or payment problems.~~

~~(E)~~

(D) Making referrals to the appropriate state agency regarding studies, investigations, audits, or enforcement that may be appropriate to protect the interests of consumers.

~~(F)~~

(E) Coordinating and working with other government and nongovernment patient assistance programs and health care ombudsperson programs.

(2) The office shall employ necessary staff. The office may employ or contract with experts when necessary to carry out the functions of the office. The patient advocate shall make an annual budget request for the office which shall be identified in the annual Budget Act.

(3) ~~The~~ *Until January 1, 2013, the* office shall have access to records of the Department of Managed Health Care ~~and the Department of Insurance~~, including, but not limited to, information related to health care service plan or health insurer audits, surveys, and enrollee or insured grievances.

(4) The patient advocate shall annually issue a public report on the activities of the office, and shall appear before the appropriate policy and fiscal committees of the Senate and Assembly, if requested, to report and make recommendations on the activities of the office.

~~(c) Commencing on January 1, 2013, the office shall also~~

(5) The office shall adopt standards for the organizations with which it contracts pursuant to this section to ensure compliance with the privacy and confidentiality laws of this state, including, but not limited to, the Information Practices Act of 1977 (Chapter 1(commencing with Section 1798) of Division 3 of the Civil Code). The office shall conduct privacy trainings as necessary, and regularly verify that the organizations have measures in place to ensure compliance with this provision.

(c) In enacting this act, the Legislature recognizes that, because of the enactment of federal health care reform on March 23, 2010, and the implementation of various provisions by January 1, 2014, it is appropriate to transfer the Office of Patient Advocate and to confer new responsibilities on the Office of Patient Advocate, including assisting consumers in obtaining health care coverage and obtaining health care through health coverage that is regulated by multiple regulators, both state and federal. The new responsibilities include assisting consumers in navigating both public and private health care coverage and assisting consumers in determining which regulator regulates the health care coverage of a particular consumer. In order to assist in implementing federal health care reform in California, commencing January 1, 2013,

the office, in addition to the duties set forth in subdivision (b), shall also do all of the following:

(1) Receive and respond to all inquiries, complaints, and requests for assistance from individuals concerning ~~all~~ health care coverage available in California.

(2) Provide, *and assist in the provision of,* outreach and education about health care coverage options *as set forth in subparagraph (A) of paragraph (1) of subdivision (b),* including, but not limited to:

(A) Information regarding applying for coverage; the cost of coverage; *and* renewal in, and transitions between, health coverage ~~programs; and education about how to navigate the health care arena, including what health care services a plan or insurer offers or provides, how to select a plan or insurer, and how to find a doctor or other health care provider.~~ *programs*.

~~(B) Information and referral for all types of payers, including public programs such as Medi-Cal, Healthy Families, and Medicare; private coverage, including employer-sponsored coverage, self-insured plans, unsubsidized Exchange coverage, and Exchange coverage with tax subsidies or tax credits; and other sources of care, such as county services, community clinics, discounted hospital care, or charity care.~~

~~(3) Educate consumers on their rights and responsibilities with respect to health care coverage.~~

~~(4) Advise and assist consumers with resolving problems with obtaining premium tax credits under Section 36B of the Internal Revenue Code.~~

~~(5) Provide explanations to consumers on resolving problems related to health care services, and, if necessary, provide direct assistance to consumers in filing complaints, grievances, or appeals with the appropriate regulator or public program.~~

~~(6) Advising consumers on problems related to mental health parity and coverage for substance abuse treatment, consistent with existing state and federal law, including assistance in filing complaints, grievances, or appeals with the appropriate regulator or public program.~~

~~(d) Commencing on January 1, 2013, the office may contract with community-based consumer assistance organizations to assist in any or all of the duties of subdivisions (b) and (c) in accordance with Section 19130 of the Government Code.~~

~~(e) (1) Commencing on January 1, 2013, the office shall collect, track, quantify, and analyze problems and inquiries encountered by consumers with respect to health care coverage, including, but not limited to, the complaints reported to the network of health consumer assistance organizations and the agencies under subdivision (m). The office shall publicly report its analysis of these problems and inquiries at least quarterly on its Internet Web site.~~

~~(2) The office shall track, analyze, and publicly report on complaints reported to the office under subdivision (m) according to the nature and resolution of the complaints, including, but not limited to, the age, race, ethnicity, language, geographic region, and gender of the complainants in order to identify the most common types of problems and the problems faced by particular populations, including any health disparity population.~~

~~(3) The office shall track, analyze, and report on those complaints by all of the following:~~

~~(A) Health insurer or health care service plan.~~

~~(B) Age, race, ethnicity, language preference, geographic region, and gender.~~

~~(C) The type of health care coverage program and its respective regulator.~~

~~(D) The timeliness of resolution of complaints.~~

~~(4) In analyzing and reporting complaints, the office shall take into account the number of individuals enrolled by each health insurer or health care service plan and in each health care coverage program.~~

~~(f) Commencing on January 1, 2013, in order to assist consumers in navigating and resolving problems with health care coverage and programs, the office shall do the following:~~

(B) Information and assistance regarding public programs, such as Medi-Cal, Healthy Families, and Medicare; private coverage, including employer-sponsored coverage, Exchange coverage, and other sources of care if the consumer is not eligible for coverage, such as county services, community clinics, discounted hospital care, or charity care.

(3) Coordinate with other state and federal agencies engaged in outreach and education regarding the implementation of federal health care reform.

(4) Render assistance to, and advocate on behalf of, consumers with problems related to health care services, including care and service problems and claims or payment problems.

(5) Refer consumers to the appropriate regulator of their health coverage programs for filing complaints, grievances, or claims, or for payment problems.

(d) (1) Commencing January 1, 2013, the office shall track and analyze data on problems and complaints by, and questions from, consumers about health care coverage for the purpose of providing public information about problems faced and information needed by consumers in obtaining coverage and care. The data collected shall include demographic data, source of coverage, regulator, and resolution of complaints, including timeliness of resolution.

(2) The Department of Managed Health Care, the Department of Health Care Services, the Department of Insurance, the Managed Risk Medical Insurance Board, the California Health Benefit Exchange, and other public coverage programs shall provide to the office data in the aggregate concerning consumer complaints and grievances. For the purpose of publicly reporting information about the problems faced by consumers in obtaining care and coverage, the office shall analyze data on consumer complaints and grievances resolved by these agencies, including demographic data, source of coverage, insurer or plan, resolution of complaints and other information intended to improve health care and coverage for consumers. The office shall develop and provide comprehensive and timely data and analysis based on the information provided by other agencies.

(3) The office shall collect and report data to the United States Secretary of Health and Human Services on complaints and consumer assistance as required to comply with requirements of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(e) Commencing in January 1, 2013, in order to assist consumers in understanding the impact of federal health care reform as well as navigating and resolving questions and problems with health care coverage and programs, the office shall ensure that either the office or a state agency contracting with the office shall do the following:

(1) Operate a ~~HealthHelp~~ toll-free telephone hotline number that can route callers to the proper regulating body or public

program for their question, their health plan, or the consumer assistance program in their area ~~and provide interpreters for limited-English-proficient callers~~.

(2) Operate a ~~HealthHelp~~ Internet Web site, other social media, and up-to-date communication systems to give information regarding the consumer assistance programs.

~~(g) Commencing on January 1, 2013, the office and any~~

(f) (1) The office may contract with community-based consumer assistance organizations to assist in any or all of the duties of subdivision (c) in accordance with Section 19130 of the Government Code or provide grants to community-based consumer assistance organizations for portions of these purposes.

(2) Commencing on January 1, 2013, any local community-based nonprofit consumer assistance ~~programs~~ *program* with which the office contracts shall include in ~~their mission~~ *its mission the* assistance of, and duty to, health care consumers. Contracting consumer assistance programs shall have experience in the following areas:

~~(1)~~

(A) Assisting consumers in navigating the local health care system.

~~(2)~~

(B) Advising consumers regarding their health care coverage options and helping consumers enroll in and retain health care coverage.

~~(3)~~

(C) Assisting consumers with problems in accessing health care services.

~~(4)~~

(D) Serving consumers with special needs, including, but not limited to, consumers with limited-English language proficiency, consumers requiring culturally competent services, low-income consumers, consumers with disabilities, consumers with low literacy rates, and consumers with multiple health conditions, including behavioral health.

~~(5) Collecting and reporting data on the categories of populations listed in subdivision (e), including subgroup categories of race, ethnicity, language preference, gender, and types of health care coverage problems consumers face.~~

~~(h) Commencing on January 1, 2013, the office shall collect and report data to the United States Secretary of Health and Human Services on the categories of populations listed in subdivision (e), including subgroup categories of race, and types of problems and inquiries encountered by consumers.~~

(E) Collecting and reporting data, including demographic data, source of coverage, regulator, and resolution of complaints, including timeliness of resolution.

~~(i)~~

(3) Commencing on January 1, 2013, the office shall develop protocols, procedures, and training modules for organizations with ~~which it contracts. The office shall implement and oversee a training program with continuing education components for organizations with which it contracts.~~ *which it contracts.*

~~(j)~~

(4) Commencing on January 1, 2013, the office shall adopt standards for organizations with which it contracts regarding confidentiality and conduct. ~~The office shall have the power to revoke the contract of any organization that violates these standards and shall include a clause reserving that power in every contract entered into with such an organization.~~

~~(k)~~

(5) Commencing on January 1, 2013, the office may contract with consumer assistance programs to develop a series of appropriate literacy level and culturally and linguistically appropriate educational materials in all threshold languages for consumers regarding health care coverage options and how to resolve problems. ~~These materials shall be made available to all consumer assistance programs and on the Internet Web site of the office.~~

~~(l)~~

(g) (1) Commencing on January 1, 2013, the office shall develop protocols and procedures for *assisting in* the resolution of consumer complaints ~~and the establishment of responsibility or referral, as appropriate, with regard to the following agencies:~~

~~(A) The federal Department of Labor regarding employee welfare benefit plans regulated under ERISA.~~

~~(B) The Health Insurance Counseling and Advocacy Program as provided in Section 9541 of the Welfare and Institutions Code~~

~~and, as appropriate, the federal Centers for Medicare and Medicaid Services regarding the Medicare Program.~~

~~(C) The Department of Managed Health Care regarding coverage under health care service plans regulated under Chapter 2.2 (commencing with Section 1340) of Division 2.~~

~~(D) The Department of Insurance regarding policies of health insurance regulated under the Insurance Code.~~

~~(E) The State Department of Health Care Services regarding the Medi-Cal program.~~

~~(F) The Managed Risk Medical Insurance Board regarding the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code), and the Federal Temporary High Risk Pool (Part 6.6 (commencing with Section 12739.5) of Division 2 of the Insurance Code).~~

~~(G) The Exchange regarding coverage through the Exchange.~~

~~(2) The protocols and procedures shall include all of the following:~~

~~(A) A procedure for the referral of complaints and grievances to the appropriate regulator or public program for resolution by the relevant regulator or public program.~~

~~(B) A process for reporting to the appropriate regulator and public program those complaints and grievances that were received and resolved without filing a complaint or grievance with the regulator or public program.~~

~~(m) Commencing on January 1, 2013, the Department of Managed Health Care, the Department of Insurance, the State Department of Health Care Services, the Managed Risk Medical Insurance Board, and the Exchange shall report only data and other information in its possession to the office regarding consumer complaints submitted to those agencies, including, but not limited to, the nature of the complaints, the resolution of the complaints, the timeliness of the resolution, and the age, race, ethnicity, language, geographic region, and gender of the complainants, in a format and manner to be specified by the office. This information shall be reported according to the particular health insurer or health care service plan involved. This information shall also be reported~~

~~according to the source of coverage, including employer-based coverage, individual coverage, or specific public program coverage, including Medicare, Medi-Cal, the Exchange, or other publicly funded coverage.~~*, including both of the following:*

(1) A procedure for referral of complaints and grievances to the appropriate regulator or health coverage program for resolution by the relevant regulator or public program.

(2) A protocol or procedure for reporting to the appropriate regulator and health coverage program regarding complaints and grievances relevant to that agency that the office received and was able to resolve without further action or referral.

~~(n)~~

(h) For purposes of this section, the following definitions shall apply:

(1) "Consumer" or "individual" includes the individual or his or her parent, guardian, conservator, or authorized representative.

(2) "Exchange" means the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code.

~~(3) "Group health plan" has the same meaning as set forth in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91).~~

~~(4)~~

(3) "Health care" includes behavioral health, including both mental health and substance abuse treatment.

~~(5)~~

(4) "Health care service plan" has the same meaning as that set forth in subdivision (f) of Section 1345. Health care service plan includes "specialized health care service plans," including behavioral health plans.

(5) "Health coverage program" includes the Medi-Cal Program, Healthy Families Program, tax subsidies and premium credits under the Exchange, the Basic Health Program, if enacted, county health coverage programs, and the Access for Infants and Mothers Program.

(6) "Health insurance" has the same meaning as set forth in Section 106 of the Insurance Code.

(7) "Health insurer" means an insurer that issues policies of health insurance.

(8) "Office" means the Office of Patient Advocate.

(9) "Threshold languages" shall ~~mean Medi-Cal threshold languages~~ *have the same meaning as for Medi-Cal managed care*.

136020. (a) ~~The~~ *Effective July 1, 2012, the* Office of Patient Advocate Trust Fund is hereby created in the State Treasury, and, upon appropriation by the Legislature, moneys in the fund shall be made available for the purpose of this division. Any moneys in the fund that are unexpended or unencumbered at the end of the fiscal year may be carried forward to the next succeeding fiscal year.

(b) The office shall establish and maintain a prudent reserve in the fund.

(c) Notwithstanding Section 16305.7 of the Government Code, all interest earned on moneys that have been deposited in the fund shall be retained in the fund and used for purposes consistent with this division.

136030. (a) ~~In~~ *Effective July 1, 2012, in* addition to the moneys received pursuant to subdivision (d), funding for the actual and necessary expenses of the office in implementing this division shall be provided, subject to appropriation by the Legislature, from transfers of moneys from the Managed Care Fund and the Insurance Fund.

(b) The share of funding from the Managed Care Fund shall be based on the number of covered lives in the state that are covered under plans regulated by the Department of Managed Health Care, including covered lives under Medi-Cal managed care and the Healthy Families Program, as determined by the Department of Managed Health Care, in proportion to the total number of all covered lives in the state.

(c) The share of funding to be provided from the Insurance Fund shall be based on the number of covered lives in the state that are covered under health insurance policies and benefit plans regulated by the Department of Insurance, including covered lives under Medicare supplement plans, as determined by the Department of Insurance, in proportion to the total number of all covered lives in the state. *For the 2012–13 budget year, the apportionment shall be effective for the period from January 1, 2013, to July 1, 2013, consistent with paragraph (1) of subdivision (a) of Section 136000.*

(d) In addition to moneys received pursuant to subdivision (a), the office may receive funding as follows:

(1) The office may apply to the United States Secretary of Health and Human Services for federal grants.

(2) The office ~~shall~~ *may* apply to the United States Secretary of Health and Human Services for a grant under Section 2793 of the federal Public Health Service Act, as added by Section 1002 of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(3) To the extent permitted by federal law, the office may seek federal financial participation for assisting beneficiaries of the Medi-Cal program.

(e) All moneys received by the Office of Patient Advocate shall be deposited into the fund specified in Section 136020.

CORRECTIONS:

Text—Pages 7, 10, 14, and 15.

O